

HEALTHY LIVES, HEALTHY PEOPLE: Consultation on the funding and commissioning routes for public health

HOMELESS LINK'S RESPONSE MARCH 2011

Homeless Link is the national umbrella organisation for frontline homelessness charities in England. Currently we have more than 470 member organisations. Our members include hostels, day centres, outreach and resettlement agencies, housing advice centres, health projects, welfare rights groups and drug and alcohol services. As the collaborative hub for information and debate on homelessness, we seek to improve services for homeless people and to advocate for policy change. Through this work, we aim to end homelessness in England.

We welcome the opportunity to respond to this consultation. Our particular interest is how public health can be improved for people who are homeless:

- The consultation rightly states that good public health is strongly linked to appropriate housing and other wider determinants of health. We support an Outcomes framework which recognises the role housing plays in giving people healthier lives. We urge the new framework to integrate public health outcomes with other services such as social care and housing, in order to achieve better public health and reduce health inequalities.
- Homeless people experience many of the health and well being needs covered by the new Public Health framework at a rate far higher than the general population:

	% who smoke	% who eat 5 or more fruit a day	% with mental health need	% use drugs
General population¹	21%	29%	30 %	10% (one or more illicit drug in last year)
Homeless population	77%	7%	72%	52%

Because of their higher levels of need, homeless people use acute health services disproportionately to the general population, at 4 times the amount for health services, rising to 8 times as much for inpatient care.² We believe improving preventative and public health services can go a long way to reducing both the ill health of homeless people and the wider costs on the NHS and wider community.

¹ Taken from ONS and NHS data

² Healthcare for Single Homeless people, (DH, 2010)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

The new commissioning responsibilities for Public Health Directors and their local partners present an opportunity to improve preventative services and ensure those who have the poorest health benefit from health improvements. It is disappointing that this Commissioning Consultation comes when the Outcomes Framework is still in its consultation phase, and indicators are yet to be agreed. Therefore, some decisions about the best way to fund services to achieve these indicators is premature. However we hope there will be an opportunity to influence the development of the funding and commissioning routes as the new arrangements are put in place.

We have addressed the consultation questions most relevant to the interests of people who are homeless.

1. Is the health and wellbeing board the right place to bring together ring fenced public health and other budgets?

Health and Wellbeing Boards have the potential to improve integrated working across relevant local service provision, and will have a key role in determining local priorities based on the JSNA.

The Boards are well placed to bring together the ring-fenced public health budgets. However they must ensure they include, either through direct membership or alternative mechanisms, all the relevant stakeholders and services which deliver and meet public health outcomes in order that this budget is directed most effectively.

Housing is an important determinant of health, yet its role is underplayed in the current proposals. Without its strategic involvement in Health and Wellbeing boards, the public health reforms could be undermined.

Health and Wellbeing Boards would be strengthened if their membership included a housing representative and had greater input from relevant voluntary sector providers, as described below. We hope the guidance for the early implementer programme of Health and Wellbeing boards will encourage this approach.

2. What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

As above, current proposals about the membership of Health and Wellbeing Boards underutilise the voluntary sector. There are no clear mechanisms for how agencies not formally part of this structure can both help determine commissioning priorities and feed into service development.

We suggest these considerations should be taken:

- A clear process for stakeholders to feed into health improvement plans, including a mechanism for routinely inviting voluntary and community sector (VCS) agencies to participate on areas relevant to their areas of expertise. There should also be clear routes for engagement so that the Board can operate in the 'equal and transparent manner'. This could be via a sub-group; open and transparent channels for groups to feed in their ideas (e.g. using for example web portals and targeted consultation with less visible groups) and extended membership on the Health and Wellbeing Boards. Local authorities

should be accountable to this input and be required to demonstrate how it has been incorporated into health improvement plans. Papers should be available in the public domain with sufficient time for comment and input. HealthWatch should also be given authority to scrutinise health improvement plans.

- The new framework may open up opportunities for a wider range of providers to deliver health and wellbeing services. Many small, local agencies currently provide very effective and targeted services which fall into the remit of Public Health. However, they often deliver low volume services to very complex client groups where outcomes can be harder to achieve, and require a 'spend to save' investment which commissioners can be unwilling to take.
- This means that commissioning may favour larger providers who can carry this risk. Their capture of the market could stifle innovation and prevent the necessary transfer of resources into primary and community care. We hope the new regulatory regime acknowledges this potential pitfall and also supports community based providers who are well placed meet the needs of disadvantaged patient groups, rather than routinely favouring large providers who can carry a greater financial risk upfront.

3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

If NHS Commissioning is too clinically driven, there is a danger it will not have the necessary expertise on public health issues. Consortia and local authorities must work closely via the Health and Wellbeing board to ensure this expertise is shared and commissioning decisions are underpinned by the more holistic and preventative model of public health.

The VCS is well placed to provide NHS commissioning with this expertise. As outlined above, often these agencies are those who best understand the needs of local people and are providing the services to them, particularly more vulnerable groups who often have the highest health needs.

The *Inclusion Health*³ guidance encouraged commissioners to draw on a more varied evidence base of local need, which draws on the experience both of patients and voluntary sector groups working with them. There should be a similar expectation for all NHS commissioning to do similar, to ensure they do not rely solely on clinical data but broader qualitative intelligence about public health, including intelligence from more excluded patient groups.

The Homeless Link Homeless Health Needs Audit⁴ is a means to measure the needs of a local homeless population and would offer commissioners a rich source of data about public health issues. We would be happy to advise on other sources of intelligence which could be utilised.

5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment that we should take into account when developing the policy?

