Portfolio Holder (Health)
Decision Making Session

Agenda

Tuesday 29 March 2011

A Portfolio Holder (Health) Decision Making Session will be held in Committee Room 1 at **SHIRE HALL, WARWICK** on **Tuesday 29 March 2011 at 9.00 a.m**.

The agenda will be:

1. **General**

   (1) Members' Disclosures of Personal and Prejudicial Interests.

   Members are reminded that they should declare the existence and nature of their personal interests at the commencement of the item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

   Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration.

   (2) Minutes of the meeting held on 4 October 2010

2. **White Paper: 'Healthy Lives, Healthy People – Our Strategy for Public Health in England' –Proposed response to consultation**

   Report of the Assistant Chief Executive – To follow

3. **Any Other Urgent Business**

JIM GRAHAM
Chief Executive
Warwickshire County Council
March 2011

Cabinet Portfolio Holder for Health: Councillor Bob Stevens
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Minutes of Cabinet Portfolio Holder (Health) Decision Making Session held on 4 October 2010

Present: Councillor Bob Stevens (decision maker)
Councillor Les Caborn

Officers: Monica Fogarty, Assistant Chief Executive
John Linnane, Joint Director of Public Health
Simon Robson, Head of County Partnerships
Janet Purcell, Executive and Member Support Manager
Clare Edwards, CYP & F Directorate

1. Members Declarations of Personal and Prejudicial Interests

None

2. Consultation on White Paper: Liberating the NHS & Transition of Link to HealthWatch

Councillor Bob Stevens considered the report of the Assistant Chief Executive and Strategic Director of Customers, Workforce & Governance that presented a proposed joint response to the Government's consultation on forthcoming health proposals.

During discussion Councillor Les Caborn suggested that paragraph 19 be amended to make clear the concern regarding the scrutiny role being subsumed within the Health and Well Being Board. A number of other amendments were made as shown in italics in the attached appendix.

Councillor Bob Stevens also agreed that a response to the Achieving Equity and Excellence for Children should be included in this response to the White Paper so allowing one integrated response to be returned to the Department of Health.

Resolved

That the appended response, subject to any further minor amendments by the Assistant Chief Executive and to the inclusion of a response to the Achieving Equity and Excellence for Children, be submitted to the Department of Health as the Council's integrated response to the White Paper.

3. Any other items of business

None

……
Leader

The meeting rose at 13.10 pm

Portfolio Holder (Health) Decision Making Session – 4 October 2010 **Appendix**

NHS Warwickshire and Warwickshire County Council

JOINT RESPONSE TO THE WHITE PAPER EQUITY AND EXCELLENCE: LIBERATING THE NHS

The response to the White Paper is presented as follows:-

- **General response in relation to the Government strategy for the future of the NHS, Social Care and Public Health**
- **Specific response to the questions posed by the Department of Health**
- **Response with a specific focus on the consultation regarding the proposed establishment of HealthWatch (Annex 1)**

General Response

1. We welcome and support the Government's strategy as outlined in the White Paper, which upholds the values and founding principles of the NHS; namely comprehensive services, available to all, free at the point of use and based on clinical need, not the ability to pay. As public agencies, we are committed to taking the changes forward, together and in partnership between NHS Warwickshire and Warwickshire County Council.

2. We support the approach described in the White Paper to enable the user/patient and their carers to be more in control of their care through the drive to provide more personalised approaches to service provision and more information to facilitate patient choice. We also support the strengthening of the local patient and public voice through the new arrangements led by local authorities and the driving up of standards through revised regulatory and inspection arrangements of both acute and community based health and social care provision.

3. We strongly support the approach to strengthen democratic legitimacy at the local level and the role of local authorities in promoting the joining up of local NHS services, social care and health improvement. Similarly, the Council welcomes the proposals to lead the Public Health function and to ring-fence the Public Health budget as integral to underpinning the Local Authority's role in co-ordinating, joining up and integrating NHS and social care provision to provide more effective outcomes for the health and well-being of individuals and communities.

4. We appreciate that the White Paper describes a long-term plan for the NHS, not just for this parliamentary term. However, if the long-term goal is to provide for a NHS, which is coherent, stable, with sustainable service improvement, the initial early years implementation of this far reaching reform needs to be considered and supported by a national framework, proportionate, not bureaucratic, to enable the acceptable management of risks, both at a local and national level, during this huge transformation.

5. We welcome the consistent message throughout the White Paper that local authorities will have much greater autonomy to direct resources to meet agreed local priorities, whilst at the same time having greater transparency and accountability to the public in how it uses these resources to improve the quality of life, health and well-being of its citizens and communities. We see this enhanced role being explicit through the strengthened role in the JSNA.

