NATIONAL HOUSING FEDERATION

Housing for health: worlds aligned

A tool for local influencing

business for neighbourhoods

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Foreword

This National Housing Federation report provides everyone interested in housing and housing related support with the information they need to understand patterns in health commissioning practice, and how these can relate to housing. More than ever before, we can expect that the setting of priorities and outcomes will be undertaken at a local level. There is, therefore, a major role for local organisations in influencing local health dynamics, including the way in which services are commissioned.

Evidence shows that housing tackles inequalities, advances good health, and prevents the need for acute health interventions, all of which will remain priorities for the health service in the new world. Housing related support also delivers considerable cost benefits to the health service – around £315 million in a year.

The Federation remains deeply concerned at the uncertain future facing the funding and contracting environment for housing related support. Without the support service they rely on, vulnerable people across England could be left to fend for themselves. We must acknowledge that pressure on the health service is likely to increase if there is less support available to prevent the need for hospital admissions and facilitate faster hospital discharge, for example.

Some health bodies are already realising the benefits of working collaboratively with other sectors, by commissioning and supporting housing and related services. We see examples of Primary Care Trusts (PCTs) co-funding health equality workers, independent living projects for older people, hospital discharge schemes and much more. But here we show that too many health commissioners are missing opportunities to meet their objectives by opening up to working with voluntary and community organisations.

This resource can and should be used as a local influencing tool to make sure that vulnerable people continue to be supported in the future. It is up to us as a sector to make the case for health sector backing for the care and support services that older and vulnerable people rely on.

With the health service undergoing a major period of reform, the Federation's sister publication *Health and housing: worlds apart?* helps the housing care and support world to understand this shifting environment. We deliver real solutions to health challenges, and in doing so, we save the health service money. As the dust settles on health service reform, the housing sector must be ready to work across traditional sector boundaries and play our role in shaping the new health world.

David Orr

Chief executive
National Housing Federation

1: Introduction

It is a critical time in the development of health policy. Andrew Lansley MP, the Secretary of State for Health, has set out ambitious and far-reaching plans to reform and restructure the health service, which will see the entire health service in a period of significant change. The Government White Paper, *Equity and excellence: Liberating the NHS,* published in July 2010, lays out one of the most significant reorganisations of the NHS since its establishment over sixty years ago. Although these changes will be far reaching, the Government is committed to ensuring that access to NHS services will remain *'free at the point of use and based on clinical need, not the ability to pay'*[1] and will be funded through general taxation.

Fundamental changes to the way that health services are commissioned and provided, against the background of a period of financial austerity, mean that understanding the health landscape and how to engage with the new order will be crucial for those organisations wishing to bid for funding or to provide services in the new health system. How the health service and other stakeholders are able to adapt to this changing environment will shape the way that they work with each other going forward. This will be the case especially for the housing, health and social care interface.

In order to build the case for health investment in housing, it will be increasingly important for housing associations to use local data about the performance of health commissioners, and NHS and local authority priorities to tailor services to resonate with budget holders and funders. This report is designed to give members of the National Housing Federation and other providers of housing and housing related support, an insight into the changing landscape of health policy and the new points of engagement which will be important going forward. It also begins to bring together the disparate sources of information which housing associations can use to build a picture of health services in their locality and in England as a whole.

This report should be read alongside its sister publication, *Health and housing: worlds apart?*, which describes the health policy environment for housing associations, with practical examples of how some are already working effectively with the health service. This report develops the themes established in *Health and housing: worlds apart?* and focuses on sources of publically available data to provide insights around local prioritisation and action. This report is a useful resource for all those who wish to improve health outcomes through housing solutions, including representatives of people with long term conditions, local authorities, health care commissioners and housing associations.

1. Department of Health, *Equity and excellence: Liberating the NHS,* July 2010

2: Opportunities for housing

This report outlines several opportunities for providers of housing and related care and support, to help them to ensure that housing plays an active role in improving the health of vulnerable people. These opportunities are summarised below.

1. NHS commissioning structures will remain in their current form for the immediate future. This provides continuing opportunity for housing associations to engage with local health commissioners. However, housing associations could begin to engage with new commissioning structures and groups as they emerge in what is a fast-reforming environment.
2. There is an opportunity for housing associations to capitalise on the 'any willing provider' policy. They may wish to advance their dialogue with NHS and public health commissioners about how housing can support the delivery of improved health outcomes. This might include inviting health commissioners to visit a local housing related support service, or offering a full evaluation of the cost benefits associated with particular schemes.
3. The multiplicity of commissioners for different types of health interventions will mean that housing associations should consider how to engage with commissioners across the different structures in health, public health and social care. Housing associations may wish to work collaboratively with each other to maximise this engagement.
4. The transfer of public health to local authorities presents an opportunity for housing associations to build on existing relationships to make the case for investment in housing services to improve public health outcomes.
5. Housing associations will need to continue to work both with the NHS and with social care to ensure social housing adequately reflects the health needs of their local population. In many areas this is already taking place to good effect – such as mental health, early discharge from hospital and maintaining independence for people with long term conditions. There is an opportunity for housing associations to restate the case that provision of housing can help to tackle local problems and reduce the burden on the health service.
6. Housing associations can engage with Health and Wellbeing Boards as these emerge, and can help to ensure housing needs are reflected in the Joint Strategic Needs Assessment (JSNA). Specifically, local partners should consider how existing housing and neighbourhood data can help support this process, and should look to align the JSNA with assessment of local housing needs.
7. Although evidence exists to support the cost-effectiveness of housing interventions, there is a role for housing associations in continuing to collect and evaluate data to further demonstrate health outcomes and cost benefits of their services.
8. Housing associations can play a role in the new health world by working with commissioners of health and social care services to demonstrate the financial benefits of increased co-operation and partnership working.
9. NICE quality standards present an opportunity to ensure that the value of housing is reflected across a range of areas, such as mental health, and long term conditions. It will be important that providers of housing services demonstrate their role in delivering these standards.
10. There is a role for housing related support in helping prevent avoidable re-admissions to hospital. Health commissioners will need evidence of this from housing associations and others in order to reflect this role in their local priority setting.
11. Housing associations can use the data in the annexes to this report to gain an insight into commissioning performance and local priorities in their area, and to influence this practice going forward.

3: Reform of the health care system

The NHS White Paper, published in July 2010, represented perhaps the most significant change in the way the NHS works since it was first created in 1948. Understanding the system and the effect it will have on local health providers and commissioners will be essential to engagement with these local NHS and public health organisations. This section considers the changing environment, and the opportunities that this environment will present for housing associations interested in forging closer relationships with the NHS.

Systems and structures

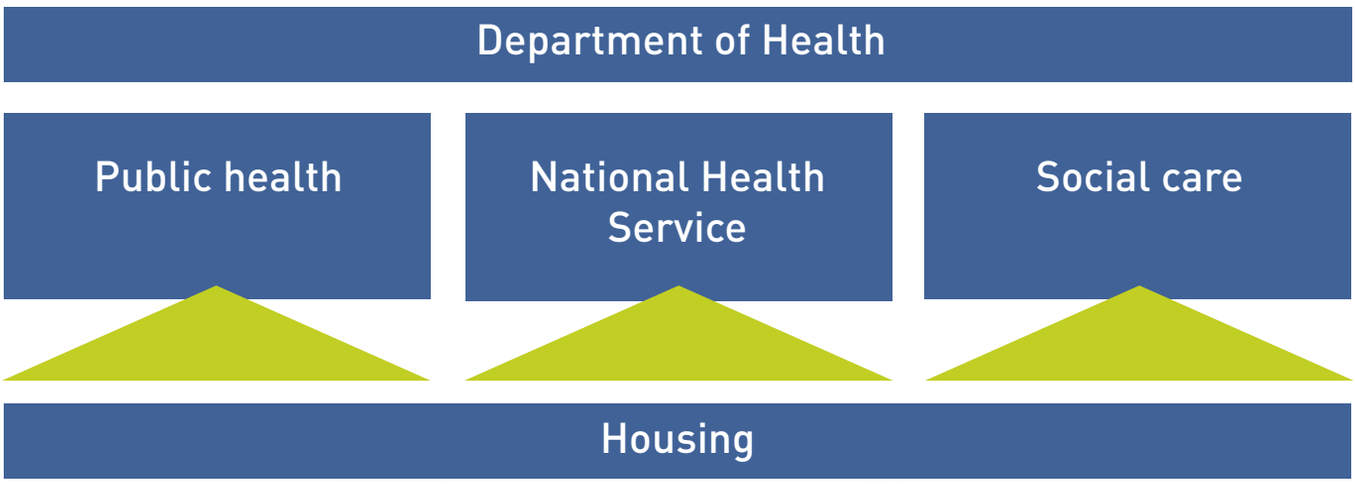
Equity and excellence: liberating the NHS sets out fundamental changes to the systems and structures upon which the health service is currently based. These changes will see competition introduced into the system, leading to two currencies becoming increasingly important: quality and cash.

It is anticipated that in the new world, the Department of Health oversees three distinctive services: a public health service, the National Health Service and a social care service (see Figure 1 below).

Housing is an issue which sits firmly across all three of these services and will, therefore, present a number of important touch points. For example, housing associations may have a role to play in helping the NHS to discharge patients back into the community, assisting local authorities in delivering public health interventions by providing high quality housing stock, and supporting social care through both residential and floating support.

It will be imperative that housing associations have an understanding of how the different levers and channels for engagement have changed as a result of the new structures and the opportunities that this presents.

Figure 1: New health system architecture and touch points for housing



Commissioning structures

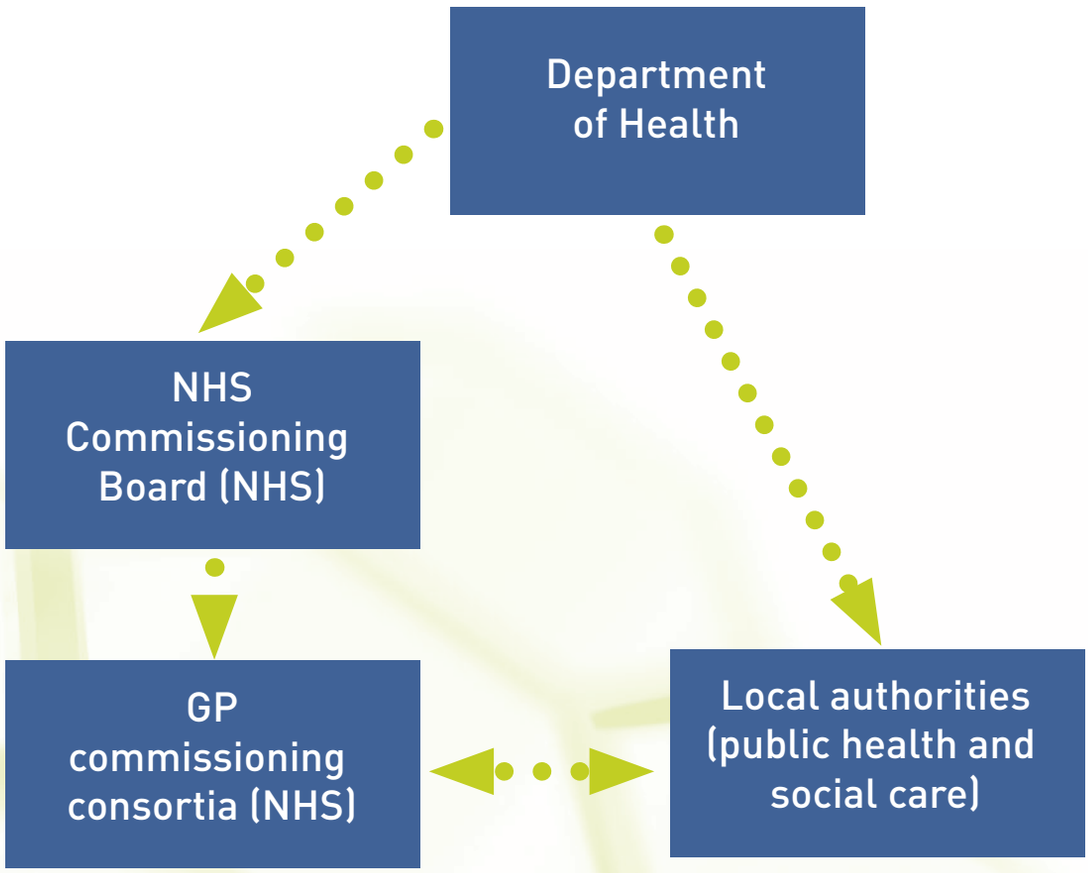
One of the most significant elements of health sector reforms is in the commissioning of services. The Government is determined to make the health service more patient centred and believes that this can be achieved if the way that services are commissioned changes.

The main powers of the Department of Health in relation to the NHS will be:

- Setting a formal mandate for the NHS Commissioning Board
- Holding the NHS Commissioning Board to account
- Acting as the arbiter of last resort in disputes between NHS commissioners and local authorities
- Publishing national service strategies
- Determining the comprehensive services which the NHS provides
- Accounting annually to parliament for overall performance.

Importantly, the Department of Health will have no authority to intervene with specific providers, with the exception of the three high security mental health units. One of the main functions of the Department of Health will be to oversee each of the three health services: the NHS, public health and social care. The new commissioning structures for each of these services are shown in Figure 2 and outlined in further detail below.