³ Inclusion Health, DH 2010

⁴ www.homeless.org.uk/health-needs-audit

If the new Public Health framework is to meet its stated aim of 'improving the health of the poorest, fastest' it must take into account inequalities which exist and often cut across the most excluded groups in the population (such as those with multiple needs, rough sleepers, homeless people, those in drug treatment, or in contact with the criminal justice system). Inequalities in health outcomes are experienced beyond those included in equality legislation and this must be taken into account if these enduring health inequalities are to be addressed.

7. Do you consider the proposed primary routes for commissioning of public health funded activity to be the best way to a) ensure the best possible outcomes for the population as a whole, including the most vulnerable b) reduce avoidable inequalities in health between population groups and communities?

The proposed routes offer an appropriate way to deliver these outcomes, but only if these are closely aligned and integrated with GP Consortia and other commissioners or health services. Many individuals will be accessing services commissioned under different routes, so pathways and outcomes must complement each other. Ensuring commissioning plans are underpinned by the same assessment and understanding of need (in the JSNA) is crucial to achieve this goal.

We would also point out that it does not make sense to provide some services at a local authority level. Some low volume services – including specialist services such as for complex dual diagnosis - may need to be provided at either a regional or unitary level. Indeed, there is a danger that if this is not done then such services could be lost under the new arrangements if deemed too low volume and hence not cost effective.

New routes must enable opportunities for jointly commissioned services in these cases. The JSNA should be used as one mechanism to inform these decisions but specialist expertise should also be sought from agencies working with vulnerable population groups, such as homeless people. If public health services are not provided or accessible to these groups, this will incur high costs in the long term and fail to reduce inequalities among these groups who often fall beneath the radar of mainstream services.

8. Which services should be mandatory for local authorities to provide or commission?

There are a number of services which are crucial to protect the health of the wider community. Screening and immunisation, for TB and other diseases, should be widely available and fully resourced. There has been an increase of TB among homeless populations in recent years (up to 200 times that of the general population), yet screening and treatment services are under threat. Failure to provide these services could lead to a major public health issue for which local authorities must take responsibility.

While the provision of these services should be mandatory, this should not be to the detriment or marginalisation of other services which may appear less critical to health protection for the wider population – i.e. there is less risk of contagion. For example, services for mental health and harm reduction services for substance misuse can prevent more severe health problems developing in a population. To ensure mandating certain services does not sideline others, services should be developed in response to the needs identified in the JSNA and the health and wellbeing strategies.

To improve the health of ‘the poorest, fastest’, some services will need to be prioritised which is why mapping health inequalities and health improvement areas should be at the core of the JSNA process.

10. Which approaches to developing an allocation formula should we ask ACRA to consider?

An approach for the ACRA should primarily look at population health measures.

Utilisation, or underutilisation of services in certain areas, does not necessarily indicate a lack of need. Under utilisation can exist if services are poorly promoted for example, or if there are access barriers which prevent them being used by those in need. Caution should also be used by cost-effectiveness driving forward the formula. While an important consideration, some services – particular low volume- can be expensive but yield significant health outcomes and prevent longer term health problems developing in the future.

Population measures, while useful, should ensure they consider areas of deprivation and need within more affluent areas. This can often get overlooked in larger population areas. For example, the life expectancy for the most affluent parts of Westminster is 12.7 years longer than in the most deprived areas. Westminster has one of the country’s highest concentration of homelessness and associated poor health outcomes . Allocation must take into account groups which experience intense inequality and deprivation even if they are small in number, as their health needs are likely to be among the most costly and severe in the community and the formula must be weighted to reflect this fact. A measurement of the homelessness population (using data on bedspaces and rough sleeping data) offers one way to calculate this impact.

12. Who should be represented in the group developing the formula?

The formula should reflect the different factors upon which health improvement is dependent. Providers of housing related support should have some representation, as progress in many areas of health improvement will be difficult to achieve unless the role of housing is considered.

13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes framework to the health premium?

The following factors need to be considered:

- Variation in the ‘baseline’ of need in an area: levels of need vary and change depending on the wider determinants (levels of unemployment, levels of affordable accommodation, etc.) and these changes must be considered and reconsidered when measuring progress over time.
- Considering the longer term nature of progress: some public health improvements will not be immediately realised. Some improvements do not follow linear patterns and require prolonged engagement or interventions. Areas should not be punished or disincentivised for offering services which do not offer a quick fix but instead achieve outcomes over a longer period of time.

14. How should we design the health premium to ensure that it incentivises reductions in inequalities?

The health premium should not be viewed as the sole incentive for reducing inequalities. Reducing health inequalities should be the aim of the wider public health agenda, and a theme running throughout the five domains of the new Outcomes Framework. As such, the health premium should be designed to encourage local authorities and their partners to address areas of more acute inequality which may require additional resources or more targeted interventions. It should not be designed as a proxy for reducing inequalities across all areas of health improvement – a fundamental aim implicit in Public Health.

As such, the premium should measure progress against the most acute areas of inequality as identified in the JSNA and health and wellbeing strategy. In this way, areas will have a greater incentive for tackling issues which may carry additional risk and will not be penalised for addressing issues whose outcomes can be harder to achieve.

Helen Mathie
Homeless Link
March 2011

Homeless Link, Gateway House, Milverton Street, London SE11 4AP
[+44 \(0\) 20 7840 4430](tel:+442078404430) | info@homelesslink.org.uk | www.homeless.org.uk
Chief Executive: Jenny Edwards | Chair: Ann Skinner | Charity Registration No. 1089173 Company
Registration No. 4313826