Specific responses to the Department of Health consultation questions. (Each paragraph has a reference number in Bold e.g. "Q1" which links it to the list of questions in Annex 1)

6. Local HealthWatch should have a formal role in seeking patient and user views. We support the view that this is carried out through HealthWatch's membership of the Health and Well-being Board. This would enable public engagement and democratic scrutiny to become embedded in the local health and social care accountability framework. **(Q1)**

7. HealthWatch should take on the wider role with responsibility for complaints advocacy and supporting individuals to exercise choice and control. HealthWatch must have a key role in offering objective support to those who need it. Consequently, we would support reform of the current national NHS complaints service to be devolved to local authorities. Through the commissioning of HealthWatch, customised local support to people who want to make a complaint could be more easily achieved. **(Q2, Q3)**

8. We propose the development of a 'service specification' developed collaboratively with existing providers (LINks). This would provide an informed basis for local authorities to commission effectively Local HealthWatch. **(Q3)**

9. Within service specifications, we welcome a focus on clear **local** outcomes measures. The scrutiny role and reporting of such measures will enable elected members to exercise influence and accountability on the role and impact of local HealthWatch. **(Q4)**

10. The Local Authority must ensure that through contracting/commissioning arrangements, HealthWatch's independence from health and social care commissioners and providers is maintained. In addition, the Government could support the Local Authority's ability to commission effective outcomes through HealthWatch by ensuring HealthWatch has statutory rights as well as responsibilities. Whilst being accountable to the Health and Wellbeing Board, HealthWatch needs to have vested authority and power to require responses from all providers and commissioners of services. **(Q5, Q6)**

11. Effective commissioning by local authorities in respect of maximising the Local HealthWatch outcomes and impact for patients/users must not be undermined by HealthWatch England assuming authority and/or management responsibilities over Local HealthWatch. Therefore we welcome clear delineation of responsibilities at both the national and local level. **(Q3)**

12. Effective commissioning would be greatly strengthened by the local authority being proactive in holding HealthWatch to account in the event of under–performance. **(Q3)**

13. We support the proposals outlined within the White Paper for stronger institutional arrangements, within local authorities, led by elected Members to support partnership working across Health and Social Care and Public Health. In order to develop personalised health and social care, joint, integrated working is essential. The proposal of a statutory role within each upper tier local authority to support joint working on health and well-being is considered essential. **(Q7)**

14. We support proposals to create a statutory Health and Well-being Board and recommends that the Government allows freedom and flexibility as to how the Board would work in practice locally and set local priorities. **(Q7)**

15. We support the proposals for the Board's main functions as outlined in the White Paper. In addition to these the Board should also have as an explicit key function ensuring resources are *commissioned* towards identified priorities which address areas of deprivation and prevailing poor health outcomes. This could be achieved through giving the Board a lead role in determining strategies and allocation of placed-based health budgets. **(Q8)**

16. We recommend strongly that Children's Trusts have a duty to cooperate with the Health and Wellbeing Board. It is suggested that one of the key areas of *business* of the Board would be to maximise and ensure positive experiences of people with learning disabilities moving seamlessly from children to adult service provision. **(Q10)**

17. We anticipate that the Health and Well-being Board will be responsible for the citizens within the geographical area of Warwickshire (the County). In order to enable the Health and Well-being Board to have involvement and impact where it makes sense with other neighbouring Boards the provision of a framework within which to develop wider working would be welcomed. **(Q11)**

18. *We would expect the Health and Wellbeing Board to undertake a strategic role, for example managing the interface between hospital discharges and social care provision.*

    We consider that the Health and Well-being Board should have a small, tight membership in order to carry out its key strategic role, agree joint NHS and social care commissioning of specific services and agree allocation of place-based budges on cross cutting health issues. **(Q12)**

19. *We are unsure how the scrutiny role* can be subsumed within the Health and Wellbeing Board. Potentially, it might be more efficient, avoid duplication of effort, be less confusing and enable clarity around democratic accountability. However, as currently described, the Health and Wellbeing Board is clearly an executive body and there would be an inherent conflict of interest in undertaking a scrutiny role in relation to its own function. We also believe that the Health and Wellbeing Board should be a high level body which focuses on

strategy. The Department of Health needs to consider more rigorously how best to achieve democratic accountability and transparency within the Health and Wellbeing Board context. **(Q14)**

20. We recommend that the Health and Wellbeing Board produce an Annual Report, which is considered by *local executive bodies*, *including GP consortia*. The Annual Report would support accountability of the Board's performance, impact and activities. **(Q13, Q16)** *and should also be submitted to the National Board.*

21. We recommend that *all partners (including adult social care and GP Consortia)should* be compelled to address the identified priorities with the JSNA. The GP consortia should be encouraged to work alongside community partners to ensure commissioning decisions/approaches reflect the public voice and local priorities. This can be delivered through patient participation groups, HealthWatch and voluntary groups. **(Q13, Q17)**