Figure 2: New health commissioning structures



The National Health Service

Commissioning in the NHS is currently undertaken by Primary Care Trusts (PCTs), overseen by Strategic Health Authorities (SHAs). Many of these existing commissioning structures will be dismantled under the government's health reforms with the intention of bringing commissioning closer to the patient. PCTs and SHAs will be abolished and their functions will largely be transferred to the NHS Commissioning Board and GP commissioning consortia.

The NHS Commissioning Board

The Coalition Government's Health Bill will introduce *"an independent NHS board to allocate resources and provide commissioning guidelines"*[2]. The NHS Board's statutory duties will be to:

- Secure comprehensive health services
- Deliver improvements in the physical and mental health of the population
- Deliver improvements in the diagnosis and treatment of illness.

The Board will commission some services directly, such as those where a larger population makes services viable (such as for transplant or maternity services). In addition to this, it will commission family health services so GP consortia do not directly commission services from themselves. The Board will design model contracts for GP commissioners to adapt and use with providers and they will also design the structure of the tariff and other financial incentives.

Under current proposals it is unlikely that the NHS Board will directly commission services from housing associations. This duty will be passed to GP commissioning consortia.

GP commissioning consortia

The Government has pledged to *"devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia"*[3]. For this reason, GP commissioning consortia will be the routine commissioners of most NHS services, with consortia potentially controlling 80% of the NHS budget. This is intended to encourage continuity of care for patients. Consortia will have freedom to commission services which achieve the best and most cost-effective outcomes whilst *"ensuring wherever possible that any willing provider has an equal opportunity to provide service"*[4].

If government proposals on commissioning are accepted and put in place, NHS services provided by housing associations will primarily be commissioned by GP commissioning consortia once they have been established and this responsibility is passed over from PCTs. This will make new GP commissioning consortia, in whatever form they take, of central importance to any housing association wishing to provide services to the NHS.

As Figure 3 shows, NHS commissioning reforms are going to take a significant amount of time to put in place. It is, therefore, vital that housing associations continue to engage with existing structures and through current mechanisms whilst reforms are being put in place.

2. Cabinet Office, *The Coalition: our programme for government*, May 2010
3. Department of Health, *Equity and excellence: Liberating the NHS*, July 2010
4. Department of Health, *Liberating the NHS: Commissioning for patients*, July 2010

Figure 3: Key milestones in NHS and public health reforms[5]

Health Bill published	Autumn 2010
Vision for social care published	November 2010
Public Health White Paper published	December 2010
SHAs separate commissioning and provider functions	Winter 2010
NHS Commissioning Board established in shadow form	April 2011
GP consortia in place in shadow form	2011/12
NHS Commissioning Board fully operational	April 2012
Public health service fully operational	April 2012
Ring-fenced public health budgets established	April 2012
NHS Commissioning Board makes allocations for 2013/14 directly to GP consortia	Late 2012
GP consortia take on responsibility for commissioning	2012/13
SHAs abolished as statutory bodies	2012/13
GP consortia to take full financial responsibility	April 2013
PCTs abolished	From April 2013

Public health

Once PCTs have been disbanded, responsibility for commissioning public health services will be passed to local authorities. This will give local communities greater control over public health in their locality. The Secretary of State, through a national public health service, will set national objectives for improving population health outcomes. It will be up to local authorities to determine how they will fulfil these objectives, including through commissioning NHS (or other) services. Payment from the public health service will be linked to the outcomes achieved in improving the health of local residents.

At the time of writing, it was expected that a Public Health White Paper would be published in winter 2010 to lay out proposals for the public health service in more detail. It will be important that housing associations are aware of the Public Health White Paper and are ready to engage with local authorities as the commissioners of public health. Poor housing conditions are proven to lead to a wide range of health conditions and health inequalities. Living in cold and damp housing can cause a range of health problems, such as asthma, skin problems, coughing and wheezing. Overcrowding increases the risk of infectious or respiratory disease[6]. Working in partnership with housing associations to deliver new affordable homes is essential for local authorities looking to avoid preventable costs to the NHS through avoiding the health problems associated with poor housing.

As well as this focus on prevention, housing associations are increasingly providing wellbeing services in the community, including provision of community health workers, cookery training, sports and fitness provision and healthy eating and living initiatives.

5. Department of Health, *Equity and excellence: Liberating the NHS,* July 2010
6. BMA, Housing and Health: building for the future, BMA, 2003

Social care

Many services currently sit awkwardly between health and social care. As these services have historically been separate in funding and delivery, this has led to difficulties in the commissioning of services, such as those for people with mental health problems, older people and people who experience homelessness.

At the time of publication, it was anticipated that the government's vision for social care would set out the framework for a personalised care and support service which helps to prevent more intensive interventions. In order to determine how best to fund social care and support the Government has also established the independent Commission on the Funding of Care and Support[7]. The Commission will make recommendations on how to achieve a sustainable and affordable system for funding care and support. It is anticipated that a new social care service will be established drawing on the conclusions of the Commission to improve the integration of health and social care.

Social care is already an area where housing associations are successfully making the case for investment in housing. The aspiration of health reforms is to make health and social care more aligned. However, it is unclear if this aspiration will be translated into reality. As such, housing associations will need to continue to find imaginative ways to foster greater integration between health and social care, and are in an excellent position to do so.

Co-ordinated local commissioning

The Government recognises the importance of joint, integrated working to ensure that the health system is personalised and reflects peoples' health and care needs. It acknowledges that when services are not joined-up this can lead to frustration. Housing sits across the fault lines of the different services and should, therefore, be positioned as an exemplar of how joined-up services can be successfully achieved. A narrative and practical examples about how housing associations are working across the multiplicity of health services should be developed and shared with key stakeholders, including commissioners across the new structures once they emerge.

GP commissioning consortia have been highlighted as an essential way of supporting this, as they will have a duty to work with the wider NHS and social care to deliver: high quality care, an efficient use of NHS resources and improved patient experience. In addition, the increased role of local authorities in the delivery of public health and social care will provide support to foster partnership working. This partnership working, and acknowledgement that GP commissioning consortia and local authorities will need to take a holistic view of the needs of their local health economy, provides a great opportunity for housing associations to showcase services which span the three services and to demonstrate how joined-up working can successfully be achieved.

Place-based budgets and Total Place

Total Place was an initiative launched by the previous Government, designed as a 'whole area' approach to public services. This collaborative approach was introduced with the intention of reducing costs and improving quality of services. The programme was introduced in 13 pilot areas.

The original Total Place pilots are no longer being managed as a central government programme, although the new Government has expressed support for the principles behind it. Local services are increasingly considering the benefit that can be achieved through the use of place-based budgets, covering the locally relevant expenditure of all key public sector partners, with minimum ring-fencing.

For the period covered by the data in this report, the Total Place pilots were in place.

7. Department of Health, *Written Ministerial Statement, Terms of Reference for the Commission on the Funding of Care and Support,* July 2010

Joint Strategic Needs Assessment

The requirement on PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of their local community was introduced in 2007, and was seen as a key way of encouraging collaborative working between local organisations.

The JSNA involves understanding the current and future health and wellbeing needs of the population, over both the short term and the longer term, and should provide a framework to examine all the factors that impact on the health and wellbeing of local communities, including employment, education, housing, and environmental factors.

Under the plans set out in the NHS White Paper earlier this year, responsibility for developing JSNAs will be given to local authorities, with newly introduced health and wellbeing boards playing a key role. Local authorities will therefore have responsibility for ensuring a closer working relationship between health and areas where the council has responsibility such as housing[8]. Local partners should consider how existing housing and neighbourhood data can help support this process, and should look to align the JSNA with the Strategic Housing Market Assessment, (SHMA), or any future assessment of local housing needs.

Health and Wellbeing Boards

The Government is proposing the establishment of Health and Wellbeing Boards to promote integration and partnership working between the NHS, public health, social care and other local services. It is anticipated that Health and Wellbeing Boards will sit in the local authority and could agree joint commissioning of some cross-cutting health services, such as the strategy for place-based budgets.

Health and Wellbeing Boards will be central to improving collaboration in local services, with a responsibility to promote integration and partnership working between the NHS, social care, public health and other local services. These Boards will formalise and increase the responsibility that local authorities have for improving health outcomes in their local area.

Personalisation

Alongside structural changes such as the Health and Wellbeing Boards described below, the Government plans to increase focus on personalisation in health and social care. Local authorities are expected to offer personal budgets to all new service users and people who are subject to care reviews, by October 2010. It is expected that the use of personal budgets will become more widespread, and increasingly all local commissioners should be clear about the impact of direct purchasing of care by individuals, to ensure that there is a sufficient supply of services to meet local needs.

People will need to have a wider choice in how their needs are met, including in the provision of both health and housing services. As funding mechanisms are extended for use in health, it will be important for housing associations to consider how the services they provide can play a role in delivering better, personalised health outcomes.

The role of service providers

Providers of health related services remain an important part of the health landscape. The proposals for reform to the health service will see the completion of the purchaser/provider split in health. The theory of this approach is that separating purchasing (commissioning) functions from those of providers will create a system which drives quality and efficiency through competition. This will free NHS providers and give them much greater autonomy. The 2010 *Liberating the NHS* White Paper stated that *"we will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an 'any willing provider' approach for community services, reducing barriers to entry by new suppliers."*[9] This should lead to a plurality of providers emerging in the market and give housing associations a bigger scope to provide health services in a competitive market.

Opportunities for housing providers

1. NHS commissioning structures will remain in their current form for the immediate future. This provides continuing opportunity for housing associations to engage with local health commissioners. However, housing associations could begin to engage with new commissioning structures and groups as they emerge in what is a fast-reforming environment.
2. There is an opportunity for housing associations to capitalise on the 'any willing provider' policy. They may wish to advance their dialogue with NHS and public health commissioners and with other NHS providers about how housing can support delivery of improved health outcomes. This might include inviting health commissioners to visit a local housing related support service to help inform their understanding of the benefits of supported housing to the health service, or offering a full evaluation of the cost benefits associated with particular schemes.
3. The multiplicity of commissioners for different types of health interventions will mean that housing associations should consider how to engage with commissioners across the different structures in health, public health and social care. Housing associations may wish to work collaboratively with each other to maximise this engagement.
4. The transfer of public health to local authorities presents an opportunity for housing associations to build on existing relationships to make the case for investment in housing services to improve public health outcomes.
5. Housing associations will need to continue to work both with the NHS and with social care to ensure social housing adequately reflects the health needs of their local population. In many areas this is already taking place to good effect - such as mental health, early discharge from hospital and maintaining independence for people with long term conditions. With the introduction of new health structures and commissioners, there is an opportunity for housing associations to restate the case that provision of housing can help to tackle local problems and reduce the burden on the health service.
6. Housing associations can engage with Health and Wellbeing Boards as these emerge, and can help to ensure housing needs are reflected in the Joint Strategic Needs Assessment (JSNA). Specifically, local partners should consider how existing housing and neighbourhood data can help support this process, and should look to align the JSNA with the Strategic Housing Market Assessment (SHMA) or any future assessment of local housing needs.

8. Department of Health, *Liberating the NHS: Local democratic legitimacy in health,* July 2010
9. Department of Health, *Equity and excellence: Liberating the NHS,* July 2010

4: The financial context

The country is in a period of significant financial austerity, with the squeeze on public expenditure expected to last through the period of the Spending Review and beyond. Despite this, the Government has committed that health spending will increase in real terms for each year of the 2010-15 Parliament, pledging to *"guarantee that health spending increases in real terms in each year of the Parliament"*[10]. In addition to this, the public health service will benefit from a ring-fenced proportion of this budget, but as yet the parameters for this have not been determined.

Despite these commitments, the health budget is still likely to meet the increasing demand for health services, while the NHS is asked to make 3% efficiency gains each year, and the scope of what is included within the health funding and the ring-fenced public health budget is likely to increase. Funding for the health service could be vulnerable to leakage as activities currently paid for by other departments are reclassified as health spending. The NHS may be expected to use its protected budget, at least in part, to increasingly work with other public bodies to deliver services. For example, funding for sporting facilities and educational interventions could be reclassified as public health interventions to access this funding rather than being paid from alternative funding revenues controlled by other government departments.

The social care budget will not benefit from a ring-fence like the NHS and public health budgets and, therefore, it will not be protected from spending cuts. This may lead to restricting local care services, more reliance on families to become carers and third sector organisations. Reduced provision of social and community care is likely to have an impact on the NHS, as some individuals will have to access NHS services to fill the gap. Indeed, the freeze on council tax will mean that local authorities do not have increased funds to invest in social care interventions, and the budget for the Supporting People programme is already being squeezed and cut.

Although the October 2010 Spending Review gives an extra £2 billion of funding for social care, support and care for vulnerable people will still take a hit when we take into account cuts to housing related support services funded by Supporting People.

Housing providers need to be competing on a level playing field with other providers at a time of financial austerity. Commissioners of health services will be led, or guided by, clinicians who are used to making decisions based on clinical evidence. It will, therefore, be crucial for the housing sector to make the financial case for investment on robust evidence of quality, effectiveness, efficiency and cost-effectiveness. There is a small, but growing, amount of evidence that integrated health and wellbeing services can lead to financial benefits. It has been estimated that integrated early intervention programmes can produce savings of between £1.20 and £2.65 for every £1 spent[11].

Housing associations should collect information and data about the outcomes and cost-effectiveness of services in order to build a persuasive case for commissioners to invest in this area. Similarly, health commissioners will need to be persuaded that taking positive risks and looking at a wider spectrum of evidence can ultimately help them to meet health outcomes.

