



House of Commons  
Communities and Local  
Government Committee

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**The role of local  
authorities in health  
issues**

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**Eighth Report of Session 2012–13**

*Volume I: Report, together with formal  
minutes, oral and written evidence*

*Additional written evidence is contained in  
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## The Communities and Local Government Committee

The Communities and Local Government Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for Communities and Local Government.

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in a printed volume.

Additional written evidence may be published on the internet only.

### Committee staff

The current staff of the Committee are Glenn McKee (Clerk), Sarah Heath (Second Clerk), Stephen Habberley (Inquiry Manager), Kevin Maddison (Committee Specialist), Emily Gregory (Senior Committee Assistant), Mandy Sullivan (Committee Assistant), Nyree Barrett-Hendricks, (Committee Support Assistant) and David Foster (Assistant Media Officer).

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## Summary

The return to local government on 1 April 2013 of a responsibility to improve the health and wellbeing of local people is welcome. Councils, through the services that they commission and deliver, already have an influence over the day-to-day conditions in which people live, so they are well placed to make the most of a move away from a medical model of health, based on clinical treatment, to a social model, based on health promotion, protection and disease prevention. They will need to use every power, department and service at their disposal, however, if they are fully to grasp this opportunity and tackle the causes of *the causes* of poor health: the social, economic and environmental reasons why people experience ill health or develop unhealthy behaviour.

Central to the new system will be Health and Wellbeing Boards, whose members include councillors, GPs, directors of local services and community groups. They will need to focus on health promotion among all age groups, not become constrained by an undue focus on health and social care commissioning and integration. With few powers and no budget to commission services themselves, they will have to display leadership, build relationships and use their influence locally to turn their health and wellbeing strategies into reality. Individual authorities will have their own priorities, but we recommend that they bear in mind the importance of early years interventions. We also call on the Government to consider devolving more employment initiatives, including elements of the Work Programme, and conclude that Ministers must be prepared to use national levers to underpin public health initiatives at the local level.

Health and Wellbeing Boards will be part of a complex new structure, including Clinical Commissioning Groups and two new national bodies, Public Health England, which exists only in shadow form until April 2013, and the NHS Commissioning Board. Many are still unclear who will be in charge locally in the event of a health emergency, and the Government needs to set out the lines of responsibility between these organisations and confirm that Public Health England will have sufficient staff in its local teams to deal with contingencies. We also recommend the Government reviews new regulations restricting the local Director of Public Health to acting as an adviser on emergency arrangements.

The new arrangements for screening and immunisation services are the responsibility of the NHS Commissioning Board, but they lack a local dimension. We see a strong case for devolving these services, along with public health services for children up to five years old and childhood immunisation services, to public health staff within local government under Directors of Public Health. There are still concerns that not all Directors of Public Health will report directly to local authority chief executives. They appear to have conflicting responsibilities for accountability, both sitting on and policing Health and Wellbeing Boards.

We welcome the increase in ring-fenced public health funding, but its delayed announcement left local authorities with a great deal of work to do to finalise their budgets in a short period and should not be repeated. The grant formula also contains a perverse incentive. Over time areas that perform well might have their funding reduced. This needs to be reviewed, especially given its conflict with the Health Premium, which rewards

improvement in reducing health inequalities. The Premium seems unfit for purpose in itself and should at least be delayed until a better formula has been devised. In the medium term, if public health is to become an overarching priority for all local authority departments, it will require an overarching budget, and we call on the Government to provide local authorities with community budgets to direct resources at people and places, rather than organisations.

The Government needs to address concerns about local authority and NHS access to each other's data. Councils will need staff in place who can analyse that information and turn it into strategies that local councillors and communities understand. The Government also needs to establish a single point of ministerial contact to support local authorities in their new health role. Health and Wellbeing Boards will need guidance from NICE and Public Health England, but regulation and scrutiny should take place locally, through Healthwatch and local overview and scrutiny committees. It is unclear how local accountability in the new arrangements extends to Clinical Commissioning Groups, and we question why councillors should be barred from sitting on Groups' Boards.

# 1 Introduction

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1. Local government is responsible for many services that affect the conditions in which people live—conditions that in turn affect the length and quality of people’s lives. From housing and planning, to environmental health, education, transport, social care and library services, the decisions that councillors and their officers make every day have an impact on the health and wellbeing of their local population—and contribute to what are known as the social determinants of health.

2. Local authorities have a long history of involvement with public health. Indeed, they emerged in part as an organised response to the health needs of local people, when industrialisation, overcrowding and the spread in the 19th century of what are now called communicable diseases required, among other things, local health boards to undertake sewerage, clean water provision and slum clearance projects. The links between local government and population health were geographical and political: the boundaries of district councils were based on those of urban sanitary authorities, and the principle of elected individuals being democratically accountable for the health of local people was maintained into the early 20th century and survived the creation of the National Health Service in 1948. For the past 40 years, however, local authorities have not had a specific statutory responsibility to improve the health of the people in their area.<sup>1</sup> Under the National Health Service Reorganisation Act 1973, the public health functions of local authorities were transferred to the NHS. The NHS and local government continued, however, to work in partnership, through joint consultative committees, local partnership boards and local strategic partnerships. Although the latter were strengthened under the Local Government and Public Involvement in Health Act 2007, they were not mandatory.<sup>2</sup> The loss of public health from local government was a matter of regret for many, and the progress of these various partnerships remained patchy and uneven.<sup>3</sup>

3. In May 2010, the Government, in its White Paper, *Equity and Excellence: Liberating the NHS*, set out its intention to strengthen the role of local government in local health services,<sup>4</sup> and two months later in a further White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, the Coalition made it clear that “local government and local communities will be at the heart of improving health and wellbeing for their populations and tackling inequalities.”<sup>5</sup> *Healthy Lives, Healthy People* was the Government’s response to Sir Michael Marmot’s 2010 review of health inequalities, commissioned in 2008 by the then Labour Government. The review concluded:

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1 The Local Government Act 2000 gave local authorities a statutory responsibility to improve the economic, social and environmental circumstances in their area; the Health Act 2001 conferred the power of health scrutiny upon them.

2 See The King’s Fund, *Health and wellbeing boards: System leaders or talking shops?*, April 2012, p 7, and Health Committee, Twelfth Report of Session 2010–12, *Public Health*, HC 1048-I, paras 6ff for further details on the history of collaborative working in public health.

3 See Health Committee, Second Report of Session 2000–01, *Public Health*, HC 30-I, paras 126–135 (location of public health); and paras 136–146 (partnerships).

4 The King’s Fund, *Health and wellbeing boards: System leaders or talking shops?*, p 1

5 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, cm 7985, November 2010, executive summary, para 4

Efforts to reduce health inequalities must address the wider social and economic determinants of health inequalities in society and how these play out in the quality of early years experiences, of education, economic status, employment and quality of work, of housing and environment and effective systems for preventing ill health.<sup>6</sup>

The review also said:

Local Government plays a crucial role in the lives of citizens and in the prospects of the areas for which they are responsible [...]. Greater emphasis should be given to the pivotal role of Local Councils in delivering health improvement and reducing health inequalities in leading local partnerships.<sup>7</sup>

[...] people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability”.<sup>8</sup>

4. The outcome of these reviews, and a wider review of the health service, was the Health and Social Care Act 2012. Under the Act, Primary Care Trusts (PCTs) will be abolished, with many of their responsibilities for public health transferred from the NHS back to local government. Section 12 states that “each local authority must take such steps as it considers appropriate for improving the health of the people in its area.”<sup>9</sup> Unitary and upper tier (that is, county) councils will have responsibilities for public health, ranging from cancer prevention and tackling obesity to drug misuse and sexual health services.<sup>10</sup> Directors of Public Health and their teams will move from the NHS to work within local government—appointed jointly by local authorities and the Secretary of State for Health but accountable to local authority chief executives—and the public health work force will be reorganised.<sup>11</sup> Directors of Public Health will assume responsibilities for discharging local authorities’ public health duties. Local authorities themselves will commission or provide public health and social care services, including those for children between five and 19 years old, some sexual health services, public mental health services, physical activity, anti-obesity provision, drug and alcohol misuse services and nutrition programmes. A crucial aspect of local government’s new role will be its responsibility for creating and running statutory Health and Wellbeing Boards (HWBs), which will oversee local commissioning, and health and social care integration.

## Health and Wellbeing Boards

5. Under the legislation, local authorities with responsibilities for public health will have a statutory duty to create an HWB, to undertake a Joint Strategic Needs Assessment (JSNA) of their area and, informed by the JSNA, to develop a new Joint Health and Wellbeing

6 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, p 39

7 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, p 158

8 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, p 16

9 Health and Social Care Act 2012, section 12

10 Ev 165, Department of Health and Department for Communities and Local Government, para 5

11 Ev 165, para 11. Directors of Public Health will be appointed by local authorities and, through Public Health England, by the Secretary of State.