22. We extol the use of Equality and Health Impact assessments on major decisions affecting citizens and communities in respect of NHS, social care, public health, strategic planning, commissioning or provision. Similarly, as partners we would seek to engage Local Government Improvement and Development, to draw upon national best practice in improving the local NHS, Social Care and Public Health system. **(Q9, Q17)**

23. Finally, we are concerned that marginalised groups and communities with poorer health do not become further marginalised. Incentives to encourage actions based upon the findings of the Joint Strategic Need Assessment with outcome measures for the Board to be judged on what it achieves for these communities (as opposed to how it achieves outcomes) would be welcomed. **Q17)**

Appendix – Annex 1

HealthWatch

1.1 What needs to happen for local HealthWatch to fulfil its new functions around health complaints advocacy? In particular to support people who do not have the means or capacity to make choices about their care?

The following factors should be taken fully into account:

a) Adequate levels of funding from central government – and if this could be ring-fenced for the purposes of Healthwatch, so much the better.

b) The advocacy service should be seen as a collaborative venture which brings together, under the coordination of the County Council, the range of existing advocacy services that to work towards collaboratively a common purpose. These organisations include a wide range of 3rd sector organisations, all of which should play a full part. We would also ensure that District/Borough Councils are involved in the development of local Healthwatch as they are providers of important services such as housing and council tax/housing benefit. Links should also be made with Coventry City Council as the local provider trust for mental health includes their area.

c) In short, local Healthwatch would best be seen as a coherent alliance of existing groups and organisations, funded to deliver the complaints advocacy service – with the County Council playing the key coordination role by ensuring that the service is of high quality, demonstrates value for money, and are accessible by all – especially the seldom heard.

d) The LINK experience offers many lessons and we should all learn from them. The good progress made by the LINk in the recent past should be seen as the foundation on which the advocacy service should be established.

e) The service should be free at the point of delivery, and steps should be taken via publicity and community networks to promote the service in particular to those who may not have the means, confidence, or capacity to make choices about their care.

f) Government should enable the establishment of local Healthwatch (including the complaints advocacy service) to take place and for providers to be selected by the County Council through a process of collaborative commissioning rather that insisting on rigid procurement rules. By doing so, a service specification could be developed collaboratively with existing providers taking fully into account their knowledge, experience, track record, and, most importantly their community knowledge and existing links with patients and service users.

g) Local Healthwatch will need to link well with existing patients advocacy consortia – the PALS Service in Warwickshire is a significant service (NHS Warwickshire has already dealt with 700 queries from them so far this year)

h) We have concerns that local Healthwatch may be expected to be all things to all people and there is a risk involved in attributing too many responsibilities to it too

soon – this would not only damage its development but would also adversely affect the progress made by the Warwickshire LINk over the past twelve months

1.2 What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

We repeat the points made under 1.1 above

2 Healthwatch role

2.1 What should be done to embed local HealthWatch as the local consumer voice, and HealthWatch England as the national voice for health and social care consumers?

The following factors are relevant in addition to the points raised under 1.1 (above):

In relation to <u>local</u> Healthwatch:

a) Helpful locally relevant publicity and promotional activities

b) The use of community development techniques to the promotion, and marketing of local Healthwatch

c) Ensuring the independence of local Healthwatch from service providers and commissioners

d) Embedding local Healthwatch within the democratic framework of local government and ensuring that elected representatives play a full part in the development and monitoring of the service via local scrutiny arrangements (in Warwickshire the Adult Social Care and Health Overiview & Scrutiny Committee) and the forthcoming statutorily based Health & Well Being Board (there will be a need to ensure that duplication / confusion is avoided)

e) Ensuring that local Healthwatch is linked well with the wide range of existing advocacy and engagement opportunities available to Warwickshire citizens

f) Ensuring that local Healthwatch has statutory rights as well as responsibilities – especially in relation to Enter View and a right to make representations and demand responses from all service deliverers, service commissioners and the local Health and Well Being Board

In relation Healthwatch England:

a) Ensuring that it does not assume authority and management responsibilities over local Healthwatch

b) Ensuring its independence from the Department of Health, the Quality Care Commission and all other aspects of the regulatory regime

c) Embedding accountability for Healthwatch England activities to local Healthwatch organisations

d) Ensuring that the public is fully aware of the activities and responsibilities of local Heathwatch

Additionally (unlike with the LINks') there should be no requirement on the part of the local authority to establish by contract a hosting arrangement. Independence can be secured in more effective, subtler and cheaper ways.

The responsibility should be given to local authorities to demonstrate the independence of local Healthwatch and NOT for a central government driven model to be imposed on them.