Opportunities for housing providers

7. Although evidence exists to support the cost-effectiveness of housing interventions, there is a role for housing associations in continuing to collect and evaluate data to further demonstrate the health outcomes and cost benefits of their services. This might include information on housing stability, neighbourhood, access to health and social care services, and promoting healthy habits.
8. Housing associations can play a role in the new health world by working with commissioners of health and social care services to demonstrate the financial benefits of increased co-operation and partnership working.

5: Opportunities for engagement

As the previous chapters have demonstrated, there are many new and existing levers for engagement with the health service, across the NHS, public health and social care. This is also explored further in this report's sister publication, *Health and housing: worlds apart?*

As more responsibility for the commissioning of services is devolved to GP consortia and local authorities, it will be more important than ever to understand local health economies, local services and the priorities of local commissioners. Some quantitative data is available which may assist housing associations in the understanding of their local area. The following sections of this report look at the insights that can be gathered from this publically available data. This data enables us to build a picture of the issues that are important to local commissioners, as well as the variations in services and outcomes across the country.

Data in this section is broken down to PCT or local authority level. PCTs will remain an important point of engagement with housing associations until they are abolished in 2013. In the longer term, the data collected at PCT level will provide a benchmark against which the progress of commissioning by GP consortia can be measured and understood.

The raw data from these analyses is included in the Annexes. Housing associations with an interest in engaging with local health services are encouraged to use this data in building their case for joint working. They may also wish to review local data that is not centrally collected to develop a still fuller picture of how the provision of increased housing support could improve health outcomes in their area.

Health Commissioning

Knowing how commissioners are performing gives an insight into how best to engage with them and into the situation on the ground in each locality. The World Class Commissioning initiative was set up in 2007 as an England-wide programme designed to improve the quality of commissioning within the NHS. According to a Department of Health document from December 2007, *"commissioning competencies are the knowledge, skills, behaviours and characteristics that underpin effective commissioning."*[12]

The performance management of commissioners is evolving and will continue to do so when the new structures are formally established. The World Class Commissioning assurance process will no longer be the performance management system used for NHS commissioners. Despite this, data from the first year of the World Class Commissioning initiative does give a useful insight into the performance of commissioning and local commissioning priorities across the country.

As part of the World Class Commissioning assurance process, PCT commissioners were scored across ten competencies which are outlined in Figure 4.

10. Cabinet Office, *The Coalition: our programme for government,* May 2010
11. Turning Point, *Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care.* February 2010
12. Department of Health, *World Class Commissioning: Competencies* , December 2007

Figure 4: World Class Commissioning competencies in year one of the assurance process

Are recognised as the local leader of the NHS
Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
Prioritise investment according to local needs, service requirements and the values of the NHS
Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
Secure procurement skills that ensure robust and viable contracts
Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes

Most of these competencies are of relevance to housing associations. We have analysed the data coming from this programme in order to illustrate the current levels of performance and to build a picture of how health commissioners set their priorities locally. During the assurance process, PCTs were awarded a score of between one and four, with one being the lowest and four the highest, for each of these competencies. Across all ten competencies, no PCT scored higher than a three on any element in year one of the assurance programme.

Collaborative working

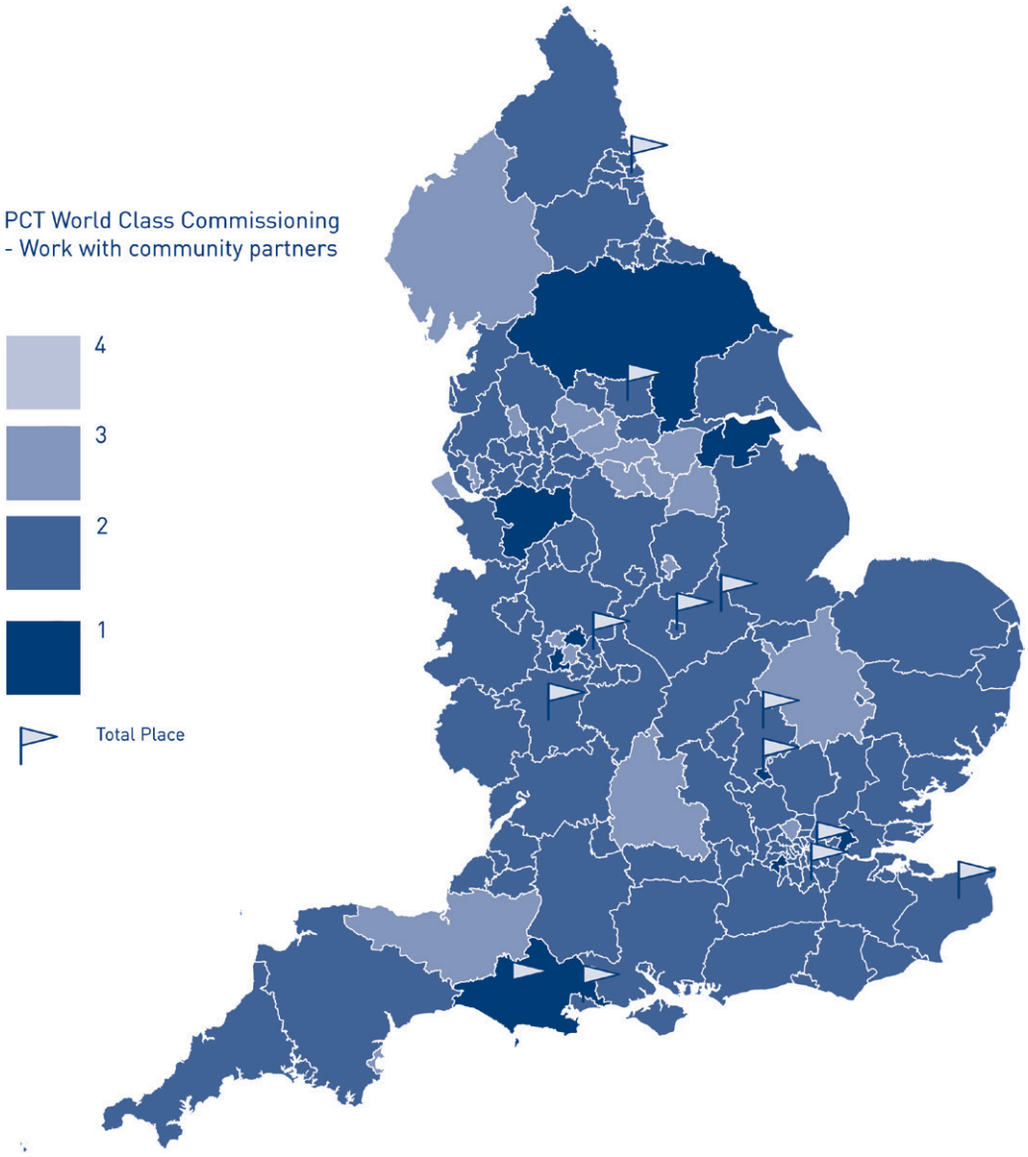
The benefits of collaborative working are clear, and the ambition of increased integration between NHS, public health services and the social care service is welcome. Research has shown that services that join up a number of different interventions into a single package of support can offer savings across a number of service areas. It has been estimated that integrated early intervention programmes can produce savings of between £1.20 and £2.65 for every £1 spent.[13] One scheme run by The Cyrenians shows that providing a package of support including drug treatment, support for health and other needs and training support leads to sustained employment for vulnerable people and the annual average cost to the public purse is reduced by 89%.[14]

Competency two of the World Class Commissioning process is particularly relevant to housing associations working in the health sphere.

> *"Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities."*

Data about commissioner performance on this competency gives a useful insight into community collaboration geographically across the country. Figure 5 shows the scores that PCTs achieved on competency two in the first year of the World Class Commissioning assurance process[15] and cross references this with the areas where Total Place pilots (now placed-based budgets) have been in operation.

Figure 5: Scores achieved by PCTs on competency two - work with community partners



Only 20 out of 152 PCTs scored level three, with the majority (124) achieving level two. There are eight PCTs which achieved only level one against the indicator, suggesting that they need to make significant improvements in their joint working with local authorities and other community partners. Understanding how well health commissioners have performed on their work with community partners gives an insight into the effectiveness of partnerships in each locality. This knowledge is useful for housing associations to gain an understanding of current practice in each locality. Full data about the performance of each PCT can be found in Annex 2, and will be a useful resource for housing providers looking to understand their local health partnership environment.

Perhaps surprisingly, there appeared to be no relationship between those PCTs involved in the Total Place pilot scheme[16] and the score awarded on this competency. It seems, then, that it may take some time for the Total Place scheme to start to make a substantive difference to commissioning behaviour. Sheffield PCT, for example, has very few joint working arrangements in place, and yet describes itself as 'an active member of Total Place'.

13. Turning Point, *Benefits Realisation: Assessing the evidence for the cost benefit and cost.effectiveness of integrated health and social care.* February 2010.
14. Clare Wigmore (2009) Virginia House Self Build Economic Cost Benefit Analysis, Tyneside Cyrenians.
15. MHP Heath Mandate, *CommIT,* July 2009
16. Leadership Centre for Local Government, *Total Place, http://www.localleadership.gov.uk/totalplace/totalplaces/,* Accessed August 2010

Analysis by the NHS Confederation's PCT Network has, however, shown that there was an improvement in commissioners' scores at competency two between years one and two of the World Class Commissioning assurance process.[17] The average score achieved in 2008/09 was 2.11, rising to 2.65 in 2009/10. This represents an increase of 26% and suggests that some of the barriers to collaborative working are being reduced. Increases in competency scores were universal across those assessed in both years, and the increase of 26% should, therefore, be seen in light of a 40% increase in competency scores across the board.

This increase in performance between years one and two of the World Class Commissioning assurance process could be explained in part by programmes, such as place-based budgets (formally Total Place) and Supporting People that are designed to encourage a collaborative approach to the provision of local services.

Figure 6: Case Study - Bradford Total Place Pilot[18]

Bradford Total Place Pilot

Bradford was a pilot site for the Total Place programme. The pilot focused on three themes:

- Young people leaving care
- Offenders over 18 leaving prison
- Older people with mental health-related problems leaving hospital.

Particularly relevant for collaborative working between the NHS and local authorities is the management of older people with mental health-related problems leaving hospital. This area was selected as a way of improving the service user experience, improving the service for those involved in delivery and receipt of the service, and of achieving financial savings.

By improving discharge planning and providing more appropriate support in the community, the aim was to reduce the number of people being discharged directly into long-term residential care by up to 50%. The potential efficiency gains from this would be around £1.8million.

The changes are also intended to reduce re-admissions amongst the target patient group. NHS Bradford & Airedale estimates that during 2008/09, 324 people over 65 with mental health problems were re-admitted to hospital. Based on an average cost of stay of £2,384, Bradford District Partnership estimates that a reduction of 25% in readmissions would save £193,104.

These efficiency savings will be achieved by investing to save. Investment will be necessary in:

- Improved cross-organisational training on supporting older people with mental health problems
- Care home and liaison psychiatry
- Increased crisis support and enablement
- Increased home from hospital support.

The Bradford case study provides a valuable example of the service improvements and savings that could be possible through increased joint working and collaboration. However, the work ongoing also highlights a number of barriers to joint working that are preventing increased collaboration across the country. A number of these barriers are set out in Figure 7.

17. NHS Confederation's PCT Network, *PCT World Class Commissioning assurance results 2009/10*, 3 August 2010
18. Bradford District Partnership, *Total Place Pilot Final Report*, February 2010

Figure 7: Barriers to joint working

Budgets are not aligned	• Budgets within the health service, social care and local government are not aligned • Investment from one budget may lead to savings in a different budget, which can be unattractive to payors
Priorities of health commissioners and local authorities differ	• The interests and perspectives of health commissioners and local authorities have led to priorities not being aligned • Priorities have often been developed in isolation and not taken a broader, holistic view how to achieve the best outcomes dependent on the needs of the area
Lack of consistent activity data	• Boundaries of local authorities and health commissioning areas are not co-terminous leading to data being collected based on different geographical areas • Related data are often collected by different bodies with different frequencies and in different ways making it difficult to compare
Culture of siloed working	• Workings between different types of commissioners and providers have been isolated, in part because of the use of different 'languages' and perspectives • Different types of commissioners and providers are not used to routinely workingtogether and considering the broader picture

The reforms of health care systems and structures, as outlined above, will go some way in addressing a number of the existing barriers to joint working. Indeed partnership working and encouraging different parts of the health service to work together collaboratively is a central tenet of the government's health policy. The NHS White Paper proposes the establishment of Health and Wellbeing Boards, which will embed public health within the locally accountable framework and foster closer working between health and other services commissioned by the local authority. Health and Wellbeing Boards should drive forward joined-up prioritisation between GP commissioning consortia, the NHS Board and local authorities. Alongside this, a new patient advocacy organisation, HealthWatch, will be set up to stimulate scrutiny to ensure that the disparate parts of the health service work together.

Despite these possible advances in joint working once new structures are in place, there is a significant threat that the new architecture may entrench or establish barriers to joint working. Moving to a system where there are three distinct services, public health, national health and social care, may create three new silos of working and, as budgets are not going to be connected or aligned, this could reinforce barriers particularly during the economic downturn. The impact of siloed budgeting will, therefore, need to be considered. Analysis published in the British Medical Journal has suggested that some aspects of population health are more sensitive to changes in investment in social welfare, such as housing and benefits, than changes to spending in healthcare.[19]

This provides an opportunity for housing associations to show how joint working can be achieved, by demonstrating genuine collaboration and partnership working with commissioners and other providers of health services, and the financial benefits for all three services of investment in housing interventions.