Strategy (JHWS).<sup>12</sup> The primary duty of HWBs will be to encourage integrated working between the NHS, public health and social care.<sup>13</sup> This provision, according to the King's Fund, "emerged unscathed from the wider controversies surrounding the Health and Social Care Bill, and has been almost universally welcomed."<sup>14</sup> The 2012 Act prescribes for HWBs a minimum membership requirement of:

- at least one councillor of the local authority, nominated by the council leader/mayor/local authority;
- the director of adult social services for the local authority;
- the director of children's services for the local authority;
- the director of public health for the local authority;
- a representative of the Local Healthwatch organisation for the area of the local authority;
- a representative of each relevant Clinical Commissioning Group (CCG); and
- such other persons, or representatives of such other persons, as the local authority thinks appropriate.<sup>15</sup>

In April 2012 the King's Fund found in a survey that most Boards had appointed a senior councillor as their Chair.<sup>16</sup> Some 138 local authorities participated in the Department of Health's early implementers programme, creating shadow HWBs, in order to establish and test their procedures in time to assume their new duties in April 2013.<sup>17</sup>

### *Clinical Commissioning Groups*

6. HWBs will include among their statutory members CCG representatives, thereby bringing together locally elected politicians and clinicians. The 2012 Act transfers responsibility for commissioning £65 billion of secondary care—including elective hospital care, urgent and emergency care, rehabilitation and most community health services—from PCTs to CCGs, made up of general practitioners (GPs) and at least one registered nurse and a doctor who is a secondary care specialist. Some 211 had been established by January 2013.<sup>18</sup> CCGs whose boundaries fall within, or coincide with, those of the local authority area will be entitled to have one representative on the local HWB. CCGs will

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12 Health and Social Care Act 2012, section 194(1); joint strategic needs assessments were introduced in the Local Government and Public Involvement in Health Act 2007.

13 Health and Social Care Act 2012, section 195

14 The King's Fund, *Health and wellbeing boards: System leaders or talking shops?*, p 1

15 Section 194(2) of the 2012 Act

16 The King's Fund, *Health and wellbeing boards: System leaders or talking shops?*, p 12; of the 48 boards surveyed, 25 had appointed as their Chair the portfolio holder for health, adult social services or children's services; 17 had appointed the council leader or deputy leader.

17 Department of Health, letter to local authority leaders and chief executives, 20 June 2011, [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127759.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127759.pdf)

18 See NHS Commissioning Board website, press release, 23 January 2013 [www.commissioningboard.nhs.uk/2013/01/23/wave2-auth/](http://www.commissioningboard.nhs.uk/2013/01/23/wave2-auth/).

receive a range of back-office services from regional Commissioning Support Units, which we discuss in chapter 3.

### *The Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy*

7. HWB members will use their experience, priorities and evidence to produce a Joint Strategic Needs Assessment. In turn, this will inform the Board's Joint Health and Wellbeing Strategy, which, the Department of Health has said, "will encourage a shared understanding of local priorities across public health, health and social care."<sup>19</sup> The Department of Health has made it clear, however, that HWBs are "not just about strategies and assessment."<sup>20</sup> It sees them being the "lead commissioning" vehicle for particular services such as learning disabilities or dementia. In this way, the Department has stated, HWBs will be better able to support integration among commissioners and to promote more integrated provision for patients and care users—"joining up social care, public health and NHS services".<sup>21</sup>

### *Public Health England*

8. Nationally, local authorities and HWBs will work with two organisations. First, Public Health England (PHE), a new executive agency of the Department of Health, will incorporate the functions of the outgoing Health Protection Agency and, through its local centres and in partnership with local government, be responsible for front-line health protection. It will commence work on 1 April 2013 and:

- commission or provide national prevention and early presentation campaigns;
- provide infectious disease prevention services and co-ordinate outbreak management programmes;
- deliver the preparedness for and responses to health emergencies such as flu pandemics;
- provide the NHS and local authorities with guidance and advice; and
- compile and distribute health data.<sup>22</sup>

Organisationally, PHE will have four regional centres and 15 local centres.

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19 Department of Health letter to local authority leaders and chief executives, 20 June 2011, [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127759.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127759.pdf)

20 Department of Health letter to local authority leaders and chief executives, 20 June 2011, [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127759.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127759.pdf)

21 Department of Health letter to local authority leaders and chief executives, 20 June 2011, [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127759.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127759.pdf)

22 Commissioning fact sheet for clinical commissioning groups, NHS Commissioning Board, July 2012, [www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf](http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf)

### ***The NHS Commissioning Board***

9. The second national organisation with which local authorities and HWBs will work, the NHS Commissioning Board (NHSCB), was established in October 2012 as an executive non-departmental public body. It is responsible for authorising the creation of new CCGs and, from April 2013, for some local health care commissioning formerly carried out by PCTs and Strategic Health Authorities, and some national commissioning of specialised services. The NHSCB will commission primary care such as GP services, dentistry and ophthalmology, and more specialist services such as cancer provision, prisoner health care and secure psychiatric services. In relation to public health, the NHSCB will commission:

- services for children from pregnancy to age five, with responsibility for this due to transfer to local authorities in 2015;
- immunisation programmes;
- national screening programmes;
- public health care for people in prison and other places of detention; and
- sexual assault referral services.<sup>23</sup>

Organisationally, the NHSCB has four regional centres and 27 local area teams (LATs).

### ***Local Healthwatch***

10. The 2012 Act also established Healthwatch England to represent users of health and social care services, and to create a network of Local Healthwatch (LHW) organisations, with one in every local authority area. LHW will deal with health and social care. In contrast, its predecessor, the Local Involvement Networks (LINKs), which it replaces, dealt only with health care. Local authorities will commission and fund the LHW and, from April 2013, may provide their NHS advocacy and complaints service under the LHW banner.<sup>24</sup> Local Healthwatch is entitled to one seat on the HWB, allowing the local authority to fulfil its duty under the Act to involve patients and the public in devising the JSNA and JHWS.<sup>25</sup>

### ***Health Scrutiny***

11. Under the legislation, the local authority as a whole holds health scrutiny powers, but it may choose to continue to operate its existing health overview and scrutiny committee. Under the Act, “relevant NHS bodies” or “relevant health service providers”, such as CCGs

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23 Commissioning fact sheet for clinical commissioning groups, NHS Commissioning Board, July 2012 [www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf](http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf)

24 Health and Social Care Act, section 185(4)

25 Health and Social Care Act, section 182

and the NHSCB, may be required to consult the local authority, to attend before it or to provide information to it.<sup>26</sup>

### ***Reaction to the transfer of public health responsibilities back to local government***

12. The policy of moving public health back to local government has on the whole been greeted favourably. The Local Government Association stated:

We are convinced that the most effective use of resources to improve public health is to combine the public health professional workforce, with its specialist expertise and intelligence, with mainstream council plans and services.<sup>27</sup>

The District Councils Network agreed, citing local authorities' "powers, expertise and experience to promote better public health/health equality and ensure more effective health prevention with the link to sport and fitness, well-being, social care, housing and education."<sup>28</sup> The Chartered Institute of Environmental Health told us, "public health is coming home,"<sup>29</sup> and the British Medical Association and the Royal College of Nursing also gave a broad welcome to the thrust of the measures.<sup>30</sup>

13. **We welcome the return of public health responsibilities to local government and in particular:**

- **the introduction of Health and Wellbeing Boards, which will count local councillors among their members and, in many cases, senior councillors as their Chairs;**
- **the transfer of directors of public health and their teams from the NHS to local authorities; and**
- **the opportunity for local councils to focus all their activities, from education to housing, on the health and wellbeing of their local residents.**

These changes are part of a complex set of reforms across local government and nationally. Local authorities and, in particular, Health and Wellbeing Boards will have to work hard to involve local people in their work, and we expect that the operation of the new arrangements will be reviewed by a select committee in two years' time. This inquiry therefore provides not only an examination of the preparations at the point of implementation of the new arrangements, but a starting point for a follow-up inquiry.