2.2 How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

a) In so far as Healthwatch England is concerned, its governance arrangements should ensure that it is distanced from the authority of central government and that it has three way accountability to central government, local government and the local Healthwatch.

b) Its governance arrangements should include obligatory involvement of national 3rd sector organisations and national coalitions of patient and community groups.

c) Regarding local Healthwatch, it should be a membership organisation, with its governing body being drawn from and elected by its membership. The local authority should have the right to nominate a councillor to champion the role of Healthwatch within local democratic arrangements.

d) Healthwatch England should assume the key role of facilitating the transfer of good practice and mutual support between 'branches' of local Healthwatch.

e) The over-riding principle that should apply is that of subsidiarity with decision making being made at the level closest to patients, service users and communities

2.3 How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

a) Local Healthwatch should work in a collaborative and inclusive way. It should forge positive relationships with the consortia based on an assumption of equal value and mutual respect.

b) The same principles should apply to all commissioning bodies which should be given a statutory duty to ensure that they co-operate with local Healthwatch.

c) To give further strength to its position, local Healthwatch should be given the legal rights set out in 2.1 f) above.

d) As a matter of good practice, local commissioners should be required to establish an annual commissioning programme which would be shard with local Healthwatch thus giving it at the earliest possible stage the opportunity to shape and determining a relevant and manageable annual work programme.

2.4 What needs to happen for local HealthWatch to support the needs of vulnerable people –such older or very frail people? What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

a) Within the alliance of advice / advocacy organisations referred to in paragraph 2.1 above, the local authority should ensure that carers and local organisations representing these groups are actively involved.

b) Adequate levels of resourcing is again a key to success

c) The local authority should be put under a legal responsibility to ensure that the rights of these individuals and groups are championed

d) It may be necessary to ensure that appropriate statutory linkages are made with regard to the Mental Capacity Act for those individuals who cannot:

- understand the information relevant to decisions
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate the decision.

3 Governance Arrangements and Funding

3.1 What governance arrangements need to be put in place to ensure that accountabilities are clear for all parties?

The following points are made:

a) In relation to all governance issues – form should follow function. Hence, governance arrangements should be considered in detail when the precise shape / form of Healthwatch England and local Healthwatch have been established.

b) Government is advised against imposing a strict governance model for local Heathwatch. This should be a matter for local determination within the context of a broad statutory framework

c) There should be no legal requirement for the local authority to contract out hosting services to external bodies (see 2.1 above).

d) Healthwatch England should come under the umbrella of the Centre for Public Scrutiny (CfPS)

e) The governance arrangements for Healthwatch England should ensure that representatives of local Healthwatch 'branches' are actively involved in its management

3.2 How should HealthWatch England be constituted within the CQC structure?

It should be independent of the legal structure of CQC but accountable to it for performance

3.3 What role, if any, should HealthWatch England play in holding local authorities to account for how local HealthWatch is operated?

a) This is a matter for local determination, and local Healthwatch should primarily be accountable to its membership and locally elected representatives

b) The local authority should be under a legal responsibility to ensure that an Annual report of local Healthwatch activities and performance is produced and published.

3.4 What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

See 3.3 above

3.5 What needs to happen to ensure transparency over how HealthWatch funding is spent by local HealthWatch and by local authorities?

The following should apply:

a) Financial support from central government for the local Healthwatch funding should be hypothecated ./ ring-fenced

b) The local authority should be under a responsibility to prepare an annual set of accounts in line with sound accounting practice

c) The Annual Report and Accounts should be published and formally signed off by the senior financial officer at the local authority in consultation with the Chair of the Health and Well being Board

4 Breadth of the role and balancing competing interests

4.1 How will local HealthWatch cover both health and social care services?

The following points are made:

a) Local Healthwatch should be held to account by the local authority and its broader membership to ensure an appropriate balance

b) Those managing and supporting local Healthwatch should ensure that it has access to and animates community organisations and networks representing both health and social care

c) It should be recognised that the dividing line between health and social care is often unclear and occasionally illusory – especially from the patient / service user and care perspective. It is the service that counts – not its classification

4.2 ‘What role should local HealthWatch play in seeking patients’ views on whether local providers and commissioners are taking account ‘of the NHS Constitution?

a) Local Healthwatch should be a statutory consultee in relation to the establishment of the constitution

b) Health commissioners should be under a responsibility to produce an annual report demonstrating, amongst other matters, its adherence to the constitution – and local Healthwatch should be a statutory consultee and with the formal legal right to publically respond and comment

4.3 What needs to happen to ensure an effective balance is achieved between HealthWatch England and local HealthWatch?

We have already responded.

4.4 What role should HealthWatch England play in achieving this balance?

We have already responded.

5 Relationships

5.1 HealthWatch England will need to develop working arrangements with the NHS Commissioning Board, Monitor, Department of Health and CQC. What principles should underpin these relationships?

a) The major principle that should apply is the right to independently and publically challenge the activities and performance of these bodies

b) Coupled with this, both Healthwatch England and this group of bodies should seek to establish positive and collaborative relationships based on mutual trust and respect

5.2 What needs to happen to build relationships between local HealthWatch and other local partners, such as local authorities or GP Commissioning Consortia?