Helping NHS commissioners achieve their priorities

NHS commissioners are faced with a huge number of local challenges and must choose priorities for their area. The World Class Commissioning assurance process required PCTs to select eight commissioning priorities. Commissioners were able to select these from a list of 54 nationally defined indicators, with the option to select two locally defined indicators.

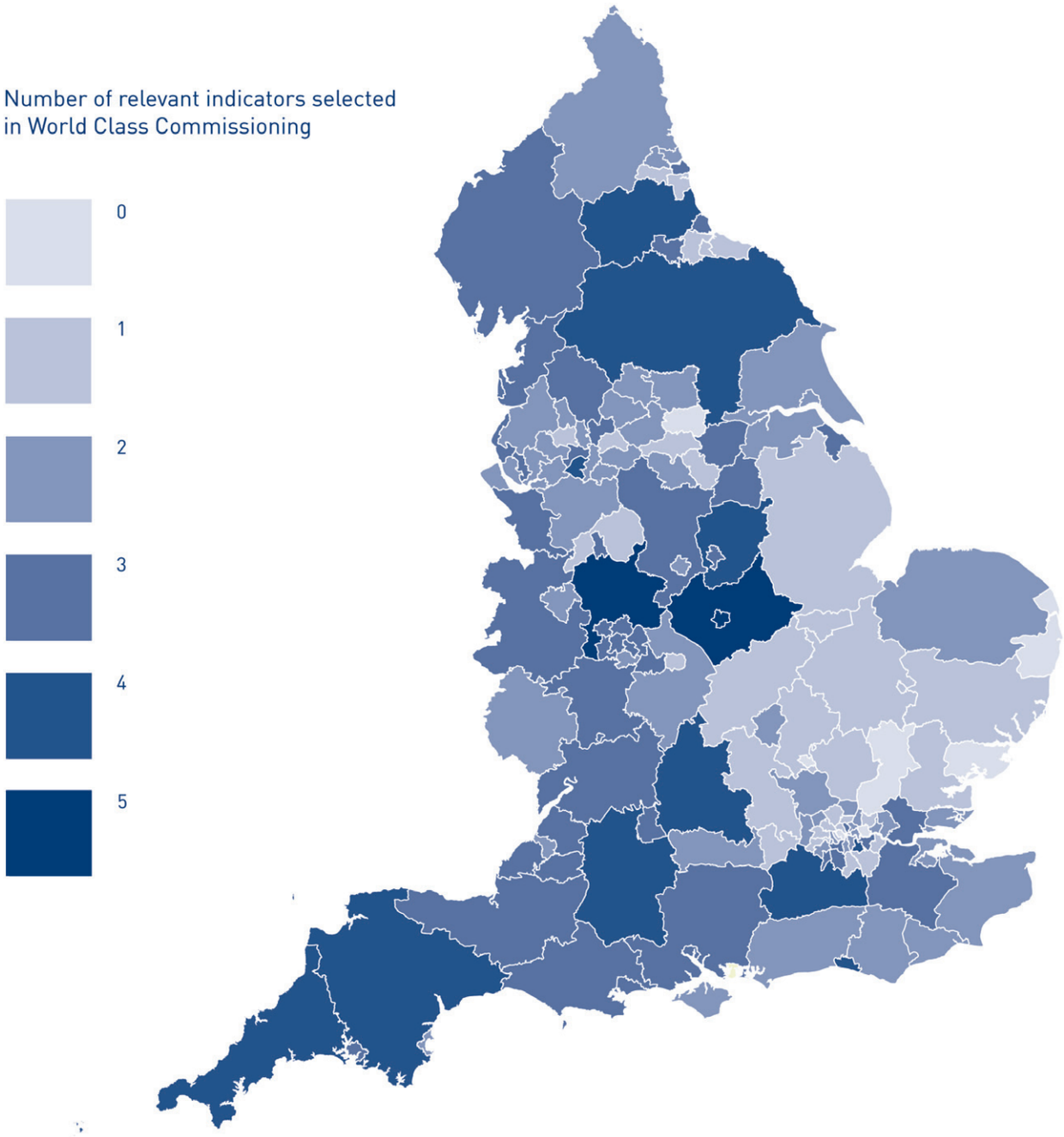
A number of the priorities identified through the World Class Commissioning process are relevant to housing associations. These include:

- Reducing delayed transfers of care
- Independence for older people
- Health improvement in deprived areas
- Rate of hospital admissions per 100,000 for alcohol related harm
- Adults in contact with secondary mental health services in settled accommodation
- Unscheduled hospital admissions in people aged 75 and over per 100,000 population
- Reducing acute inpatient admissions to mental health units.

Figure 8 shows the PCTs that have chosen to focus on indicators identified as being relevant to the provision of housing and housing related support (full data is available in Annex 2). As an example, Leicester City PCT has prioritised five issues which fit well with the joint working agenda.

19. D. Stuckler et al, *'Budget Crises, health and social welfare programmes'*, British Medical Journal, 24 June 2010.

Figure 8: Number of relevant indicators selected in year one of World Class Commissioning[20]



20. MHP Heath Mandate, *CommIT,* July 2009

NICE quality standards

NICE quality standards are currently being developed as markers of excellent care.[21] These quality standards are produced in collaboration with NHS and social care representatives, along with other partners. They are based on available evidence and set out the structures and processes of care, as well as the best outcomes for patients. Importantly these standards are supposed to cover the entire care pathway, including discharge back into the community, where this is appropriate to the topic. To date, three quality standards have been developed: stroke, dementia, and venous thromboembolism prevention.

As housing is a genuinely cross-cutting issue, there is an opportunity to show how housing solutions can help commissioners to achieve against quality standards at various different points in the pathway. It is important that these standards place an emphasis on the role that the health sector should play in pulling in housing interventions. Housing providers should see these standards as opportunities to work with the health service to provide innovative solutions; they are not expected to be bound by health sector quality standards.

In the dementia standard, for example, there are a number of quality statements which could be fulfilled, at least in part, by ensuring that appropriate housing and adaptations are in place for people with dementia[22].

Quality standard on dementia

The quality standard for dementia was published in June 2010, and defines a high standard of care for people with dementia. Particularly relevant for housing associations, the following are quality markers included in the standard:

- People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care, that identifies a named care co-ordinator and addresses their individual needs
- Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs
- People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health
- People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs
- Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

21. National Institute for Health and Clinical Excellence, *NICE quality standards, http://www.nice.org.uk/aboutnice/qualitystandards/MoreInfoAboutNICEQualityStandards.jsp,* Accessed August 2010

22. National Institute for Health and Clinical Excellence, *Dementia quality standards,http://www.nice.org.uk/aboutnice/qualitystandards/dementia/dementiaqualitystandard.jsp,* Accessed August 2010

Housing associations should work with local health services to identify how they can help in the delivering of this quality standard, and should look towards the further ten which are in development:

- Specialist neonatal care
- Depression
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic kidney disease
- Diabetes
- End of life care
- Alcohol dependence
- Glaucoma
- Breast cancer
- Chronic heart failure.

In total, 150 quality standards will be published by 2015. A formal consultation with stakeholders takes place in the development of all quality standards. This is an opportunity to make the case that the care pathway does not end when a patient is discharged from secondary care and that by ensuring appropriate housing and housing related support in place, the health sector can prevent people being unnecessarily re-admitted to secondary care.

Quality standards are a new driver for quality across the health service. These are as yet untested, and it is not yet clear how they will be implemented. This provides an opportunity for housing associations to identify relevant areas where housing has an important part to play in achieving high quality care. The development of relevant quality standards should be used as a lever to begin dialogue with commissioners and providers about the role of housing related support.

Providing support in the community

The 2010 Neighbourhood Audit carried out by the Federation demonstrates the contribution that many housing associations are making to their local communities, contributing to their health and wellbeing. The audit identified over 6,800 community projects led by housing associations, from the provision of sports and community facilities to employment and wellbeing services. Housing associations annually invest at least £435 million in this work.

At least 656 of these community projects focused on improving the wellbeing of the local population, and evaluation of the schemes suggests that over 406,000 people have benefited. The audit findings revealed that housing associations provide access to wellbeing services including:

- Community health workers
- Cookery training
- Cycling
- Drugs health initiatives
- Harm reduction initiatives
- Health and safety promotions
- Health clinics
- Healthy eating and living initiatives
- Mental health initiatives
- Older people's health and well-being initiatives
- Partnerships with local health providers
- Sexual health advice
- Sports and fitness provision

Case study: St. Vincent's Housing Association

St Vincent's Housing Association manages around 3,000 homes. At its sheltered housing scheme in Rochdale, the association works in partnership with the local health centre, diabetic nurse, oral hygienist, healthy walking and healthy eating representatives, smoking cessation advisers and drug awareness outreach team to provide health checks and healthy living advice in an area with a large Asian population. Around 140 people have benefited from this initiative so far. Health service providers recognise this approach is a good way to engage hard-to-reach groups and more events continue to take place. St Vincent's has also organised healthy eating courses for Asian women.

Housing associations are already showing leadership in providing community services. This should be highlighted and developed as a model which could be easily adopted by local authorities to respond to the needs of their local health economy.

Quality, Innovation, Productivity and Prevention

In this period of financial constraint in the NHS, the Quality, Innovation, Productivity and Prevention Programme (QIPP) will continue to be highly important. The programme highlights the need for more efficient care pathways, often by providing more care in the community.

Housing associations should ensure that their offer to the health service provides support for efficient and high quality care pathways. Housing support services are well placed to support this shift from acute to community care, and to prevent unnecessary admissions to hospital. As the QIPP agenda develops, it is important that providers of housing related support seek to map the outputs and outcomes of their services against meeting those set out in the QIPP programme.

The data provided in this report provides collateral for housing associations wishing to make the case for efficiency to their local health service.

Reducing the burden on hospitals

Housing-related support provides essential preventative services to vulnerable groups, helping around one million people at any one time. An evaluation of the cost benefits of housing related support estimated that investing £1.6 billion annually in housing-related support services generated in-year savings of £3.41 billion to the public purse by avoiding more expensive acute services.[23] This includes £315.2 million across a range of health costs, including hospitals and other acute costs.

The National Housing Federation's work with the Department of Health's Care Services Efficiency Delivery team also demonstrated the cost savings to health and social care from reduced hospital admissions possible from the appropriate use of housing related support.[24]

These two key tstudies are important indicators, acting as a key backdrop to local case-making. The methodology used in these studies is based on looking at the alternative service provision in relation to housing related support. So, when looking at a particular scheme, housing related support providers are reflecting on what their services do which is more effective or cheaper than the alternative. This is a hugely helpful argument to present to health audiences looking for solutions to the challenges they face in meeting local health outcomes and reducing costs.

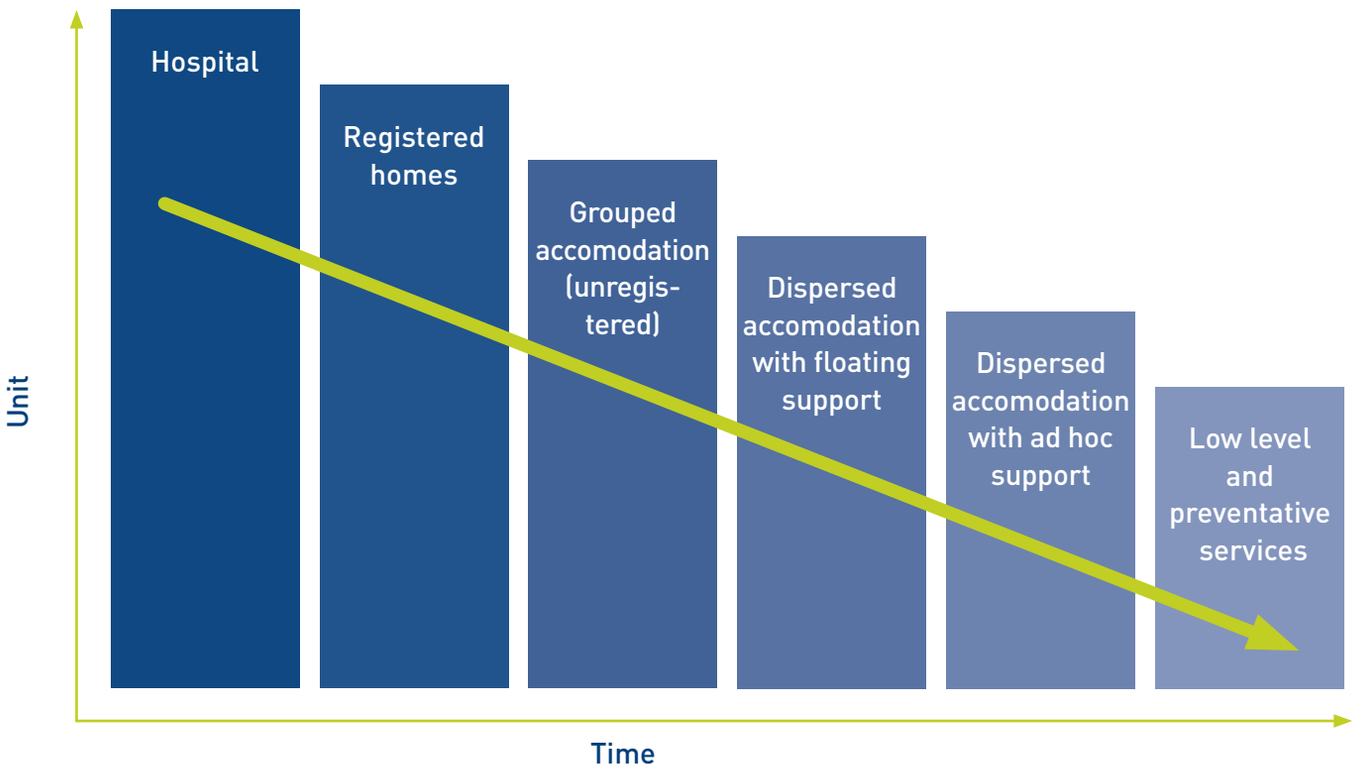
23. CapGemini, *Research into the financial benefits of the Supporting People programme*, Communities and Local Government (CLG), 2009

24. Department of Health, *Support Related Housing*.www.dhcarenetworks.org.uk/csed/Solutions/supportRelatedHousing/

One way in which savings to the health service have been achieved is through the provision of adaptations in housing stock, funded through the Disabled Facilities Grant (DFG). Aids and adaptations can have a significant impact on an individual's ability to live independently. A survey by the Joseph Rowntree Foundation found that 77% of people who had adaptations to their homes perceived a positive impact for their health.[25] Through adaptations, housing related support can enable people to live independently in their own homes and so reduce the pressure in acute and social care.