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26 The Local Government Association, *Get in on the Act: Health and Social Care Act 2012*, p 13, [www.local.gov.uk/c/document\\_library/get\\_file?uuid=81914af4-5de6-4ccb-93e2-3764523dd8b0&groupId=10171](http://www.local.gov.uk/c/document_library/get_file?uuid=81914af4-5de6-4ccb-93e2-3764523dd8b0&groupId=10171)

27 Ev 89

28 Ev 93

29 Q 2 [Graham Jukes]

30 Ev 100, 104, 83

## Our inquiry

14. We received 40 written submissions to our inquiry and held five oral evidence sessions. We visited Kent to see how the county council, its district councils and local GPs had been preparing for the transition to their new responsibilities, and saw in Gravesend a Healthy Living Centre that provided a range of services, from anti-smoking programmes to job clubs, for local people. We also visited Sweden to hear how its highly devolved health care system works, to learn more about how local councils deliver and integrate public health, health and social care, and to see an example of a care organisation, created through the merger of county and district services, integrating the provision of health and social care for people of all ages.

15. We thank all those who contributed to our inquiry, including the individuals and organisations who supplied us with written and oral evidence, and Kent County Council and the Grand Healthy Living Centre in Gravesend for hosting our visit. Finally, we are particularly grateful to our specialist adviser, Professor David Hunter, of Durham University.<sup>31</sup>

## Our report

16. Our report falls into five parts. In Chapter 2 we consider what the arrangements for public health, including its integration with health and social care, will look like at local level, and in particular the role of HWBs, their priorities, accountability and links to local NHS bodies. Chapter 3 assesses the JSNA and JHWS, the importance attached to them, how the composition of HWBs will affect them, the information and communication strategies that need to accompany them and how local government might ensure the local NHS adheres to them. Chapter 4 looks at the causes of the causes of poor health and what a multi-faceted approach to the issue looks like, including the role of local authorities, communities, providers and central Government in promoting better public health and ensuring better disease prevention. Chapter 5 analyses the national perspective, including the preparedness of PHE and local authorities to deal with a health emergency, the arrangements for screening and immunisation through the NHSCB and the risk of fragmentation of some services, in particular the commissioning of children's public health care. Finally, in Chapter 6, we examine the way in which the new public health system will be financed, discuss whether the funding formula is fit for purpose in the medium and longer term and consider whether the money should remain ring fenced or, in time, become part of a community budget.

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31 Professor David Hunter declared the following interests: non-executive director of the National Institute of Health and Clinical Excellence; Principal Investigator, National Institute for Health Research School for Public Health Research, for research study on prioritisation methods in local government on public health interventions.

## 2 Public health at the local level

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### The role of Health and Wellbeing Boards

17. Although local government lost its statutory responsibility for public health under the NHS Reorganisation Act 1973, partnership work between local authorities and the NHS continued. Councils also retained their responsibility for certain public health services, such as environmental health, adult social care and leisure, so, as Sheffield City Council pointed out:

It is misleading to suggest that the Government's decision to transfer public health responsibilities to local authorities marks an introduction of the public health role into councils. Local authorities have always had a key role in addressing the health and wellbeing needs of the population.<sup>32</sup>

The Health and Social Care Act 2012 broke with the recent past, however, by placing on upper tier local authorities and unitary authorities a statutory duty to create a Health and Wellbeing Board (HWB) and, using the local JSNA established under the Local Government and Public Involvement in Health Act 2007, to develop a new Joint Health and Wellbeing Strategy.

18. As we noted in Chapter 1, the 2012 Act prescribes the minimum membership requirement for HWBs.<sup>33</sup> The local HWB's primary duty will be to encourage integrated working between the commissioners of NHS, public health and social services.<sup>34</sup> The Government envisaged HWBs as a "crucible" for integration in each local area,<sup>35</sup> adding that they would be

the forum for local authorities, the NHS, local Healthwatch, communities and wider partners, to share system leadership of both health and care services and population health [...]. The Government's approach to implementation of health and wellbeing boards recognises that accountability for setting up boards is local—with the approach depending on local circumstances and priorities.<sup>36</sup>

19. Liam Hughes, independent Chair of Oldham shadow HWB, told us there was ample evidence of loose partnerships having failed to achieve significant changes but "this time [...] it feels different," with more "focus" and "commonality" between CCG members and councillors in Oldham and the "18 or 19" other boards he had worked with.<sup>37</sup> He did, however, query the extent to which those with responsibility for services that dealt with the social determinants of health—worklessness, transport, leisure—were making an appearance on HWBs. He said, "very few [...] have enlisted Board expertise from people with a background in spatial planning, regeneration and housing; sports, culture and

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32 Ev 129

33 See also the Health and Social Care Act, section 194(2).

34 Health and Social Care Act, section 194

35 Ev 167, para 34

36 Ev 166 and 167, paras 23 and 31

37 Q 168

leisure; or economic development, commerce and industry.”<sup>38</sup> Notwithstanding such reservations, local government and health organisations broadly welcomed the policy of reconnecting health, public health and social care through a local body on which councillors, officers, clinicians and the public were represented. The Local Government Association said HWBs were “the single most important component of the new health landscape” and the “engine house that drives a new system-wide approach to health improvement based on a shared understanding of health and wellbeing needs.”<sup>39</sup> The British Medical Association (BMA), while more guarded in its reception, still noted the central role of HWBs, which would be “vital to the coordination of the new healthcare system.”<sup>40</sup> David Buck of the King’s Fund, however, cautioned against expecting too much of them too quickly.<sup>41</sup>

20. We asked about the preparedness of HWBs to take on their new responsibilities. On the one hand, Cllr Steve Bedser from the LGA told us that councils had undertaken “some very good comprehensive self-assessment work,” with the “good news [...] that 95% of local authorities are in an advanced state of readiness.”<sup>42</sup> On the other hand, we heard from Professor Chris Bentley, an independent population health consultant, who, from his work with public health departments, HWBs and CCGs over the past 18 months, had reservations. He explained that commonly HWBs were planning to meet quarterly and questioned:

How much momentum can be generated and maintained that way? [...] How can the HWB become the ‘beating heart’ of local process for improving health and wellbeing? A number of these meetings will then have a large membership, and impossibly long and tight agendas.<sup>43</sup>

He explained that HWBs which met so infrequently would require “pretty durable structures that will do things between meetings,” and he asked what were “the governance structures that sit below the Health and Wellbeing Board and allow it to motor and produce stuff between the potential talking-shops of meetings?”<sup>44</sup> A recent assessment of HWB administration found that the “initial approximate minimum cost of running an HWB is £150,000 a year, based on six meetings and 10 people, but could be over £300,000 for large boards who meet more frequently”.<sup>45</sup>

Professor Bentley did, however, commend Haringey Council, whose HWB consisted of 12 members and which worked as a joint commissioning body, had an operational partnership group, “two or three” committees reporting through the operational group, a provider group and a group for communities and patient input.<sup>46</sup> We heard of similar

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38 Ev 125

39 Ev 90, para 4

40 Ev 102, para 21

41 Q 3

42 Q 119

43 Ev 153

44 Q 274

45 Derek Miller, “Achieving cost-effectiveness for health and well-being boards” in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 114

46 Q 274



arrangements in Kent, which was setting up HWB sub-committees co-terminous with the county's CCGs;<sup>47</sup> and Newcastle and Sheffield City Councils both had plans to develop sub-committees to deal with service delivery and specific pieces of work.<sup>48</sup>

21. Professor Bentley's other concern about the operation of the HWBs was that they did not "bring powers."<sup>49</sup> Instead, the system would rely on bringing people together in the same place, their agreeing to a decision and taking it back to their individual organisation to implement it. This in turn would rely on leadership and relationships, which he said "brings more patchiness into the system."<sup>50</sup> Therefore not only is the composition of HWBs and sub-committees crucial to the successful operation of the system, so too is the relationship between their members.<sup>51</sup> Dr Mike Grady of the University College London Institute of Health Equity, explained that the most effective partnerships would be created through "a network of relationships that allow people to trust each other," not because of a statutory requirement,<sup>52</sup> but he had found that across the country practice "varies quite considerably."<sup>53</sup> Professor Bentley also concluded that "many local arrangements are not coming together with the definition and precision in governance necessary to generate step changes in population health and wellbeing".<sup>54</sup>

**22. We conclude that the successful operation of Health and Wellbeing Boards is crucial to the new arrangements. Boards should aim to be creative by including where possible those individuals with responsibility for the social determinants of health, including those working in education, planning and economic development. The obvious danger with the new Boards, however, is that the initial optimism surrounding their establishment and first year or two in operation will falter and go the way of previous attempts at partnership working that failed and became no more than expensive talking shops. To succeed, Health and Wellbeing Boards will need to work on the basis of relationships and influence, and this will depend on both people and structures. This can be a strength, as it will, for example, allow for local discretion over Board membership, but also a weakness, because a Board will have few demonstrable powers with which to require council departments, clinicians and the local arms of national bodies to adhere to its strategic priorities, as set out in its Joint Health and Wellbeing Strategy. Local authorities will need to rely not only on the organisations and structures that they create, but on the relationships that they develop with individuals and groups if they are to grasp this opportunity and work effectively with these partners. This is the right approach but could make demands on local authorities' leadership and relationship-building skills.**

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47 Ev 144, para 5.4

48 Qq 177, 181

49 Q 277

50 *As above*

51 Cllr Steve Bedser of the Local Government Association told us he was "encouraging [...] local government not to obsess about structures and wiring diagrams and to focus on relationship building and partnerships." [Q 106]

52 Q 250; drawing an analogy with an orchestra, with local government acting as the conductor and HWB members as the musicians, playing their part when required, Dr Grady explained that HWBs would need to ensure that flexible structures were in place, with "the right players in the room to address the right issue" if they were to be "more than the talking shop that local strategic partnerships became."