See paragraph 2.3 above.

6. Transition during 2011/12

6.1 What do we need to take into account for the transition of LINks into local HealthWatch?

The following apply:

a) Ensure an ongoing dialogue between Department of Health, local government, community organisations, Primary Care Trusts and all other stakeholders to ensure that the transition is capably managed and that the model for local Healthwatch is built on:

- Collaboration and
- Takes fully into account the lessons learned from the LINKs

b) Responsibility for securing the transition should rest with the local authority

c) The local authority should be empowered to take the management of the LINk in house for a minimum period of 12 months and should be released from the

existing statutory responsibility to secure the hosting of the LINk by an independent organisation (on terms)

d) Guidance to local authorities that any under-spend on the LINk accounts should be ring-fenced and carried forward to 2011/12 to support work on the transition.

6.2 What support will LINks need during this period?

The following apply:

a) Adequate levels of funding - if possible ring-fenced to the purposes of the LINk

b) Access to independent advice and support

c) The establishment of a positive can do organisational culture within the LINk, the local authority and with all key stakeholders

d) Sufficient support / resource to ensure that the LINk continues to deliver its functions notwithstanding its imminent demise

6.3 What additional skills will staff and volunteers require to deliver the expanded functions, and how can they be developed?

a) It may be inappropriate to view the introduction of local Healthwatch as a mere 'expansion of functions'. We suggest that it would be preferable to regard this as a new development building on the experiences and successes of the LINk and its forerunners

b) Additional skills may not always be required – it will be more important to secure a positive approach coupled with gaining a clear understanding of the individual advocacy role, including an awareness of existing organisations and groups that already deliver the function locally

c) A training and development programme should be developed and delivered locally which is geared to managing the transition and participants acquiring the necessary skills and knowledge to deliver local Healthwatch by March 2012

d) Some additional resources may be required to achieve the transition but it is suggested that these could be found from savings that would result from taking the management of the transition in-house within the local authority

6.4 What are the organisational and resource implications of expanding LINks' functions?

a) Organisational implications have already been addressed through this response.

b) It is at this stage difficult to predict whether and if so to what extent additional resources would need to be invested by central government.

c) In relation to the **management and support** of local Healthwatch our instinct is that the current level of funding (Area Based Grant 2010/11) may be sufficient so long as the local authority is released from the requirement of contracting with an independent host organisation

d) Additional resources will be required to enable the delivery of the complaints / advocacy service – although the requirement will be limited so long as existing local organisations and networks are empowered to deliver.

Agenda No 2

AGENDA MANAGEMENT SHEET

Name of Committee	**Portfolio Holders (Health) Decision Making Session**
Date of Committee	**29 March 2011**
Report Title	**Consultation Response on White Paper: Healthy Lives Healthy People**
Summary	This report presents a joint response from Warwickshire County Council and NHS Warwickshire to the Government's consultation in respect of forthcoming health proposals.
For further information please contact:	Monica Fogarty Assistant Chief Executive Tel. 01926 412514 or monicafogary@warwickshire.gov.uk Dr. John Linnane Director of Public Health Tel: 01926 431491 John.linnane@warwickshire.nhs.uk
Would the recommendation decision be contrary to the Budget and Policy Framework? [please identify relevant plan/budget provision]	N/A
Background papers	

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	
Local Member(s)	☐	
Other Elected Members	X	Cllr Caborn, Shilton, Tooth and Rolfe
Cabinet Member		
Chief Executive		
Legal	x	Jane Pollard
Finance		

Other Chief Officers	X	Monica Fogarty, Wendy Fabbro, Marion Davis
District Councils	☐	
Health Authority	☐	
Police	☐	
Other Bodies/Individuals	☒	Via Health Transition Group Meeting held on 21.03.11

FINAL DECISION

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐
To Council	☐
To Cabinet	☐
To an O & S Committee	☐
To an Area Committee	☐
Further Consultation	☐

Agenda No 2

Portfolio Holder (Health) Decision Making Session

29 March 2011

Consultation Response on White Paper: Healthy Lives Healthy People

Report of the Assistant Chief Executive & Director of Public Health

Recommendation

That the Cabinet Portfolio Holder (Health) approves the attached response (Appendix A) for submission to Central Government on 31st March 2011.

1.0 National Context

1.1 Attached as Appendix A to this report is a joint response that has been drafted by the County Council and NHS Warwickshire in response to the following papers that have been issued by the Government under the banner 'Healthy Lives, Healthy People'

a) Healthy Lives, Healthy People White Paper: Our vision for Public Health in England
b) Healthy Lives, Healthy People*:* consultation on the funding and commissioning routes for public health
c) Healthy Lives, Healthy People: Transparency in Outcomes

1.2 The paper has been drafted in partnership and has been based on consultation events that have been held at county and borough/district level. The summary of the opinions have been summarised within the document which is divided into a summary of overall responses and then individual responses to questions raised within the three documents.