Keeping patients in hospital is often significantly more expensive than providing support in the community. Also, over time, people's needs change and the level of support that they require also changes. If housing associations can help people, where appropriate, to move as far along the spectrum of types of support that they require, then money will be saved in the longer term. According to the Department of Health's report *Putting People First,* fully integrated housing and health will enable increased independence and can be highly cost effective. This is outlined in Figure 9 below.[26]

Figure 9: Lowering dependence, increasing independence[27]



Housing associations should collect and present data on the investment that they make locally, including housing adaptations and supporting vulnerable people. They will need to make the case for further investment in these cost-effective areas.

Further information on how housing can form a part of the care pathway can be found in the National Housing Federation's earlier report, *Health and housing: worlds apart?*

25. Joseph Rowntree Foundation, *The Effectiveness of Housing Adaptations*, August 2001.
26. Department of Health, *Support related housing: Incorporating support related housing into your efficiency programme,* February 2009
27. Department of Health, *Support related housing: Incorporating support related housing into your efficiency programme,* February 2009

Re-ablement and post-discharge support

The NHS Operating Framework sets out priorities for the NHS for the year ahead to assist in planning. The five national priorities included in the NHS Operating Framework are:

- Improving cleanliness and reducing hospital acquired infections
- Improving access through achievement of the 18 week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services
- Keeping adults and children well, improving their health and reducing health inequalities
- Improving patient experience, staff satisfaction and engagement
- Preparing to respond in a state of emergency, such as an outbreak of pandemic influenza.[28]

In June 2010, the Government issued a revision to the *Operating Framework for the NHS in England 2010/11*[29] to put patients at the heart of the decision-making process, to remove centralised targets and to decentralise responsibilities. Importantly, in this revision re-ablement and post-discharge support were included as new priorities for the NHS. In particular, the Operating Framework makes clear plans to change the tariff for 2011/12 to cover re-enablement and post-discharge support. Re-ablement services are specified as those which help people with poor physical or mental health to accommodate their illness. A key way of achieving this is identified as encouraging *"the use of services such as community health services; social care; home adaptations (including telecare), and extra-care housing. These services should contribute to improved patient outcomes and significantly reduce the risk of emergency re-admission into hospital, which increased by 50% from 1998/99 to 2007/08."*[30]

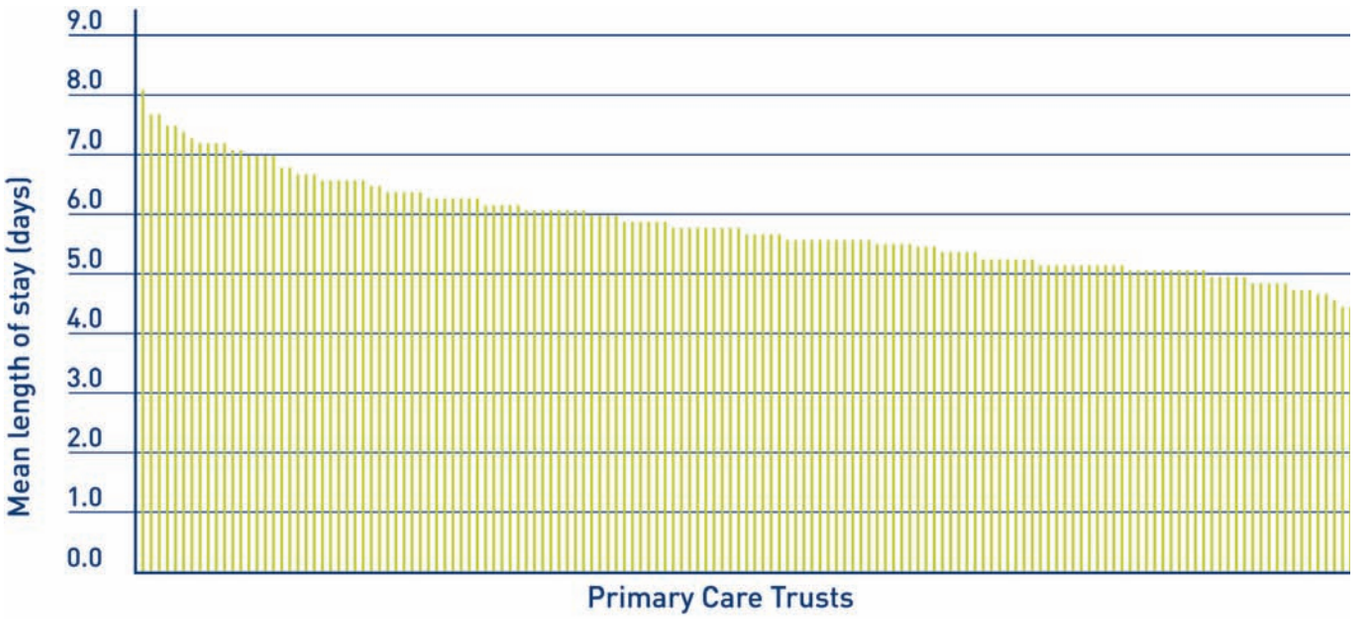
Improving hospital discharge

In the *Revision to the Operating Framework for the NHS in England 2010/11,* the Government's intention was confirmed to make hospitals responsible for patients for the 30 days immediately following discharge. On this, the Operating Framework states *"if a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment. This strengthens an existing expectation that avoidable readmissions due to poor quality care are not reimbursed. From 1 December 2010, we expect providers and commissioners to apply the provisions of this guidance if they are not already doing so. Making hospitals responsible for a patient's ongoing care after discharge will create more joined-up working between hospitals and community services and may be supported by the developments in re-ablement and post-discharge support. This will improve quality and performance and shift the focus to the outcome for the patient."*[31]

Figure 10 shows the notable variations that exist in the mean length of stay by commissioner. These variations can be explained by a number of factors, one of which is delays in discharges because appropriate care is not available in the community. Considering the situation in each locality and how this compares to the national average is helpful in gaining a picture of whether housing associations could offer solutions to support quicker discharge from hospital. Information about the performance of each individual commissioner can be found in Annex 2.

28. Department of Health, *The NHS in England: The operating framework for 20010/11*, December 2009
29. Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, June 2010
30. Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, June 2010
31. Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, June 2010

Figure 10: Variations in mean length of stay by PCT [32]



Data on delayed discharge for Q4 2009/10 shows significant variation across PCTs, ranging from 0 to 90 days. If all commissioners with delayed discharge days above the median were able to bring their admissions in line with the median, then there would have been 1,396 fewer bed days caused by delayed discharge. Taking the average cost of a bed day to be £301.55[33], this could save the NHS £420,965 in a three month period alone. This is money that could be reinvested into preventative housing services in the community. Data about the performance of each PCT can be seen can be found in Annex 2.

Figure 11 maps the variations in delayed discharges across the country, and Figure 12 highlights which commissioners chose to prioritise delayed discharge thorough the World Class Commissioning process. The World Class Commissioning indicator was chosen by only 18 commissioners (12%). Given the potential savings, this is an area that all commissioners should be focusing on. Arguably, those commissioners who chose to focus on the issue had identified delayed discharges of care as a priority issue for their local health population – those commissioners prioritising the issue had an average delayed discharge of acute patients of 25 days for the three month period, while those who did not had an average of 15 for the same time period.

32. NHS Information Centre, *Hospital Episode Statistics, Primary care trust of responsibility: Current*, 2008/09

33. Data on file, calculated from NHS reference costs code TEIXS, Inpatient Excess Bed Day HRG Data, 2008/09

Figure 11: Delayed transfers of care of acute patients[34]

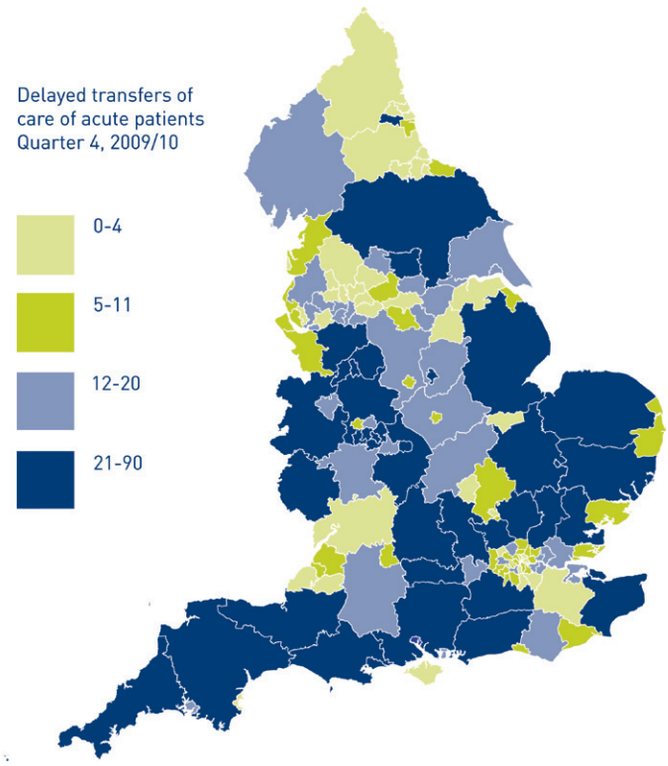
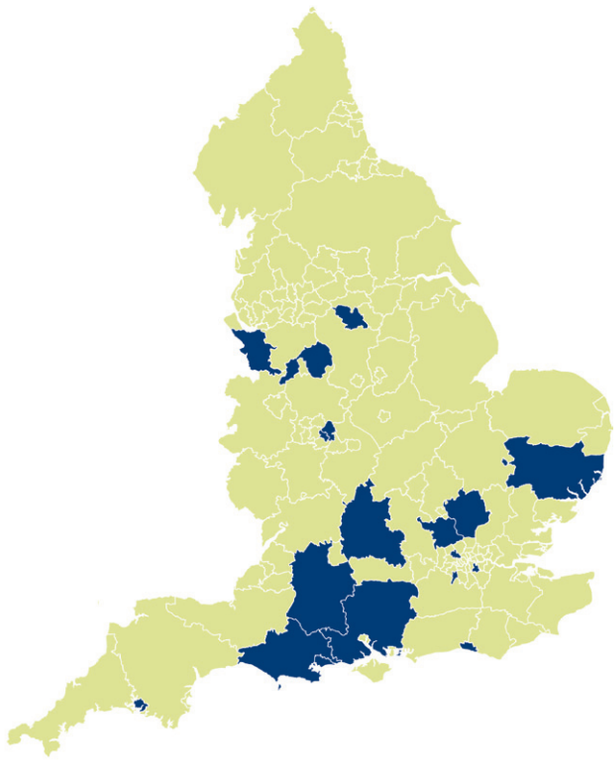


Figure 12: PCTs who selected ***delayed discharge*** as a World Class Commissioning outcome indicator[35]



One area where these variations are most pronounced is that of mental health care. Analysis carried out by the Audit Commission found that adult mental health admission rates vary six-fold and the length of stay varies 15-fold.[36] According to the analysis from the Audit Commission, if all mental health trusts with above the median level of bed days (adjusted for population) were able to reduce them to the present median, the number of beds would be reduced by 15 per cent. It argues that this would amount to £215m savings at a national level.

It is important to stress that any initiative to encourage earlier discharge of patients will have to be combined with funding the appropriate services in the community in order to reduce the risk of readmission. From 1 December 2010, hospital providers will not be paid for readmissions within 30 days of discharge.[37] This will lead to serious budget implications if providers cannot get discharge right. Also, the onus should be on health to ensure that people are discharged to settled accommodation.

Providing settled accommodation for socially excluded groups

Those receiving support can be socially isolated, have physical and mental health problems, histories of offending, or have substance dependency issues. A lack of appropriate support can generate huge costs to public services and, in some cases, create serious anti-social behaviour problems. Housing and support is vital in moving on from dependency to an independent healthy life, connected to services, work and training opportunities and social contacts. Although housing impacts on lots of different areas, this section will focus primarily on mental health as this is where the data is most complete.