53 Qq 228, 229

54 Ev 153



23. Local authorities should use the limited central prescription on their Health and Wellbeing Board membership in combination with their influence across the local community, to work with a range of people and bodies most closely linked to their areas' health needs and objectives. They might do this either by including them on the main Board or by creating a range of other relationships. These can be informal, through the cultivation of partnerships with, for example, the voluntary sector, or formal, with the development of Health and Wellbeing Board sub-committees, partnership bodies, and community groups.

## The priorities of Health and Wellbeing Boards

24. The primary duty of HWBs is to encourage integrated working between commissioners of NHS, public health and social care services.<sup>55</sup> According to the Government, HWBs “will be the forum for local authorities, the NHS, local Healthwatch, communities and wider partners, to share system leadership of both health and care services and population health.”<sup>56</sup> We heard concerns, however, about the risks of a short-termist approach being adopted by HWBs. The King’s Fund said that “Boards need to be clear about what they want to achieve [...]. There is a danger that stronger emphasis on overseeing commissioning will hinder efforts to promote integrated care”.<sup>57</sup> The Association of Directors of Public Health and the UK Faculty of Public Health voiced a similar concern, with the latter stating that “potential political tensions between their [HWBs] overseeing commissioning and promoting integration across public health, local government, local NHS and the third sector need consideration.”<sup>58</sup> The UK Healthy Cities Network told us that “much of the current [Department of Health] thinking seems to translate ‘action’ around wellbeing and health into the commissioning and provision of services,”<sup>59</sup> and Dr Mike Grady warned of a danger that the focus of public services would shift to prioritising the most vulnerable rather than seizing the opportunity for more radical reform, which “would seek to transform the ways in which services are designed and framed, taking an upstream view of the whole population”.<sup>60</sup>

25. Liam Hughes, the Chair of Oldham’s shadow HWB, while generally optimistic about the progress of the HWBs with which he had worked, said that there was limited evidence about partnerships producing sustained health improvement. He, too, noted that these partnerships had not been able to move much investment “upstream” and pointed out that it was “therefore, an act of faith that Health and Wellbeing Boards will be able to generate better outcomes for population health.”<sup>61</sup> Caroline Abrahams, External Affairs Director at Age UK, referred to the expectations being placed on HWBs, and offered a different perspective on social care which might enable it to integrate more easily with health care and public health:

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55 Health and Social Care Act 2012, section 194

56 Ev 166 and 167, paras 23 and 31

57 Ev 75, para 3

58 Ev 84, p 2

59 Ev w21, para 4.1

60 Ev 148

61 Ev 124

Traditionally, older people have not been a central focus of public health activity. We need to get those messages across that it is never too early for prevention, but it is also never too late.<sup>62</sup>

26. We heard also from Professor Gabriel Scally, of the University of the West of England, who said that commissioning was a barrier to the inclusion of public health. He told us that previous arrangements between some health authorities and local authorities had resulted in “pitched battles about the use of resources and who would pay for which particular aspect of care,”<sup>63</sup> and he considered that

the construction of health and wellbeing boards is largely to do with the NHS and adult social care interface [...]. There is a great desire, for perfectly legitimate reasons, that there should be a very good working relationship around those issues, but I do fear that public health concerns and the overall health of the population will lose out.<sup>64</sup>

Health and social care integration is a key political concern nationally and locally and will be an early focus for discussions between partners on HWBs. Professor Chris Bentley said that “currently, many areas are focussing on sharing information about priorities and initiatives, and on joint commissioning of services between [CCGs] and social care.” He hoped, however, that “more holistic approaches will evolve”.<sup>65</sup>

**27. Health and Wellbeing Boards have been given a substantial mandate to encourage integrated working between the NHS and public health and social care services. They also need to maintain a strategic and balanced outlook on their new responsibilities, focusing on promoting the health of their local population, rather than becoming exclusively preoccupied with the detail of health and social care commissioning and integration. Given that people are living longer and the cost of health care is rising, Boards will need to draw on the public health, clinical and social care expertise of their members to promote healthy and independent living among all age groups, young and old, if they are fully to take advantage of the opportunity provided by their creation to embed health promotion and disease prevention in all local services.**

## Accountability

28. If HWBs are to be responsible for integrating health care locally, they will need to be held to account for how effectively they carry out this task. The Royal College of Nursing (RCN) told us, however: “It is unclear to whom [HWBs] are accountable. Government states that they will be accountable to local people through having local councillors as members of the board who are accountable through election. The RCN does not believe this is adequate.”<sup>66</sup> The RCN added that these “things are not hardwired enough. We are not quite sure where the accountability lines are.”<sup>67</sup> Dr Penny Toff, co-Chair of the BMA’s

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62 Q 154

63 Q 59

64 Q 60

65 Ev 160

66 Ev 106, para 6.5

67 Q 60 [Dr Peter Carter]

Public Health Medicine Committee, agreed, telling us that it was “not clear how health and wellbeing boards will be held to account” for the effectiveness of joint assessments and strategies.<sup>68</sup> In contrast, Cllr Roger Gough, Cabinet Member on Kent County Council, told us that the Council saw its Health Overview and Scrutiny Committee “over time, holding us, the Board, to account for the outcomes that we seek to achieve.”<sup>69</sup> Kim Carey, Corporate Director, Adult Care and Support, at Cornwall County Council said that in her area there was a “healthy debate going on between the HWB and the scrutiny function at the moment” and there were “still some issues to be resolved”.<sup>70</sup>

29. When we asked the Under Secretary of State for Health, Anna Soubry MP, the Minister with responsibility for public health, when an intervention might take place on a poorly performing HWB, she suggested that an HWB would be responsible not for health outcomes, but for measuring and making representations to those who would be responsible: “I do not think you would have health outcomes coming from the Health and Wellbeing Boards. It is the job of the Health and Wellbeing Board to look at the outcomes in their area and start to take action.”<sup>71</sup> The Under-Secretary of State for Communities and Local Government, Baroness Hanham, acknowledged that performance monitoring would “come partly through the local authority. All of them will have health scrutiny committees,” and she suggested that, if a HWB were performing poorly, “it would be the director of public health who would be responsible for making sure the committee knew.”<sup>72</sup> We note, however, that the Director of Public Health will be a member of the HWB itself.

30. On the position of Directors of Public Health in local authorities, we heard some concerns that they would not be placed in the second management tier of the organisation, where they could report directly to the council’s chief executive. The Faculty of Public Health said some local authorities wanted Directors of Public Health to report to, for example, the director of adult social services,<sup>73</sup> while the BMA drew our attention to six unitary authorities in Berkshire which planned to share a strategic Director of Public Health, with each having an assistant Director of Public Health who would report to their Director of Adult Social Services.<sup>74</sup> The Government told us it was “clear that there should be direct accountability between the Directors of Public Health and the local authority chief executive”.<sup>75</sup>

**31. Given the Health and Wellbeing Board’s pivotal role in the new local health system, as the forum for local government, the NHS, the public and providers, each Board must be held accountable for its work. But it is unclear whether HWBs will be held responsible for health outcomes in an area. We have heard differing accounts from Communities and Local Government and Health Ministers as to how or, indeed, whether they will be. Accountability clearly cannot take place just through the election**

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68 Q 62

69 Q 257

70 Q 258

71 Q 310

72 Qq 311, 312

73 Ev 83

74 Ev 103, para 27

75 Ev 166, para 20

of the Board's local councillors, and this seems to be an area of real confusion. The questions are, what are HWBs to be accountable for, given their lack of powers; and, what sort of accountability is appropriate: democratic, procedural or financial? We were concerned also by the suggestion that the Director of Public Health, a member of the Board, would inform the scrutiny committee if the Board were performing poorly. This would place Directors of Public Health in an invidious position, and we therefore do not consider this to be a satisfactory or robust mechanism to hold Boards to account. *We recommend that the Government clarifies the procedures for holding Health and Wellbeing Boards to account, including the role it expects local overview and scrutiny committees to play and the role of the Director of Public Health, given their position as a Board member. Directors of Public Health should also report directly to the local authority's chief executive, and we urge the Government to reassert its understanding of this point, too.*