MONICA FOGARTY-Assistant Chief Executive
JOHN LINNANE-Director of Public Health
MARCH 2011

Appendix A

Joint Response to:

Healthy Lives, Healthy People White Paper: Our vision for Public Health in England

Healthy Lives, Healthy People*:* consultation on the funding and commissioning routes for public health

Healthy Lives, Healthy People: Transparency in Outcomes

NHS Warwickshire
Warwickshire County Council
V2 (22.03.11)

Foreword

Dear Secretary of State,

On behalf of NHS Warwickshire and Warwickshire County Council we would like to present our response to the suite of Health Lives, Healthy People white papers. Overall, we are very supportive of the proposals being made for public health in England and consider that there will be significant benefits of these changes for the people of Warwickshire and will allow us to build upon the strong history of partnership working that already exists in the county.

We have undertaken several deliberative events on a county wide basis and at the district and borough level where the responses have been broadly supportive of these changes. The summary of opinions raised at these events are summarised in this document.

The changes proposed to public health are significant and some issues will emerge in the detail. We strongly recommend that the government heeds the opinions of the Faculty of Public Health and the British Medical Association in finalising these arrangements to ensure that the scarce resource of skilled public health specialists and the public health infrastructure as a whole is not irrevocably damaged or fragmented which will almost certainly result in the failure of these well intentioned proposals.

Our response includes:

- A summary of the proposals that we most strongly support and the proposals that we are most concerned about in all three consultation documents
- Responses to consultation questions in *Healthy Lives, Healthy People White Paper: Our vision for Public Health in England*
- Responses to consultation questions in *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*
- Responses to consultation questions in *Healthy Lives, Healthy People: Transparency in Outcomes*

COUNCILLOR BOB STEVENS
Deputy Leader, Warwickshire County Council and Porfolio Holder for Health

BRYAN STOTEN
Chair of NHS Warwickshire

JOHN LINNANE
Director of Public Health

Proposals Most Strongly Supported or Needing Further Consideration

We have separated our responses into several sections for ease and noted under each section what we support, what we have concerns about and any suggestions for improvements.

Overall

We support:

- The government basing much of the white paper on the recommendations of the Sir Michael Marmot's report "Fair Society, Healthy Lives" to improve health and reduce health inequalities. To this end the recent Tobacco Control Strategy is to be welcomed.
- The acknowledgement that the causes of ill health are related to a wide range of influences throughout life and that the NHS alone cannot tackle these and that the responsibility for these needs to be shared across local government and communities
- The proposal that local government is best placed to influence many of the wider determinants of health
- The ability of local communities to prioritise the issues that are most important for them
- The five domains of public health that cover the broad remit of public health
- The need for public health to be professionally led by a workforce of specialist and skilled staff
- The government in balancing the state intervention/legislation and personal freedoms, however, we would like to remind the government that where issues are entrenched in society e.g. smoking, alcohol misuse the use of legislation can be the most powerful tool we have in improving public health
- The Public Health Responsibility Deal and welcome the inclusion of the commercial sector in taking their responsibility for health
- The proposed large growth in health visitor numbers
- The Public Health outcomes framework and how these measures will be jointly held by the NHS and local government.
- The continued and important role of the Chief Medical Officer
- The normalisation of an evidenced based approach to prioritisation and an emphasis on outcomes, supported by evidence from the JSNA, thereby allowing the health inequalities agenda to be addressed more robustly

We feel the following need more development and consideration:

- The relationship between local public health commissioning and the National Commissioning Board (NCB) on behalf of Public Health England e.g. screening programmes. **We suggest that, where appropriate, sub-national offices of the NCB devolve responsibility for the quality and performance management of these services to local public health departments.**

- That the evidence base for “nudging” people towards better health is limited and we await the outputs of the Behavioural Insight Unit to provide more information.
- Provision of enough flexibility to allow local communities to set the public health outcomes that they consider most important to them and that there will not be centrally dictated targets. We suggest that only the most important national priorities for public health are set centrally in order to give local flexibility for tackling local priorities and creating greater local accountability.
- There is lack of clarity about the roles of Districts and Boroughs in delivering improvements in Public health (two tier local authorities). **We suggest that the DH acknowledges the important role that district and borough councils play with regard to public health.**

The Public Health Budget

We support:

- The government’s commitment to public health and the recognition that public health budgets are often squeezed and the ring-fencing of the budget in the future. Local feedback suggested the belief that this approach would aid joint working and giving PH a legitimate remit with everyone with a greater emphasis on well being to an overarching strategic direction
- The health premium for tackling health inequalities