34. Department of Health, *Vital Signs monitoring*, Quarter 4 2009/10
35. MHP Heath Mandate, *CommIT,* July 2009
36. Audit Commission, *Maximising resources in adult mental health*, June 2010
37. Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, June 2010

Compared with the general population, people with mental health problems are one and a half times more likely to live in rented housing, with higher uncertainty about how long they can remain in their current home and four times more likely to say that their health has been made worse by their housing.[38] Poor housing can be a contributory factor to poor mental health, and mental health problems can make it more difficult to find and maintain good-quality accommodation.

This relationship between mental health and housing has been increasingly recognised in government policy. The previous Government introduced a Public Service Agreement (PSA) to increase the proportion of socially excluded adults in settled accommodation and employment, education or training. The Government is re-considering the role of PSA targets, as they are thought to rely too heavily on rigid targets. Data collection in the area continues, and allows us to build a picture of the extent to which local authorities and PCTs are providing settled accommodation for people with mental health problems and learning disabilities.

Figures 13 and 14 show the geographical variation in the two specific indicators in 2009/10:

- National Indicator 145 (NI 145): The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review
- National Indicator 149 (NI 149): The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting

Figure 13: Performance against NI 145[39]

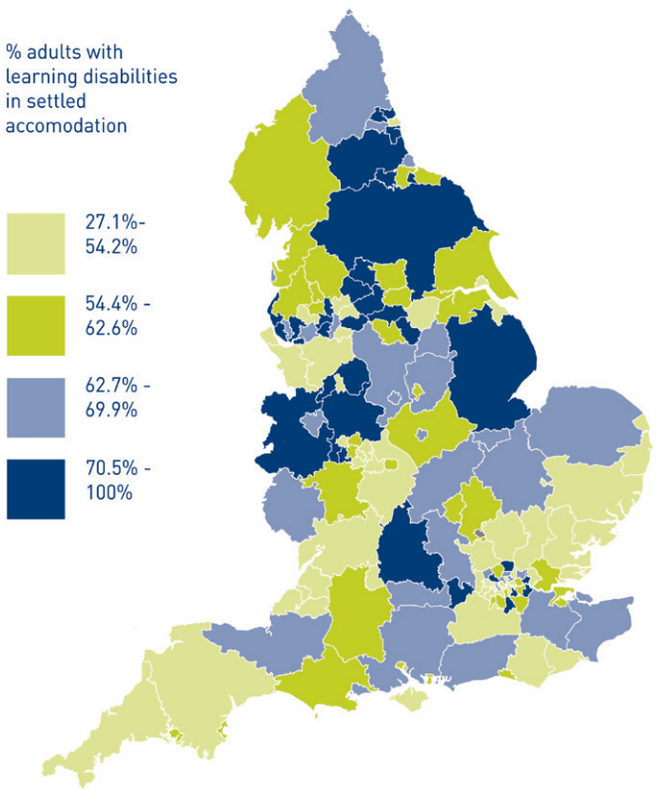
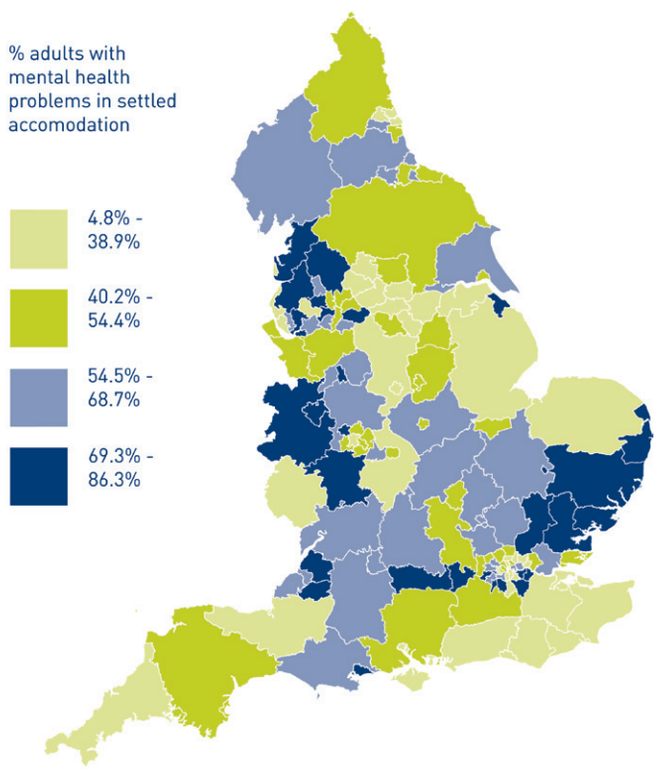


Figure 14: Performance against NI 149[40]



Knowing which areas are doing well or badly against these indicators gives housing associations and other interested parties useful information in identifying opportunities and in furthering a dialogue about how they can help to improve performance for people with Learning Disabilities or mental health problems.

38. Social Exclusion Unit; *Action on Mental Health Fact Sheet 6*, 2004
39. NHS Information Centre, *Provisional Social Care and Mental Health National Indicators*, 2009/10, August 2010
40. NHS Information Centre, *Provisional Social Care and Mental Health National Indicators*, 2009/10, August 2010

There is significant variation by commissioners in terms of performance against both of these indicators. Data recorded about NI145 shows that the percentage of adults with learning disabilities known to CASSRs in settled accommodation at the time of their assessment or latest review ranged from 27.1% in Solihull to 100% in the City of London. This reveals that there are massive variations across the country in how local authorities are performing in this critical area. The average across England for performance against this indicator is 61%. If all local authorities were to achieve at least this average, then outcomes may be significantly improved.

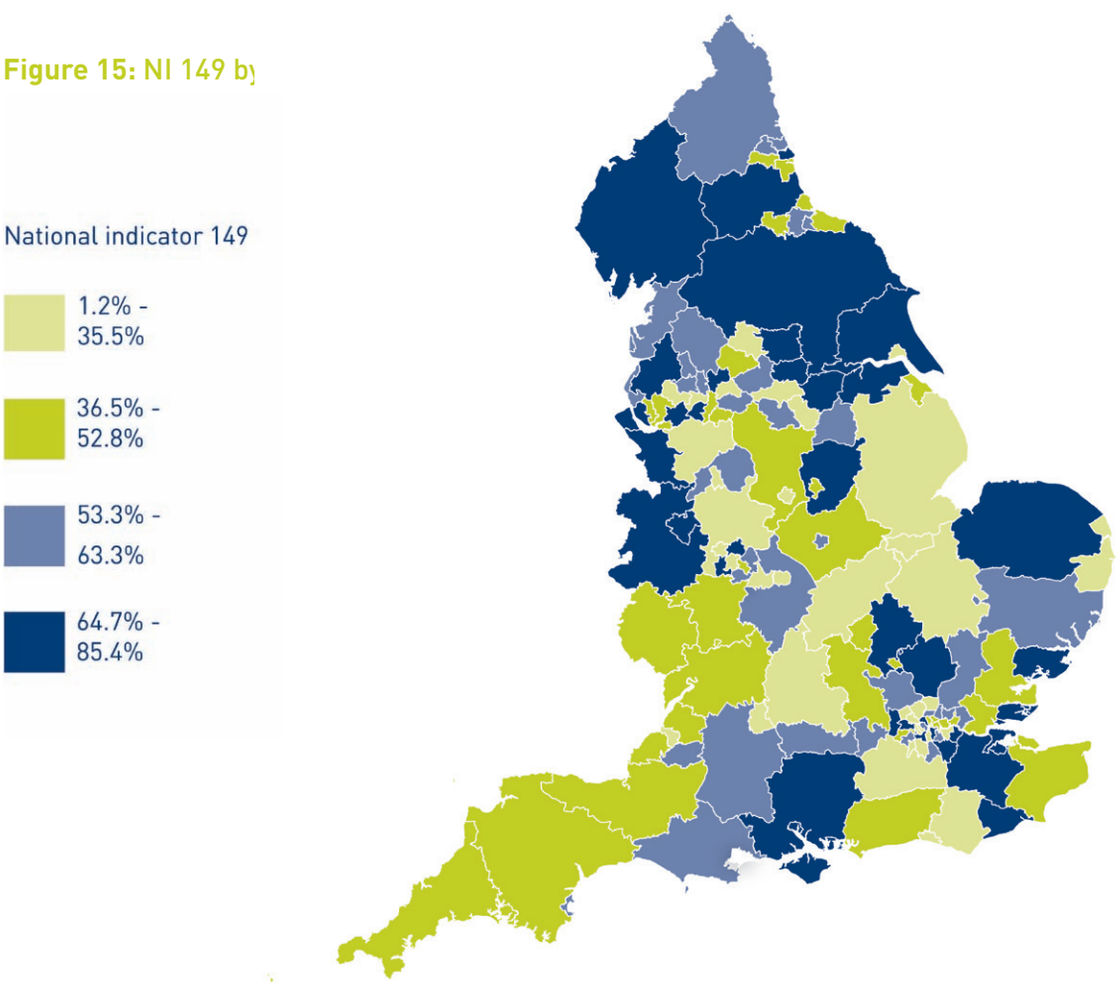
NI 149 showed variations in the percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting from 4.8% in West Sussex and 86.3% in Wokingham. The average performance in England against this indicator is lower than for NI 145, standing at just over 50%.

Where housing associations are operating in areas where their local authority is not achieving at least the average performance against indicators NI 145 and NI149, they may wish to suggest ways in which they can work with the local authority to improve performance in these areas. This data is helpful in demonstrating a strong local case for action to improve outcomes – but within a national context. Data about the performance of individual local authorities is available in Annex 3.

It is important to note that whilst this data provides a very interesting and useful insight into the performance against these indicators, collection of data against these indicators is relatively new, so there are limitations in the quality of the data. Despite these limitations, the data can give an indication of the variations in provision of settled accommodation and identify areas of good and poor performance.

Data on the percentage of adults receiving secondary mental health services who are in settled accommodation is also made available broken down by PCT, further demonstrating the need for collaboration between health services and local authorities in this area. Figure 17 shows the data for NI 149 by PCT.[41]

Figure 15: NI 149 by



41. NHS Information Centre, *Mental Health Minimum Dataset (MHMDS) Quarter 1, 2 and 3 2009/10 quarterly returns*, August 2010

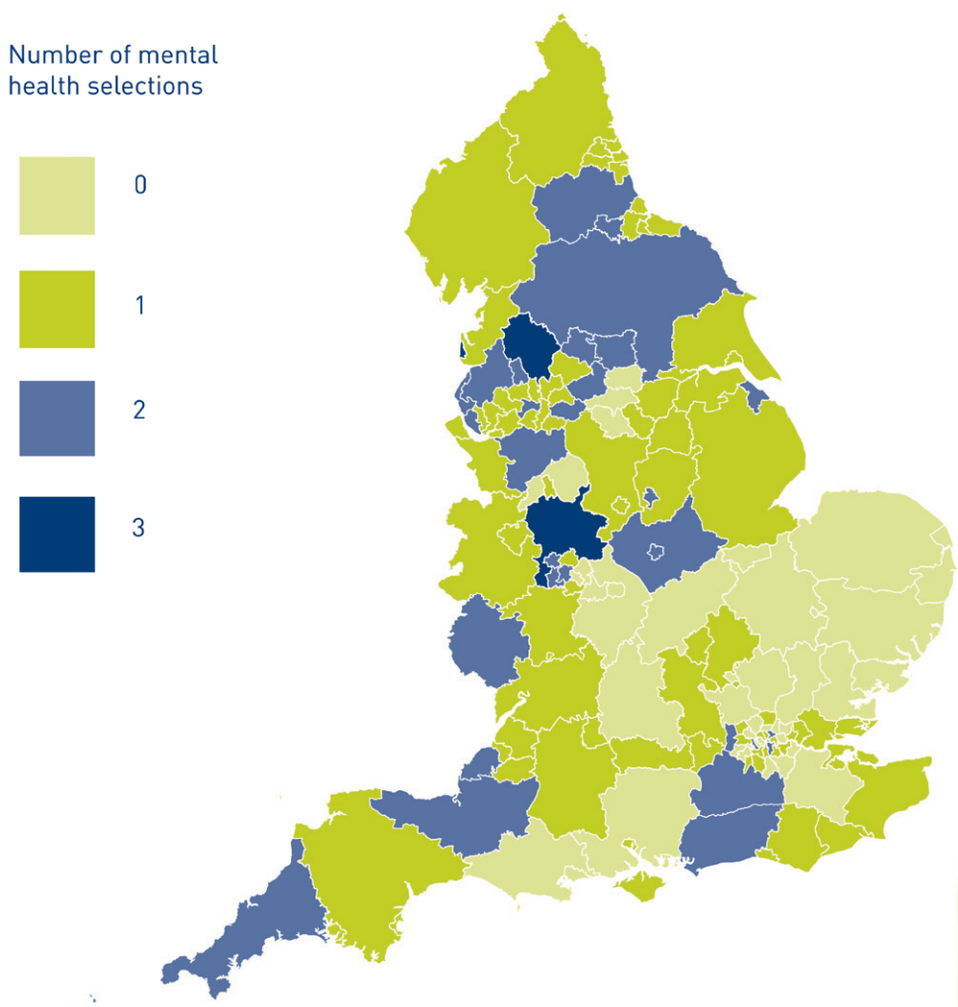
Prioritisation of mental health commissioning

Mental health services account for a significant proportion of the NHS budget, and as a result, it is an area which many commissioners have chosen to prioritise. The World Class Commissioning assurance process contained four national indicators under the theme of mental health. They were:

- Suicide and injury undetermined intent rate
- Drug treatment waiting times
- Percentage drug users' effective treatment
- Rate of hospital admissions per 100,000 for alcohol related harm.[42]

An analysis by Health Mandate found that mental health national indicators were selected 97 times (by 87 PCTs in total)[43]. In addition to the selection of these national indicators, a number of commissioners chose to prioritise mental health under locally defined indicators – covering a range of topics from access to psychological therapies to the uptake of services for alcohol misuse. 112 out of 152 PCTs chose to prioritise at least one indicator related to mental health and three PCTs prioritised three indicators relevant to mental health. Figure 18 shows which commissioners prioritised none, one, two or three indicators.