### Healthwatch

32. Healthwatch England was set up “to give a national voice to the key issues that affect people who use health and care services.”<sup>76</sup> It will include from April 2013 Local Healthwatch, which will “take the experiences that people have of local care and use them to help shape local services.”<sup>77</sup> The Government has allocated a statutory place on HWBs to a Local Healthwatch member, who will represent the interests of patients and the public locally, but it is not clear when those places will be filled. We were told that Kent and Leicestershire County Councils and Cornwall Council, for example, were either out to tender in order to establish their Local Healthwatch organisation or did not have one in place.<sup>78</sup> Dr Mike Grady, of the UCL Institute for Health Equity, told us:

Extending democracy and giving individuals and communities a voice is an essential prerequisite to addressing health inequalities [...] the co-production of health and wellbeing encourages people and communities to participate in public services on an equal basis with professionals.<sup>79</sup>

He subsequently explained, however, that across the country the tendering for and commissioning of Local Healthwatch organisations was “very variable”, and that there was “a great deal of uncertainty [...] confusion and [...] disillusionment about putting patients and the public at the centre of these reforms”.<sup>80</sup>

**33. We have heard about the importance of people having a voice in the development of local services, but Local Healthwatch, the organisation intended to give people such a voice locally, has not been established consistently throughout the country. Its development has been variable, and the establishment of strong and properly resourced Healthwatch bodies must be made a priority as local authorities and their Health and**

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<sup>76</sup> Healthwatch website, “about us”, [www.healthwatch.co.uk/about-us](http://www.healthwatch.co.uk/about-us)

<sup>77</sup> As above

<sup>78</sup> Qq 260, 266, 267

<sup>79</sup> Ev 148

<sup>80</sup> Q 261; Healthwatch is the latest in a line of patient representative groups that has included Community Health Councils, Public and Patient Involvement Forums and Local Involvement Networks (LINKs).

**Wellbeing Boards take on their new responsibilities in April 2013. We call on Healthwatch England and the Government to work with local authorities to ensure that a Local Healthwatch representative is available to take part in the deliberations of every Health and Wellbeing Board throughout the country by the end of the year.**

## **The position of national organisations in guiding and advising Health and Wellbeing Boards**

34. As HWBs begin their work, they will need to draw on national guidance and sector-led advice in order to develop their approach. They will also need to ensure they have effective leadership and partnerships. When we visited Sweden, we heard how its National Board of Health and Welfare, in collaboration with the country's Public Health Institute, was responsible for producing guidelines and spreading best practice for county councils and municipalities. The Swedish NBHW recognised that best practice was defined not just by an idea, but by the ability to deliver it. Duncan Selbie, Chief Executive-designate of Public Health England (PHE), England's equivalent of the National Board from April 2013, told us that it "will be seeking to share the evidence of what works, not telling people what to do but opening up possibilities."<sup>81</sup> David Buck, of the King's Fund, cited three organisations with a role: PHE, NICE—the National Institute for Health and Clinical Excellence, to be renamed from April 2013 the National Institute for Health and Care Excellence—and the Local Government Association. PHE and NICE would have the task of "explaining the evidence about the things that local councillors have control of" and "how that translates to what they can do about it". The Local Government Association would be helping to apply "high-level policy-type advice" to specific local circumstances. He also welcomed the fact that NICE would in future "work more closely with local authorities" on their public health and social care agendas.<sup>82</sup> In that regard, Liam Hughes, independent Chair of Oldham shadow HWB, told us: "We will need to raise the 'health literacy' of Board Members," adding, "NICE guidance, for example, is important when Boards consider their priorities."<sup>83</sup> NICE already produces quality standards for the NHS and, from April 2013, will do so for social care, including on the health and wellbeing of looked-after children and young people.<sup>84</sup>

35. Professor Chris Bentley identified a role for Public Health England in producing guidance but highlighted a potential clash of cultures between PHE and local government:

A lot of the resources in Public Health England are coming from the Health Service, and I think the question is how much local-authority-based evidence do they understand, and how they take it on board to be able to be the advisors on it.<sup>85</sup>

He also noted that PHE would be expected to get rid of some of the "patchiness" of public health care throughout the country. He did not yet know, however, whether it would,

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81 Q 3

82 *As above*

83 Ev 125

84 See National Institute for Health and Clinical Excellence, "NICE quality standards", [www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp](http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp).

85 Q 279

because “they (PHE) have still not got their knees under the desk.”<sup>86</sup> We were reassured to hear Baroness Hanham envisage a role for the Local Government Association in “advising” and “mentoring”.<sup>87</sup> Tim Baxter, head of the public health policy and strategy unit at the Department of Health, also recognised that his Department’s relationship with the NHS had historically been top-down and prescriptive. He said that “we definitely need to learn different ways of working.”<sup>88</sup> His Department was increasingly trying to co-produce guidance with the Local Government Association.<sup>89</sup> In that regard, Cllr Steve Bedser from the LGA itself drew attention to “the external scrutiny and some of the peer and mentoring support that the Local Government Association will give to authorities that are perhaps struggling to implement the new structures.”<sup>90</sup> An example was the LGA’s Knowledge Hub, a social network where councillors and officers can communicate and share learning with their local government colleagues.<sup>91</sup>

**36. Health and Wellbeing Boards are an innovation. While there are some guidelines in place, there is no template to follow and all HWBs are different. They will, however, need advice, guidance and evidence of best practice, as county councils and municipalities in Sweden have found. The job of providing this material will be in part for the renamed National Institute of Health and Care Excellence, which will have a remit to work more closely with local authorities, including from April 2013 on quality standards for social care. There will also be a role for Public Health England, as yet undefined. With its staff and resources derived in part from the NHS, it may not initially have the capacity or expertise to advise local authorities. Local government should therefore look not only to NICE and Public Health England, but to itself. As the reforms bed in, local authorities should seek out support and improvement among themselves, including, for example, through the Local Government Association’s Knowledge Hub resource.**

## The NHS Commissioning Board

### Structure

37. The Health and Social Care Act 2012 created, alongside PHE, another new national body, the NHS Commissioning Board (NHSCB). It will be responsible for: the direct commissioning of local primary care such as general practitioners (GPs), dentist and pharmacy services; the performance management of CCGs, and the commissioning of some public health services, including children’s public health from birth to five years old, and screening, immunisation and vaccination.<sup>92</sup> From April 2013, the NHSCB will control

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86 Q 294

87 Q 314

88 *As above*

89 *As above*

90 Q 59

91 The Local Government Association Knowledge Hub, <https://knowledgehub.local.gov.uk/home>

92 Cllr David Rogers OBE, “Developing relationships: the role of local government”, in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 33



a national budget of £25 billion for primary care and £1.8 billion for public health.<sup>93</sup> In addition, the NHSCB will comprise 27 Local Area Teams (LATs), based on areas previously covered by outgoing PCT clusters. These LATs have been largely aligned with another new regional group, Clinical Senates, of which there will be 12, and which will include among their members representatives of CCGs, NHSCB Local Area Teams and public health.<sup>94</sup> In the north of England region, for example, there will be nine LATs and 50 HWBs. The Clinical Senate areas are different from the NHSCB Local Area Team regions.<sup>95</sup>

### **Relationship with Health and Wellbeing Boards**

38. The complexity of these overall arrangements and the risks of confusion were demonstrated when, in a recent set of articles, the NHSCB's status in relation to HWBs was described in contradictory ways. One author said, "Most worryingly, the commissioners of primary care, dentistry and pharmacy—the NHSCB—are not occupying seats round the (HWB) table;"<sup>96</sup> while another wrote:

Representatives of the NHS Commissioning Board and Local Healthwatch will be arriving later than other members; how existing (Health and Wellbeing) board members help to create the space for meaningful participation by new members will be an important consideration.<sup>97</sup>

39. The Health and Social Care Act 2012 has not in fact prescribed NHSCB membership of the HWB, but it has provided that the NHSCB must appoint a representative to join the HWB in order to participate in its preparation of a JSNA or a JHWS. It has provided also that, if the HWB so requests, the NHSCB must appoint a representative to join the HWB "for the purpose of participating in its consideration" of the NHSCB's commissioning activities in the HWB area.<sup>98</sup> These provisions have led to criticisms, focusing on the NHSCB's potential detachment from the HWBs and the lack of accountability for its own commissioning. In contrast, some have speculated that the measures in the 2012 Act represented a "wish to impose (on Health and Wellbeing Boards) a top-down, mechanistic linear model with in-built controls and regulators."<sup>99</sup> Professor Chris Bentley asked whether the NHSCB representative on HWBs would see themselves as an inspector, "sitting there watching what is going on and being judgmental, or [...] pitch in there

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93 "Everyone counts: planning for patients 2013/14", Department of Health press release, 17 December 2012, and "Public health commissioning in the NHS", Department of Health press release, 15 November 2012.