We feel the following need more development and consideration:

- Whether the ring fenced budget handed down to local government public health departments will be sufficient to carry out the increase in activity expected by the government without being unreasonably top-sliced by Public Health England. **We suggest that local allocation of budgets must be as transparent as possible, take account of the broadening role of the local public health department under these proposals and that the budget is sufficient to resource these activities.**
- That the way in which the health premium is allocated is transparent and seen to be reasonable and fair. **We look forward to being consulted on the method on which the health premium will operate.**

The Role of the Director of Public Health

We support:

- The joint appointment of the DPH between local government and Public Health England in order to have greater influence over the wider determinants of health
- The DPH being the principal advisor to the Health and Wellbeing Board and a statutory member of the board and being a public health professional
- We strongly support the vision for the DPH and think it covers the remit well
- The requirement to produce an independent annual report on the state of the local public health

- The continued requirement for the DPH to produce an independent report on the state of public health in the local area and the DPH's role as an advocate for the health of the population

Public Health England

We support:

- The broad responsibility for preventative health care commissioning that it is proposed to give to public health
- The drawing together of the current roles of the HPA, NTA, public health observatories and cancer registries and believe that this will create stronger national and sub-national systems
- Public Health England's role for strengthening of intelligence gathering and research

We feel the following need more development and consideration:

- That if Public Health England is formed as part of the Department of Health it will loose it ability to provide independent opinion and advice on the public health due the restrictions placed upon as part of the civil services. **We suggest that Public Health England is established as a special health authority to free it from these potential restrictions.**
- That there will be local fragmentation of the public health workforce between local government, Public Health England and the NHS which will lead to professional isolation and lack of critical mass.
- That local HPUs will be relatively isolated from the local government public health departments. **We suggest that local HPUs should be accountable to the local DPH to reduce fragmentation and improve coordination.**
- That the terms and conditions of employment for professional public health staff will be significantly and adversely affected if they are moved to being employed by local government as opposed to the NHS and that this will lead to a haemorrhage of highly skilled staff. **We look forward to the government providing very clear guidance on the employment status of staff having taking advice from the Faculty of Public Health and the British Medical Association. We suggest that the government ensures that proposed employment conditions are sufficient to preserve the skills and capacity in the professional public health workforce.**

Responses to Consultation Questions

Healthy Lives, Healthy People White Paper: Our vision for Public Health in England

Q1 Role of GPs and GP practices in public health: Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

- Primary care plays a key role in preventative healthcare and early intervention. The current proposals appear robust enough to allow sufficient collaboration between GPs and public health.

Q2 Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

- Ensuring that NHS information remains available to Public Health England and local public health departments is essential to ensure that the right interventions can be made in the right places and to the right people. Bureaucratic barriers and isolationist attitudes to information sharing need to be broken down as earlier as possible. We suggest that the government makes it explicit, perhaps in legislation, that there is a strong expectation of data sharing between organisations.

Q3 Public health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

- There should be a coordinated national programme of research in these areas to avoid duplication and allow best deployment of resources
- There should be a central, national library to capture current and emerging research in these areas to allow easy access to information on a range of public health topics

Q4 Public health evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

- The use of evidence should be encouraged through local government networks

Q5 Regulation of public health professionals: We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

- We fully support the recommendations of Dr Scally's report and support his recommendation that the Health Professions Council should regulate public health specialists

Responses to Consultation Questions
Healthy lives, Healthy people: consultation on the funding and commissioning routes for public health

Q1 Is the health and wellbeing board the right place to bring together ringfenced public health and other budgets?

- Broadly we think so but would like to see the ability of the DPH safeguarded to deploy the ring fenced public health budget as s/he sees fit in collaboration with the board .

Q2 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?

- Engagement with the sector through building on existing voluntary sector networks and ensuring these feed into the H&WB Board
- Better intelligence about the existing market
- Capacity building support, targeted at groups that can help deliver commissioning priorities.
- Transitional support for groups facing cuts or changes to their funding (to develop new business models)
- Procurement processes & contract terms which do not disadvantage small agencies
- Public agencies, through the commissioning cycle, adopting a shared approach to needs assessment and market facilitation
- Ensuring support is available for people to make informed decisions around the use of personal budgets

Q3 How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

- This will be critical for ensuring needs based, evidence based NHS services in the future. All major commissioning decisions made by the NCB or GP consortia must be able to demonstrate that public health advice has been sought and should be a requirement made explicit by the Health and Wellbeing Board and scrutinsed by the overview and scrutiny committees.

Q4 Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

- Yes, there may be services that could be more appropriately or efficiently provided through alternative providers but this would have to be coordinated at a national level.

Q5 Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

- No additional comments

Q6 Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

- Yes, as long as the existing budgets for these services is included within the public health budget
- Within the Drugs and Alcohol Team budgets we would encourage the government to keep the Drugs Intervention Programme (DIP) funding within the DAAT budget

Q7 Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?
If not, what would work better?