Figure 16: number of mental health indicators prioritised through World Class Commissioning by PCT



42. Health Mandate, *National Priorities, local action?,* July 2009
43. MHP Heath Mandate, *CommIT,* July 2009

Opportunities for housing providers

9. NICE quality standards present an opportunity to ensure that the value of housing is reflected across a range of areas, such as mental health, musculoskeletal conditions, and long term conditions. It will be important that providers of housing services demonstrate their role in delivering these standards.
10. Housing associations have a significant offer to make to secondary and tertiary care providers to facilitate early discharge and a smooth and safe transition back into the community. Housing associations should seize the current opportunities to make this offer.
11. There is a role for housing related support in helping prevent avoidable readmissions to hospital. Health commissioners will need evidence of this from housing associations and others in order to reflect this role in their local priority setting.
12. Housing associations can use the data in the annexes to this report to gain an insight into commissioning performance and local priorities in their area, and to influence this practice going forward.

6: Conclusions

The health system is in a state of flux. Reforms to health systems and structures present a number of important challenges and potential opportunities for housing associations and providers of housing care and support services.

As the commissioning of health services becomes devolved closer to the patient it is hoped that commissioners will have a greater understanding of their local health economy, the people in their locality and the availability of innovative solutions to local problems. The ongoing information revolution will increasingly allow housing associations to assess the opportunities in their local area, and to use the data to best make the case for engagement, integration and collaborative working.

The wealth of publically available data about the priorities and performance of local health commissioners provides an opportunity for housing associations to build a picture about what is happening in their local economy and to begin (or continue) dialogues with health commissioners about the role that housing can play in the NHS and social care.

The development of a national public health service, commissioned locally through local authorities, will give services outside of the traditional health space an opportunity to showcase different types of services, and provide an additional route of engagement for housing associations.

Alongside these opportunities come some challenges for engagement. It will be more important than ever that housing associations are prepared for the instability in the new system, and that they ensure that examples of best practice of partnership working are not lost.

This report should be used as a resource by housing associations to help them to build – and in some cases rebuild – their relationships with local health commissioners, both in the NHS and the public health service.

Glossary

Acute care – the treatment of a patient for a brief but severe episode of illness usually in hospital.

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Joint Strategic Needs Assessment (JSNA) – is an assessment of the health and wellbeing needs of the population in a local area. They aim to establish a shared, evidence-based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities.

Health Bill – will bring forward the legislative change required for the implementation of the NHS White Paper *Equity and Excellence: liberating the NHS.*

NHS Operating Framework – sets out the priorities for the NHS for each financial year.

Place-based budgets/ commissioning – supersede Total Place pilots and involve a rethinking of principles of parliamentary and local accountability for expenditure. Also bring together service delivery.

Primary Care Trusts (PCTs) – statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their function.

Public Service Agreement (PSA) – introduced by the previous Government to detail the aims and objectives of government departments for a three-year period. They will not be continued under the current Government.

Spearhead PCT – the areas of the country with the worst health and deprivation indicators. The Spearhead group is defined on local authority data and consists of 70 local authorities that are then mapped onto PCT boundaries. There are 62 Spearhead PCTs.

Spending Review – sets out the government's priorities, and spending plans to meet these priorities, for the period 2011/12 to 2014/15.

Strategic Health Authorities (SHAs) – responsible for ensuring that national priorities are integrated into local plans and for ensuring that PCTs are performing well. The ten SHAs are the link between the Department of Health and the NHS.

Supporting People – the existing government programme which funds, plans and monitors housing related services for a wide range of client groups, such as disabled people, including those with mental health problems.

Tariff – in relation to payment by results, the tariff is the calculated price for a unit of healthcare activity.

World Class Commissioning – an England-wide programme designed to improve the quality of commissioning within the NHS. This programme has now been suspended.

Annex 1 – Sources of data used in this report

Measure	Level of data	Source	Time period
Average length of stay (days)	PCT	NHS Information Centre, Hospital Episode Statistics	2008/09
Delayed transfers of care of acute patients (days)	PCT	Department of Health, Vital Signs Monitoring	Q4 2009/10
Delayed transfers of care of non-acute patients (days)	PCT	Department of Health, Vital Signs Monitoring	Q4 2009/10
% adults receiving secondary mental health services known to be in settled accommodation	PCT and Local Authority	NHS Information Centre, *Provisional Social Care and Mental Health National Indicators*	2009/10
% adults with learning disabilities known to be in settled accommodation	Local Authority	NHS Information Centre, *Provisional Social Care and Mental Health National Indicators*	2009/10
World class commissioning indicator selection	PCT	MHP Health Mandate, *CommIT*	2008/09

Annex 2 – PCT data

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
Ashton, Leigh and Wigan	NW	S		4.8	12	10	34.6	2	2	1	
Barking and Dagenham	L	S		5.5	12	3	33.1	2	2	1	
Barnet	L			4.4	16	5	52.8	3	1	0	
Barnsley	YH	S		5.2	1	2	35.5	3	1	0	
Bassetlaw	EM			5.5	0	0	57.7	2	3	1	
Bath and North East Somerset	SW			6.5	3	15	76.5	2	3	1	
Bedfordshire	EE		y	6.0	11	0	71.1	2	1	1	
Berkshire East	SC			5.5	19	4	83.7	2	1	1	
Berkshire West	SC			5.0	22	30	85.4	2	2	1	
Bexley Care Trust	L			6.1	15	15	73.1	2	1	0	
Birmingham East and North	WM	S	y	5.9	21	17	54.6	2	3	0	y
Blackburn with Darwen Teaching	NW	S		4.3	2	1	69.6	3	2	2	
Blackpool	NW	S		6.3	3	2	73.4	2	3	3	
Bolton	NW	S		4.9	2	0	80.3	2	1	1	
Bournemouth and Poole	SW		y	6.5	30	19	70.1	2	3	0	y
Bradford and Airedale Teaching	YH	S	y	4.7	12	6	31.4	2	2	2	
Brent Teaching	L			5.4	9	6	61.1	2	1	0	y
Brighton and Hove City Teaching	SEC			5.0	11	18	6.2	2	4	1	y

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
Bristol Teaching	SW			5.9	10	2	63.0	2	2	1	
Bromley	L			5.4	4	6	74.9	2	1	0	
Buckinghamshire	SC			5.1	46	16	50.2	2	1	1	
Bury	NW	S		4.9	3	3	43.8	2	2	1	
Calderdale	YH			5.0	2	1	27.3	3	2	1	
Cambridgeshire	EE			5.7	46	23	57.5	3	1	0	
Camden	L			7.6	6	2	15.8	2	2	1	
Central and Eastern Cheshire	NW			5.2	43	9	47.1	1	2	2	
Central Lancashire	NW	S		5.5	18	10	68.0	2	2	2	
City and Hackney	L	S		6.5	2	1	48.5	2	2	2	
Cornwall and Isles of Scilly	SW			5.7	40	44	29.0	2	4	2	
County Durham	NE	S		5.2	1	6	57.0	2	4	2	
Coventry Teaching	WM	S		7.1	39	8	51.3	2	1	0	
Croydon	L		y	5.9	3	1	16.3	2	1	0	
Cumbria Teaching	NW	S		6.2	20	22	68.4	3	3	1	
Darlington	NE			5.0	0	4	54.7	2	4	2	
Derby City	EM			5.1	10	4	33.1	2	2	1	
Derbyshire County	EM	S		6.0	12	55	27.1	2	3	1	
Devon	SW			5.8	54	50	53.3	2	4	1	
Doncaster	YH	S		5.7	17	2	20.4	3	3	1	
Dorset	SW		y	7.3	33	10	57.5	1	3	0	y
Dudley	WM			4.7	21	17	45.0	2	3	2	
Ealing	L			5.3	12	18	62.8	2	1	1	
East and North Hertfordshire	EE			5.8	32	5	65.4	2	1	0	y

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
East Lancashire Teaching	NW			5.1	0	2	70.9	2	3	3	
East Riding of Yorkshire	YH			5.8	15	0	55.6	2	2	1	
East Sussex Downs and Weald	SEC			6.3	18	1	2.4	2	2	1	
Eastern and Coastal Kent	SEC		y	5.3	42	7	47.7	2	2	1	
Enfield	L			5.7	5	7	48.4	2	2	1	
Gateshead	NE	S		6.3	24	0	58.8	2	1	1	
Gloucestershire	SW			6.2	4	15	64.7	2	1	1	
Great Yarmouth and Waveney	EE			6.3	7	8	1.2	2	0	0	
Greenwich Teaching	L	S		5.7	18	0	79.0	2	3	1	
Halton and St Helens	NW	S		5.0	12	4	72.4	2	2	1	
Hammersmith and Fulham	L	S		5.6	6	10	64.7	2	2	2	
Hampshire	SC			6.0	67	40	41.6	2	3	0	y
Haringey Teaching	L	S		6.1	8	5	37.8	2	1	0	
Harrow	L			5.4	3	0	53.9	2	2	1	
Hartlepool	NE	S		5.0	1	0	59.5	2	1	1	
Hastings and Rother	SEC			6.5	11	1	11.1	2	2	1	
Havering	L			6.9	15	3	42.7	1	2	1	
Heart of Birmingham Teaching	WM	S		4.8	21	8	48.3	2	3	0	y
Herefordshire	WM			5.8	29	22	39.1	2	2	2	
Heywood, Middleton and Rochdale	NW	S		5.2	0	0	41.7	2	3	1	
Hillingdon	L			4.7	11	4	45.4	2	2	2	
Hounslow	L			5.5	6	0	76.4	2	1	0	

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
Hull Teaching	YH	S		5.4	15	0	44.6	2	2	1	
Isle of Wight NHS	SC			7.0	0	0	-	2	2	1	
Islington	L	S		6.9	4	2	47.3	2	3	1	
Kensington and Chelsea	L			6.9	5	5	56.5	2	1	0	
Kingston	L			8.0	7	2	80.1	2	3	1	y
Kirklees	YH			5.1	8	4	34.4	3	2	2	
Knowsley	NW	S		4.6	2	1	59.3	3	3	1	
Lambeth	L	S		7.0	4	1	21.4	2	2	1	
Leeds	YH			5.3	30	7	44.8	2	2	2	
Leicester City	EM		y	4.9	8	8	50.9	2	5	2	
Leicestershire County and Rutland	EM	S	y	6.0	12	5	63.3	2	5	2	
Lewisham	L	S	y	5.6	7	0	22.5	2	4	1	y
Lincolnshire Teaching	EM	S		5.7	90	13	28.2	2	1	1	
Liverpool	NW	S		5.6	10	41	16.0	2	2	2	
Luton Teaching	EE		y	4.5	2	0	58.8	1	0	0	
Manchester	NW	S		6.2	13	17	48.7	2	2	1	
Medway	SEC			4.6	15	8	17.6	2	2	1	
Mid Essex PCT	EE			5.1	34	11	78.0	2	1	0	
Middlesbrough	NE	S		4.8	1	0	67.6	2	1	1	
Milton Keynes	SC			4.4	4	4	45.6	2	2	1	
Newcastle	NE	S		7.4	0	6	18.1	2	2	1	
Newham	L	S		3.8	6	1	55.7	2	0	0	
Norfolk	EE			5.6	65	8	11.4	2	2	0	
North East Essex	EE			6.1	11	5	79.3	2	0	0	

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
North East Lincolnshire	YH	S		4.9	11	0	72.6	2	3	2	
North Lancashire Teaching	NW			7.1	9	5	77.5	2	3	1	
North Lincolnshire	YH			5.0	4	0	9.8	1	2	1	
North Somerset	SW			5.6	2	0	53.3	2	3	2	
North Staffordshire	WM			7.4	39	13	59.8	2	1	0	y
North Tees	NE	S		5.5	2	0	52.6	2	1	1	
North Tyneside	NE	S		6.0	0	0	36.5	2	2	1	
North Yorkshire and York	YH			6.3	41	13	48.9	1	4	2	
Northamptonshire Teaching	EM	S		5.1	14	0	68.4	2	1	0	
Northumberland Care Trust	NE	S		6.2	1	4	41.2	2	2	1	
Nottingham City	EM	S		6.0	30	3	43.5	3	3	2	
Nottinghamshire County Teaching	EM			6.1	20	11	44.1	2	4	1	
Oldham	NW	S		5.5	0	0	54.0	3	1	1	
Oxfordshire	SC			5.7	57	31	54.8	3	4	0	y
Peterborough	EE			4.8	4	5	54.5	2	1	0	
Plymouth Teaching	SW			5.1	13	5	43.7	2	3	1	y
Portsmouth City Teaching	SC			5.1	16	10	19.3	2	0	0	
Redbridge	L			5.4	11	16	28.4	2	1	0	
Redcar and Cleveland	NE	S		5.0	8	3	45.5	2	1	1	
Richmond and Twickenham	L			6.2	7	4	84.5	1	2	0	
Rotherham	YH	S		5.1	14	9	28.5	2	1	1	
Salford	NW	S		5.4	14	1	78.0	2	3	2	
Sandwell	WM	S		5.2	32	7	37.4	3	4	2	