94 NHS Commissioning Board, "NHS Commissioning Board: Local area teams" and "NHS Commissioning Board: Clinical Senates", staff briefing packs; see [www.networks.nhs.uk](http://www.networks.nhs.uk).

95 NHS Commissioning Board, "NHS Commissioning Board: Local area teams", staff briefing packs; see [www.networks.nhs.uk](http://www.networks.nhs.uk).

96 Neil Churchill, "Introduction: setting the scene", in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 5

97 Cllr David Rogers OBE, "Developing relationships—the role of local government", in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 30

98 Health and Social Care Act 2012, section 197

99 Dr Michael Dixon and Professor Chris Drinkwater, "Engagement with clinical commissioners", *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 39

bringing their resources to the table, and then helping to make decisions that will fit all the systems”.<sup>100</sup>

40. These potential weaknesses and concerns were reflected in evidence from the King’s Fund, which told us many HWBs were “concerned that national policy imperatives will over-ride locally agreed priorities and are uncertain about the extent to which they can influence decisions of the NHS Commissioning Board.”<sup>101</sup> In December 2012, Richard Humphries, also of the King’s Fund, concluded:

If the new boards are to promote the strategic co-ordination of all local services relevant to health and well-being, they will need to influence all commissioning activity affecting their local population, including the NHS Commissioning Board.<sup>102</sup>

The Faculty of Public Health also told us:

The NHS Commissioning Board is the major public health budget holder and needs to be held to account as any other Health and Wellbeing Board partner [...] the NHSCB should be party to every single JHWS in England, to agree to them, and to be held to account by them.<sup>103</sup>

41. **The NHS Commissioning Board, as the commissioner of primary care and significant public health services, will have a major influence over the way in which health care is prioritised locally, but its status in relation to Health and Wellbeing Boards is unclear, its interaction with other health bodies is complex and it lacks local accountability. We do not wish to prescribe membership of Health and Wellbeing Boards, and we recognise that, for now at least, Health and Wellbeing Board members will have to work together to establish constructive relationships with as many relevant bodies locally as possible. We therefore urge Boards to work closely with their NHS Commissioning Board Local Area Teams at all times, not simply when discussing their Joint Assessments, Joint Strategies and the NHS Commissioning Board’s own commissioning plans. The best way to address these concerns would be to work face to face with the NHS Commissioning Board on a regular basis.**

### **Local accountability**

42. An HWB’s inability to hold the NHSCB fully to account for its commissioning stems in part from the fact that HWBs do not hold their own funds: they cannot therefore commission any services directly, and there are no finances directly attached to the JSNA and the JHWS.<sup>104</sup> (We discuss the needs assessment and health and wellbeing strategy, which HWBs will have to produce, in the next chapter.) The 2012 Act has included a duty on the NHSCB to “have regard” to the Joint Health and Wellbeing Strategy when

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<sup>100</sup> Q 280

<sup>101</sup> Ev 75, para 3

<sup>102</sup> Richard Humphries and Claire Mundle, “Delivering integrated services”, in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 19

<sup>103</sup> Ev 86

<sup>104</sup> Madeleine Knight, “Development of the joint strategic needs assessment”, in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, p 12



developing its commissioning plans, but Madeleine Knight of the BMA has pointed out that “the lack of clarity as to what this means in practice makes it a weak lever,” and that “the HWB [...] holds no powers over local authority commissioners or the NHS Commissioning Board if their commissioning plans do not reflect its recommendations.”<sup>105</sup>

**43. There is no requirement for the NHS Commissioning Board and its Local Area Teams to adhere to a Health and Wellbeing Board’s Joint Health and Wellbeing Strategy, and there is no mechanism to hold them to account for their actions. In effect, the co-ordination of local strategies will rely on the pragmatism of local bodies, including the NHS Commissioning Board’s Local Area Teams. The Health and Social Care Act 2012 includes a duty on the NHSCB to “have regard” to the Joint Health and Wellbeing Strategy, but what this means in practice is unclear. *We call on the Government to set out in detail what Health and Wellbeing Boards can do if the NHS Commissioning Board subsequently fails to commission services consistent with these strategies. We also ask the Government to clarify what the duty on the NHSCB to “have regard” to a Joint Health and Wellbeing Strategy means in practice.***

### ***The NHSCB’s role in holding other bodies to account***

44. The NHSCB has also been given the capacity to intervene when a CCG is considered to have failed to commission services according to the Joint Health and Wellbeing Strategy, something to which the Royal Town Planning Institute drew our attention. It said, “The draft guidance on JSNAs and JHWSs states that the NHS Commissioning Board can ‘take action if the [commissioning] plan doesn’t take into account the JHWS’”, but it pointed out that “what action can be taken is not laid out.”<sup>106</sup> In supplementary written evidence, the Government explained that, under the 2012 Act, the NHSCB now had

powers to direct or dissolve a CCG [...] where the NHSCB is satisfied that a CCG is failing to discharge its functions, or there is a significant risk of it failing to discharge its functions. This would apply to the functions of working with LAs [local authorities] to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.<sup>107</sup>

**45. *Health and Wellbeing Board meetings should be attended by a representative of the NHS Commissioning Board when Clinical Commissioning Group commissioning is under discussion. Indeed, they should be attended by a representative of the national body, given its prominent role in local health matters, whenever required.***

**46. We are grateful to the Government for clarifying that the NHS Commissioning Board can direct a Clinical Commissioning Group if it fails to discharge its functions of working with local authorities to develop a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy. We urge Health and Wellbeing Boards to refer cases to the NHS Commissioning Board and it, where necessary, to make full use of this**

105 Madeleine Knight, “Development of the joint strategic needs assessment”, in *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, pp 12, 13

106 Ev 114, para 19

107 Ev 170

power to direct. But this does not deal with the action that can be taken if a CCG fails to take account of a Joint Health and Wellbeing Strategy in its commissioning. *We ask the Government to clarify what action can be taken if a CCG fails to commission services in accordance with a local Joint Health and Wellbeing Strategy.*

### 3 The development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

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#### Introduction

47. The Joint Strategic Needs Assessment (JSNA), provides the basis for the Joint Health and Wellbeing Strategy (JHWS), and will therefore be central to the work of Health and Wellbeing Boards (HWBs). The JSNA will look inwards to determine the health of the local population and outwards to the work and people necessary to improve it. We heard that the JSNA was more than just a task for the HWB to carry out; it could also reflect back to inform decisions about the HWB's own membership and strategy. Liam Hughes, independent Chair of Oldham's shadow HWB, explained that he and his colleagues had compared the skills, knowledge and experience of people on the HWB with the emerging themes of their JSNA and therefore taken on as a full HWB member someone who "understood regeneration and housing in depth."<sup>108</sup> Cllr Nick Forbes, of Newcastle City Council, also told us how its local needs assessment was going to "inform the wellbeing strategy [...]" and the wellbeing strategy itself will determine the future membership of the board."<sup>109</sup> The potential significance of the JSNA was also underlined by the Government, which stated that "through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health".<sup>110</sup>

48. Although the JSNA was introduced in the Local Government and Public Involvement in Health Act 2007 and retained in the Health and Social Care Act 2012, there were concerns that the statutory requirement to produce it would not be sufficient to influence the health and wellbeing of local communities. Professor Chris Bentley, an independent population health consultant, explained how JSNAs, despite having "been in existence for quite a few years", had been "patchy and variable". He added that a "number have been recycled for a new year" and suggested, "not many have been completely refreshed to meet their new purpose (under the 2012 Act), forming the basis of the JHWS,"<sup>111</sup> On the next step in the process, linking joint strategies to projects that deliver those strategies, we also heard that "practice is very mixed across the country".<sup>112</sup> Kent County Council told us, however, that through its JSNA and JHWS it had identified a "more holistic approach to health and wellbeing" and developed a devolved HWB structure. This had resulted in the establishment of sub-committees of its HWB based on CCG boundaries and the involvement of district councils in joint commissioning arrangements.<sup>113</sup>

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108 Q 179

109 Q 174

110 Department of Health, "A short guide to health and wellbeing boards", <http://healthandcare.dh.gov.uk>

111 Ev 153

112 Q 229 [Dr Mike Grady]

113 Ev 144, para 5.6

49. The importance of the Joint Strategic Needs Assessment should not be underestimated, as it will form the basis for the Joint Health and Wellbeing Strategy, one of the more critical health promotion measures any local authority will be involved with in terms of potential impact. The significance, resources and expertise attributed to both the assessment and the strategy will have a major bearing on the success of an individual authority's local health care work, and that of the local NHS, at least in the short term. The Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy must not therefore be viewed as tick-box forms to be produced and filed; they must be living, breathing documents to which all local health partners willingly contribute and adhere. Local authorities should look to innovative approaches, such as we saw in Kent, to use their assessments and strategies as an opportunity to devolve power and to identify local-level activity through which they can improve health and wellbeing in specific places, among certain groups of people and throughout their local area.