- Treatment of sexually transmitted disease may be best commissioned via the NHS National Commissioning Board or GP commissioning consortia.
- Health Visiting Services could equally well be commissioned by the local authority as the NHS but would allow local public health departments greater influence over the operation of these services.

Q8 Which services should be mandatory for local authorities to provide or commission?

- All those listed, as long as the existing budgets for these services is included within the public health budget

Q9 Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

- No additional comments

Q10 Which approaches to developing an allocation formula should we ask ACRA to consider?

- Based on transparent methods and using routinely collected and nationally validated data

Q11 Which approach should we take to pace-of-change?

- Incremental, over a five year period

Q12 Who should be represented in the group developing the formula?

- Association of DsPH, Faculty of Public Health, Local Government Association

Q13 Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

- That outcomes are directly attributable to public health interventions i.e. there is a cause and effect relationship between interventions and outcomes

Q14 How should we design the health premium to ensure that it incentivises reductions in inequalities?

- Ensure that it does not create a perverse incentive to not improve health overall but only focus on reducing health inequalities
- It should take into account local authorities addressing very localised pockets of health inequalities that may be hidden by surrounding areas of areas of relative affluence and good health in national statistics

Q15 Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

- Yes, but it may discriminate against populations with high proportions of deprived communities or where the churn of communities is very large making the achievement of these targets more difficult.

Q16 What are the key issues the group developing the formula will need to consider?

- Transparency in methodology
- Protection for more deprived areas where achieving improvements in health and reducing health inequalities is more difficult

Responses to Consultation Questions

Healthy Lives, Healthy People*:* Transparency in Outcomes

Q1 How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

- Be explicit that outcomes are shared across agencies and that responsibility is joint
- Advocate pooled resources
- Ensure consistency between the three outcome strands of public health, the NHS and social care

Q2 Do you feel these are the right criteria to use in determining indicators for public health?

- Yes, but also need to consider whether there is evidence that public health interventions can reasonably be expected to affect the outcomes

Q3 How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

- Some outcomes measures should relate specifically to health inequalities rather than overall population health e.g. life expectancy gap between communities as opposed to overall life expectancy

Q4 Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

- Yes, it is broadly helpful

Q5 Do you agree with the overall framework and domains?

- Yes, it broadly covers the remit of public health, although it may be helpful to include issues of NHS and social care quality where appropriate

Q6 Have we missed out any indicators that you think we should include?

- The indicator list is very comprehensive although we should be looking to develop a good measure of mental health and wellbeing

Q7 We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

- It is important the local authorities are given autonomy to choose the majority of indicators in order to tackle local priorities and create local accountability

- Domain 1

    - Life years lost from air pollution as measured by fine particulate matter
    - Population vaccination coverage (for each of the national vaccination programmes across the life course)
    - Treatment completion rates for TB
- Domain 2
    - Housing overcrowding rates
    - Fuel poverty
    - Rates of adolescents not in education, employment or training at 16 and 18 years of age
    - Proportion of people with mental illness *and or disability* in employment
- Domain 3
    - Prevalence of healthy weight in 4-5 and 10-11 year olds
    - Smoking prevalence in adults (over 18)
    - Under 18 conception rate
    - Rate of hospital admissions per 100,000 for alcohol related harm
    - Number leaving drug treatment free of drug(s) of dependence
- Domain 4:
    - Incidence of low-birth weight of term babies
    - Screening uptake (of national screening programmes)
    - Take up of the NHS Health Check programme by those eligible
    - Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Domain 5:
    - Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
    - Mortality rate from cancer in persons less than 75 years of age
    - Mortality rate from Chronic Liver Disease in persons less than 75 years of age
    - Mortality rate from chronic respiratory diseases in persons less than 75 years of age
    - Excess seasonal mortality

Q8 Are there indicators here that you think we should not include?

- Suicide rate – there is little evidence that specific interventions can affect this

Q9 How can we improve indicators we have proposed here?

- Ensure that there is consistency in indicators across the three strands of public health, the NHS and social care.
- The indicators are mostly sensible and measurable. It would be important that the indicators chosen are those that public health could reasonably be expected to have a decent influence upon. For example, whilst the proportion of people in long-term unemployment undoubtedly has an effect on health it may be considered to be at the boundary or beyond the reach of most public health teams.

Q10 Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

- Indicators that make very large impacts on health and on a large number of people e.g. smoking, cardiovascular disease, cancer, obesity

Q11 What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

- This is an excellent idea and will underline the requirement for the NHS and public health to work together

Q12 How well do the indicators promote a life-course approach to public health?

- Fairly well; there are clear areas related to early years, skills development and prevention. The years of employment and work are perhaps less well defined but are probably well covered in some of the prevention agenda.