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
Sefton	NW			5.7	7	2	8.8	2	3	2	
Sheffield	YH			6.5	6	24	46.7	3	2	0	y
Shropshire County	WM			6.9	39	8	74.0	2	3	1	
Solihull Care Trust	WM			5.4	13	0	56.9	2	3	0	
Somerset	SW			5.7	38	19	29.6	3	3	2	
South Birmingham	WM	S		6.6	31	47	50.1	2	2	1	
South East Essex	EE			6.7	10	18	57.3	2	2	1	
South Gloucestershire	SW			6.0	9	9	71.1	2	3	1	
South Staffordshire	WM	S		5.3	24	12	67.3	2	5	3	
South Tyneside	NE	S	y	6.6	1	1	26.9	2	2	1	
South West Essex	EE			6.5	15	16	62.1	2	2	1	
Southampton City	SC			8.3	66	5	-	2	3	1	
Southwark	L	S		5.1	9	4	18.7	3	2	2	
Stockport	NW			5.5	18	20	59.6	2	2	1	
Stoke-on-Trent	WM	S		6.4	36	14	70.6	2	3	1	
Suffolk	EE			5.2	34	13	83.3	2	1	0	y
Sunderland Teaching	NE	S		7.2	5	0	49.2	2	1	1	
Surrey	SEC			5.8	54	79	43.2	2	4	2	
Sutton and Merton	L			5.2	7	3	82.5	2	3	1	
Swindon	SW			5.4	6	1	61.2	2	3	1	
Tameside and Glossop	NW	S		4.9	0	2	79.8	2	2	2	
Telford and Wrekin	WM			5.5	17	1	71.8	2	2	1	
Torbay Care Trust	SW			4.8	0	3	46.6	3	3	1	
Tower Hamlets	L	S		6.2	4	7	60.8	3	2	1	
Trafford	NW			6.2	13	15	58.9	2	4	1	

								World Class Commissioning			
PCT	SHA	Spearhead status	Total Place pilot	Average length of stay 2008/09 (days)	Delayed transfers of care of acute patients Q4 2009/10 (days)	Delayed transfers of care of non-acute patients Q4 2009/10 (days)	%adults receiving secondary mental health services known to be in settled accommodation 2009/10	Score on competency 2 - work with community partners	Total number of relevant indicators selected	Number of mental health indicators selected	Selected delayed discharges of care
Wakefield District	YH	S		5.5	15	7	33.5	2	0	0	
Walsall Teaching	WM	S		6.6	17	11	51.0	1	1	1	
Waltham Forest	L			5.9	8	4	31.9	2	2	0	
Wandsworth Teaching	L			6.0	15	9	80.1	2	3	1	
Warrington	NW	S		5.0	3	5	63.2	2	2	1	
Warwickshire	WM	S		7.6	43	41	26.1	2	2	0	
West Essex	EE			6.4	22	0	66.3	2	0	0	
West Hertfordshire	EE			5.8	35	11	60.4	2	2	0	y
West Kent	SEC			5.5	3	25	29.1	2	0	0	
West Sussex	SEC			7.1	48	45	5.1	2	2	2	
Western Cheshire	NW			5.0	6	3	55.0	2	3	1	y
Westminster	L			7.1	7	6	53.8	2	0	0	
Wiltshire	SW			6.7	15	7	56.5	2	4	1	y
Wirral	NW	S		5.3	8	0	57.2	3	2	1	
Wolverhampton City	WM	S		5.1	8	12	83.0	3	3	2	
Worcestershire	WM		y	6.1	18	9	67.5	2	3	1	

Annex 3: Local authority performance against National Indicators 145 and 149

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
Barking and Dagenham	73.1%	34.3%
Barnet	57.6%	53.1%
Barnsley	85.9%	35.3%
Bath and North East Somerset UA	35.4%	77.3%
Bedford UA	57.4%	57.2%
Bexley	73.5%	74.4%
Birmingham	53.4%	51.3%
Blackburn with Darwen UA	60.7%	65.2%
Blackpool UA	62.8%	75.5%
Bolton	67.3%	81.2%
Bournemouth UA	59.3%	67.6%
Bracknell Forest UA	74.6%	82.0%
Bradford	80.9%	31.8%
Brent	79.4%	63.8%
Brighton and Hove UA	62.6%	6.1%
Bristol UA	42.2%	62.7%
Bromley	57.1%	73.9%
Buckinghamshire	65.9%	49.6%
Bury	80.5%	41.8%
Calderdale	76.1%	26.8%
Cambridgeshire	64.8%	56.6%
Camden	75.5%	14.7%
Central Bedfordshire UA	63.8%	86.0%
Cheshire East UA	34.0%	44.1%

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
Cheshire West and Chester UA	51.9%	57.4%
City of London	100.0%	-
Cornwall	48.3%	29.5%
Coventry	62.0%	54.3%
Croydon	70.5%	15.8%
Cumbria	57.1%	68.7%
Darlington UA	71.9%	54.6%
Derby UA	67.6%	33.4%
Derbyshire	63.9%	31.9%
Devon	38.8%	52.8%
Doncaster	50.7%	20.0%
Dorset	60.0%	60.5%
Dudley	71.2%	44.7%
Durham	80.8%	57.7%
Ealing	60.7%	62.6%
East Riding of Yorkshire UA	56.3%	55.0%
East Sussex	52.4%	6.7%
Enfield	74.3%	47.7%
Essex	49.8%	70.8%
Gateshead	67.6%	59.4%
Gloucestershire	53.9%	64.8%
Greenwich	58.1%	78.9%
Hackney	65.1%	49.0%
Halton UA	82.0%	74.7%
Hammersmith and Fulham	69.0%	64.9%
Hampshire	66.1%	41.5%
Haringey	69.9%	38.2%
Harrow	63.6%	52.8%
Hartlepool UA	65.6%	60.9%
Havering	42.1%	43.5%

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
Herefordshire UA	66.3%	33.3%
Herefordshire	52.0%	60.7%
Hillingdon	41.0%	47.9%
Hounslow	47.2%	77.0%
Isle of Wight UA	64.1%	-
Isles of Scilly	.	-
Islington	67.9%	47.8%
Kensington and Chelsea	62.7%	60.7%
Kent	68.5%	38.9%
Kingston upon Hull UA	54.0%	44.1%
Kingston upon Thames	59.9%	81.1%
Kirklees	73.2%	34.3%
Knowsley	64.3%	59.4%
Lambeth	59.9%	21.8%
Lancashire	54.4%	71.6%
Leeds	58.7%	45.0%
Leicester UA	63.5%	51.0%
Leicestershire	60.6%	62.5%
Lewisham	73.9%	21.9%
Lincolnshire	71.2%	28.2%
Liverpool	82.5%	16.3%
Luton UA	66.9%	61.6%
Manchester	67.4%	48.4%
Medway Towns UA	55.2%	18.7%
Merton	58.9%	83.2%
Middlesborough UA	71.6%	65.9%
Milton Keynes UA	61.2%	46.4%
Newcastle upon Tyne	85.0%	17.7%
Newham	54.4%	55.6%
Norfolk	69.6%	11.4%

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
North East Lincolnshire UA	44.6%	73.2%
North Lincolnshire UA	62.3%	10.3%
North Somerset UA	50.7%	54.5%
North Tyneside	74.3%	38.9%
North Yorkshire	78.4%	40.2%
Northamptonshire	64.7%	68.5%
Northumberland	69.7%	42.0%
Nottingham UA	61.8%	42.9%
Nottinghamshire	64.3%	45.5%
Oldham	60.9%	52.9%
Oxfordshire	80.8%	55.7%
Peterborough UA	65.5%	54.3%
Plymouth UA	50.7%	44.2%
Poole UA	78.6%	77.9%
Portsmouth UA	56.1%	19.1%
Reading UA	69.0%	84.9%
Redbridge	62.9%	28.1%
Redcar and Cleveland UA	54.6%	45.7%
Richmond upon Thames	33.9%	85.8%
Rochdale	30.1%	42.3%
Rotherham	72.4%	29.6%
Rutland UA	74.2%	70.7%
Salford	72.5%	80.3%
Sandwell	55.5%	37.7%
Sefton	79.0%	9.3%
Sheffield	58.0%	46.8%
Shropshire	75.0%	74.9%
Slough UA	69.9%	85.3%
Solihull	27.1%	56.4%
Somerset	63.3%	30.1%

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
South Gloucestershire UA	54.2%	72.3%
South Tyneside	33.1%	28.6%
Southampton UA	57.5%	-
Southend UA	74.0%	52.1%
Southwark	29.3%	18.7%
St Helens	78.9%	73.5%
Staffordshire	75.9%	64.5%
Stockport	51.8%	59.2%
Stockton on Tees UA	58.8%	52.7%
Stoke-on-Trent UA	51.6%	71.6%
Suffolk	49.7%	69.3%
Sunderland	76.1%	49.4%
Surrey	49.0%	43.3%
Sutton	55.4%	81.0%
Swindon UA	41.1%	62.8%
Tameside	74.9%	78.9%
Telford and Wrekin UA	68.4%	72.1%
Thurrock UA	59.2%	63.0%
Torbay UA	55.7%	47.0%
Tower hamlets	50.0%	61.4%
Trafford	72.4%	60.1%
Wakefield	57.9%	33.5%
Walsall	58.0%	50.1%
Waltham Forest	39.3%	33.0%
Wandsworth	44.8%	81.5%
Warrington UA	66.9%	63.5%
Warwickshire	52.8%	26.4%
West Berkshire UA	67.5%	84.9%
West Sussex	67.9%	4.8%
Westminster	52.6%	54.4%

Local Authority	NI 145 - The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review	NI 149 - The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting
Wigan	52.3%	34.4%
Wiltshire	57.4%	59.8%
Windsor and Maidenhead UA	64.7%	85.3%
Wirral	52.4%	57.5%
Wokingham UA	64.5%	86.3%
Wolverhampton	49.4%	83.0%
Worcestershire	59.1%	71.6%
York UA	57.1%	71.3%
England average	**61.0%**	**50.1%**

Annex 4: Relevant indicators selected in year one of World Class Commissioning, as included in Figure 8

National indicators	
4.	Under 18 conception rate
12.	Life expectancy: Males
13.	Life expectancy: Females
14.	Deaths from chronic liver disease
35.	Delayed transfers of care
39.	Suicide & injury undetermined intent mortality rate
40.	Drug treatment waiting times
41.	Percentage drug users effective treatment
42.	Rate of hospital admissions per 100,000 for alcohol related harm
54.	Percentage of all deaths that occur at home

Locally defined indicators with a relevance to mental health
Mental Health Access
Number of people entering dementia services
Mental health – dementia
Patients diagnosed with dementia
Patients with dementia with an agreed care plan
Numbers assessed by dementia services
Out of work due to mental health problems (locally defined)
Mental health patients in employment
Access to psychological therapies: referrals for depression/anxiety as a % of the PCT population (locally defined)
Patients with depression/anxiety offered psychological therapies
Local outcome for mental health linked to the benefits of psychological therapies
Access to talking therapies
Proportion of those classified as neurotic entering psychological therapy (locally defined)
Access to psychological therapies (locally defined)

Locally defined indicators with a relevance to mental health continued
Number of people accessing psychological therapies within two weeks
Access to psychological therapy and return to work
Access to psychological services
Mental health: Number of people helped to recover from depression and anxiety by IAPT therapy services and number of adults trained to recognise and offer help for mental health first aid training.
Completed CBT interventions rate per 1,000 over 16s
Uptake of services for alcohol misuse
Reduce acute inpatient admissions to mental health units
Mortality rate for people with mental health and learning difficulties
Learning disabilities
Adults in contact with secondary Mental Health Services in settled accommodation
Primary care mental health services
Carers receiving needs assessment or review and a specific carer's service or advice and information
Number of carers as a % of clients receiving a community-based service
Proportion of carers receiving a 'carer's break' or a specific carers service as a percentage of clients receiving community-based care
Percentage of working age people on out of work benefit
Health Improvement in Deprived Areas
Reduction in emergency bed days
Rate (standardised) of emergency admissions to all hospitals per 100,000
Emergency bed days
Emergency Admissions for FNOF (Age 65 or over)
Independence for older people
Unscheduled hospital admissions in people aged 75 and over per 100,000 population
People with LTC supported
Proportion of those with LTC supported to be independent and in control of their condition
Primary care access (locally defined)
Adults that live independently at home (locally defined)
Percentage of non-elective admissions with length of stay of 0 and 1 days
Falls
Increase spending outside acute setting
28 day unplanned readmission
Patients managing their own care
Rate of claims for Incapacity Benefit/Severe Disability Allowance

NATIONAL HOUSING FEDERATION

Alongside its sister publication, *Health and housing: worlds apart?*, this key National Housing Federation report offers anyone involved in housing with the tools they need to engage with and influence the health sector, as a new health world emerges. Housing and housing related support offer the health service real solutions to the challenges it faces – and offer demonstrable cost savings. By using the data in this report, housing providers can analyse local priority setting, understand what motivates health commissioners, and become a key part of integrated pathways to improving health for vulnerable people.

The National Housing Federation represents 1,200 not-for-profit, independent housing associations who together provide two and a half million homes for more than five million people in England.

National Housing Federation

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