## Data sharing and information management

50. If HWBs are to produce the JSNAs that give them an accurate picture of the health needs of local people and allow them to develop the right strategies to deal with those needs, they will need full access to a range of data—from the health, public health and social care sectors. As we have already noted, this will require the cultivation of relationships with local partners who are not, for reasons of running the HWB efficiently, full-time members of the HWB itself, and the input of evidence from Public Health England (PHE) and NICE. Importantly, however, it will also necessitate changes to the way in which information—non-patient-specific information, in particular—can be shared between the NHS and local government.

51. Sheffield City Council, noting the need to combine health and local authority data in order to provide services such as home insulation, extra care for older people and support for vulnerable adults, told us: “We still seem unable to exchange data for these important issues due to data protection or organisation ‘security’”.<sup>114</sup> Kent County Council, too, explained that, “A crucial outstanding issue relates to Information Governance and the ability to share non-patient specific information between the NHS and local authorities.”<sup>115</sup>

Professor Bentley told us that NHS organisations with Caldicott Guardian status—Caldicott guardians being NHS staff who ensure patient data are kept secure—were “allowed to transfer quite a lot, with the confidence that it will be handled safely and securely,”<sup>116</sup> but this arrangement had not resolved the issue for Kent. The Council explained how it had “engaged at both a national level (Caldicott review) and locally in various work streams to address information exchange”, but it said that, if this issue was not resolved, “the effective delivery of transformative services between social care, public

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<sup>114</sup> Ev 132, para 41

<sup>115</sup> Ev 143, para 3.5. The Caldicott review refers to an appraisal of the Caldicott Guardian arrangements, whereby NHS organisations with Caldicott Guardian status include staff who ensure patient data are kept secure.

<sup>116</sup> Q 283

health and health will be critically compromised.”<sup>117</sup> Summing up the situation, Sue Ryder told us:

Data collection through the JSNA must be improved [...] The JHWS will only be as robust as the data on which they are based [...]. We are concerned that the preparations for the new system and implementation aren’t robust enough.<sup>118</sup>

From the private sector, Celesio UK, a community pharmacy chain incorporating Lloyds Pharmacies, stated that

pharmacists must as a priority gain access to patient healthcare records to enhance patient care. The record should work across health and social care to support integration [...]. The retention of a core data set in developing JSNAs is essential in ensuring that the needs of communities are properly assessed.<sup>119</sup>

52. When we put witnesses’ concerns about information sharing to the Government, the Under-Secretary of State for Communities and Local Government, Baroness Hanham, said:

Information sharing across government and departments is fraught [...]. The issue is that local authorities do not know what they can pass on to the health service [...]. There is a huge area that we need to get to grips with in government. We need to involve the Information Commissioner, but the whole issue of information sharing, particularly now within the Department of Health and public health, will hold us up.<sup>120</sup> [...]

I think we ought to have a national view across government as to what we can do in terms of giving advice about the information that can be shared.<sup>121</sup>

Professor Bentley suggested there was a need for “an Information Governance Strategy exploring and facilitating the flows of data and information around the system, necessary for delivery of the strategy and its programmes”,<sup>122</sup> and he considered that it would be a “good idea” if this were an area in which PHE provided guidance.<sup>123</sup>

**53. Any joint assessments and strategies will only be as good as the information on which they are based, but there is ignorance and misunderstanding of the current information-sharing arrangements. *If strategies are to be based on sound evidence, the Government must involve the Information Commissioner in clarifying what data local authorities and the NHS can share. This should be done by the end of this year, so that authorities have time to use any new guidance in the development of assessments and***

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117 Ev 143, para 3.5

118 Ev 117, paras 3.3, 4.1, 4.2

119 Ev 114, 115, paras 1.4, 4.2

120 Q 307

121 Q 308

122 Ev 164

123 Q 283

**strategies for 2014–15. We recommend that Public Health England publicise widely guidance on how local authorities can manage their data and information.**

### ***Building relationships with other sectors***

54. In order to ensure comprehensive and reliable assessments, HWBs will have to work with local partners, including the voluntary and community sectors and other service providers. The National Heart Forum explained how the voluntary sector and non-health agencies often had valuable insight into at-risk populations, which ought to be taken into account in developing the JHWS.<sup>124</sup> Age UK drew attention to the difficulties they had experienced when trying to work with HWBs, telling us how local branches had reported personnel changes, use of jargon and time and cost pressures acting to exclude smaller groups' representing marginalised people from participating in the JSNA. It also emphasised the need to draw on a wide range of information, stating

there has traditionally been an over-emphasis on health conditions and dementia when addressing older people's needs in JSNAs [...] this does little to influence policy to support active ageing and [...] risks [...] concentrating on addressing health and support needs.<sup>125</sup>

55. We heard that local authorities had begun to develop frameworks within which to work with these sectors. Cornwall Council explained its role as one of four pilot areas in England selected to establish the readiness of the voluntary, community and social enterprise sectors:

Board membership reflects the requirements of the Act but also includes a place for a strategic representative of the voluntary and community sector [...]. Cornwall council had already established its Voluntary Sector Commissioning Board as a strategic mechanism for engagement with the sector and proposes to develop a relationship with the Health and Wellbeing Board to deliver the outcomes in the health and wellbeing strategy.<sup>126</sup>

To provide local authorities with the information they needed Cancer Research explained how it had produced

Local cancer statistics by local authority area. These provide the latest information on cancer outcomes in each area in an accessible format. JSNA Guidance [...]. Key messages for commissioners [...] on [...] prevention, early diagnoses and treatment and a JHWS Action Sheet [...] to help health and wellbeing boards to examine their cancer priorities.<sup>127</sup>

56. From the provider perspective, Celesio UK suggested that HWBs might have little or no experience of community pharmacy. It therefore asked for clarity on how Pharmaceutical Needs Assessments (PNAs)—introduced in the Health Act 2009—would

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124 Ev w33, para 3.2

125 Ev 108, paras 2.3, 2.4

126 Ev 137

127 Ev w9, para 6

fit in with the joint assessment and strategy, noting that previous guidance stated: “PNAs [...] should be integrated into the JSNA process.”<sup>128</sup> Summing up the situation, the Faculty of Public Health noted that JSNAs were the key to addressing inequalities.<sup>129</sup>

**57. Health and Wellbeing Boards will need to make themselves accessible to, and work closely with, the voluntary and community sectors and other providers not only to deliver services, but to draw on the valuable statistics and information that these groups can supply. *We expect that local authorities, the Local Government Association and the Government itself will draw lessons from the four pilot areas establishing the readiness of these sectors.* These lessons must be disseminated as soon as possible, so that, first, local government can work out how to create structured arrangements with the potential partners, including through community sector boards, and, second, each has a defined role in the creation of Joint Assessments And Strategies.**

### **Collecting and analysing information**

58. The ability of local authorities to collate data was drawn to our attention. The Sue Ryder report, *The Forgotten Millions*,<sup>130</sup> found only 5% of 131 local authorities surveyed had detailed data on the number of people with neurological conditions for whom they provided services, while only 10% had in place a specific commissioning strategy for such people.<sup>131</sup> Age UK drew on a link between the availability of data for a particular group or condition and the existence of a strategy relevant to them, stating that “to support effective engagement, local authorities must support access to and the use of data”.<sup>132</sup>

59. Some organisations were concerned about the relocation from the NHS to local government of public health staff and of public health specialists,<sup>133</sup> Professor Bentley told us:

The transfer of public health professionals and practitioners into local authorities has been very variable, and some do not have the critical mass to do other than the minimalist ‘churning out’ of an annual JSNA report.<sup>134</sup>

He explained that “quite a lot of analytical capacity is being moved into something called Commissioning Support Units [...] to support CCGs in their commissioning” and he was “concerned [...] whether local-authority-based public health will get sufficient access to that resource.” He also referred to an historical dearth of this capacity, pointing out that “there is a lot of patchiness about how much analytical support there was and therefore will be”.<sup>135</sup>

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128 Ev 115, paras 4.4, 4.9

129 Ev 83

130 Sue Ryder, “The Forgotten Millions: Social care for people living with neurological conditions. A blueprint for reform”, November 2012

131 Ev 117, paras 4.3, 4.4

132 Ev 110, para 6.5

133 See Ev w19 [UK Healthy Cities Network], Ev 104 [Royal College of Nursing] and on public health specialists Ev 100 [BMA].

134 Ev 155

135 Q 281; as already noted, PHE, whose remit includes data collection and analysis, will have 15 local centres.



60. Local authorities will need to collect more data on the people for whom they provide services, and link that data to the development of strategies. There is, however, a lack of specialist analytical staff in local authorities to turn those data into strategies. *We recommend that local authorities and the Government keep under review the role of staff in Commissioning Support Units to ensure they are sufficiently public-health focused and councils have access to an adequate number of public health analysts. They should also consider how staff from Public Health England's local centres might assist in any local analysis.*

### Communicating information

61. HWBs will need to explain public health in their area in compelling, clear and simple language to a wide range of audiences, from council chief executives to ward-level councillors and local residents. They will also need to describe what difference a particular policy, based on a needs assessment, would make to their area or to a certain group of people over a given timescale.<sup>136</sup> For example, Cllr Steve Bedser, Cabinet Member on Birmingham City Council, told us: "When I start talking about public health in terms of helping poor people live longer lives of greater quality, it is something that my colleagues understand very readily and get very passionate about".<sup>137</sup> This process need not be one way, however, as targeted communication strategies might lead to improved data collection. Dr Penny Toff of the BMA highlighted the lack of data on marginalised and vulnerable communities and suggested that different communication strategies would be required to work with and gather information on them in the first place.<sup>138</sup>

62. In the absence of statutory powers, each HWB will need to build a wide base of support among local authorities, CCGs and, indeed, the NHSCB in order to deliver its recommendations. Professor Bentley told us this would depend on the availability not only of population health analysts and public health analysts, but of "communication specialists".<sup>139</sup> He saw the need to cultivate an informed debate with the public about priorities, but said that "often, there has been good technical analysis of data, but the presentation of the resulting information has not been converted into user friendly formats".<sup>140</sup> He explained that he had worked with Oldham Council to address high mortality rates in the borough. By comparing Oldham's rates with those of other "centres with industry", rather than with national rates, they set the mortality rate of South Birmingham (the best-performing centre) as Oldham's target and, translating "mortality rates" into "the number of people dying", worked out how many fewer men would need to die in Oldham to match the rate in South Birmingham by 2015.<sup>141</sup> Professor Bentley said:

Turning the rates into 'people' opens up the discussion. Elected members will ask how many of those would be in their constituency. GPs ask how many in their Practice; members of the public might want to know how many in their

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<sup>136</sup> See Ev 152 [Professor Chris Bentley].

<sup>137</sup> Q 121

<sup>138</sup> Q 68

<sup>139</sup> Ev 152

<sup>140</sup> As above

<sup>141</sup> As above



neighbourhood. Public health practitioners might ask how many might be South Asian.<sup>142</sup>

The pilot also identified the number of people who would need to be treated to save one life. That number, Professor Bentley explained, “begins to give the basis of costing the intervention.”<sup>143</sup>

63. On the question of who might enable councillors and officials to communicate effectively, Cllr Alan Connett, of the District Councils’ Network, said there was “a very real job for the local government sector in terms of teaching councillors”.<sup>144</sup> When we raised this with Health and Communities and Local Government Ministers, they cited the role of the Director of Public Health, who could lead, steer, put evidence before councillors and say, “Look at our smoking rates and obesity levels, and look at it in your ward, councillor”,<sup>145</sup> and whose presence in local government would allow councillors to “get involved now in a much more local way” with initiatives.<sup>146</sup> Baroness Hanham also told us training would “have to come from councils themselves.”<sup>147</sup> The Government has also stated that one of PHE’s “three key functions” will be “developing the public health workforce”.<sup>148</sup>

**64. Conveying to different audiences—chief executives, councillors, providers and local residents—in clear and simple terms ‘the story’ of public health in their area will be vital if individuals are to engage in the improvement of their own wellbeing. This may amount to talking about population health in terms of enabling people to live longer lives of greater quality, and devising campaigns that highlight the role clinicians might play in identifying a particular health need. The way in which information from the Joint Strategic Needs Assessment is communicated to people will play an important part in maintaining the momentum gathering behind Health and Wellbeing Boards and in ensuring that they succeed. There will be a significant role for the Director of Public Health, who will be able to present ward-level data to ward-level councillors, and councils will themselves need to instigate training to ensure their councillors take advantage of these new arrangements.**

**65. Given that Health and Wellbeing Boards will be required to use their influence to ensure their health and wellbeing strategies are transformed into commissioned services, they will need to learn how to capture the imagination of councillors, commissioners and their communities. Local authorities, the Local Government Association, the District Councils’ Network and Public Health England should develop the skills required to communicate public health issues and ensure locally elected representatives, Board members and public health staff have access to such training**

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142 Ev 152

143 *As above*

144 Q 121

145 Q 329 [Anna Soubry MP]

146 Q 332 [Baroness Hanham]

147 Q 332

148 Ev 166 The other two key functions are delivering services, including specialist public health services, evidence and intelligence services, in support of local government; and leading for public health, by encouraging transparency and accountability across the system.

when required. In order to convey to colleagues and residents what their local needs are, and how the Board intends to deal with them, local authorities should seek a Plain English Campaign endorsement of their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

## The engagement of councils and councillors

### *Two-tier authorities*

66. The question of engagement highlighted the role of district councils in the new arrangements. There are 27 county councils, forming upper tier authorities across much of England, with 201 district councils as the lower tier.<sup>149</sup> Under the 2012 Act, each upper tier local authority (and unitary authority) will have a statutory duty to create a HWB, establish a JSNA of their area and develop a new JHWS.<sup>150</sup> District councils will not be statutory members of HWBs,<sup>151</sup> and, although the 2012 Act requires that CCGs and local authorities continue to include the “relevant district council” when preparing a JSNA, it does not provide a role for districts in preparing the JHWS.<sup>152</sup> Many services that affect the social determinants of health are split between the two tiers. As the UK Healthy Cities Network explained:

In many instances PH (public health), social care and education will be at county-level, while planning, housing, parks and green space and environmental health are at district-level.<sup>153</sup>

67. The District Councils’ Network (DCN) was disappointed with the legislation:

It seems contradictory [...] – given the prominence of the prevention agenda – that whilst CCGs have a statutory role, there is no obligation to involve districts beyond the production of JSNAs.<sup>154</sup>

The DCN suggested that the lack of statutory recognition for districts had contributed to local confusion over the role of district authorities and “in some cases affected the adequacy of local preparations”. In some counties, it said, “there continues to be reluctance to have sufficient representation on boards (including voting rights) or to effectively communicate HWBs developments and the role of district councils locally.” The DCN concluded that “the need for district council input must be a constant, not variable factor.”<sup>155</sup> The Local Government Association took a different view, recommending that counties and districts work together to decide how districts should contribute to public health planning, and that “Districts need to find a way of cooperating among themselves to

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149 Ev w6, para 13 [Neil Blackshaw]

150 Health and Social Care Act 2012, section 194(1); joint strategic needs assessments were introduced in the Local Government and Public Involvement in Health Act 2007.

151 See Health and Social Care Act 2012, section 194.

152 See Health and Social Care Act 2012, sections 192 and 193.

153 Ev w21, para 5.5

154 Ev 95, para 4.3

155 As above

develop and present a ‘district perspective’ and collective voice on HWBs.”<sup>156</sup> Leicestershire County Council explained how its district councils were doing just that—working with the county and among themselves to represent their interests:

the Public Health team has a good relationship with District Councils. Each District Council has a public health link advising on evidence, priorities and needs assessments as well as ensuring join-up with county-wide services. There is a specific District Council Chief Executive designated as health. She co-ordinates the work of the District Councils.

Good personal relationships are at least as important as structures to make partnerships work.<sup>157</sup>

68. Cllr Alan Connett of the DCN, while recognising that “in most places [...] there will be very good informal links,” said that “that is not the same as being part of the decision-making process. Given the role that districts have, that seems to be an omission.”<sup>158</sup> The two County Council witnesses from whom we took evidence, however, both said that they had three district councillors on their main HWBs.<sup>159</sup>

69. As we noted in paragraphs 20 and 48, when we visited Kent we heard how the County Council had established, using powers provided in secondary legislation under the 2012 Act, sub-committees of the HWB. These are based on CCG boundaries and involve district council representatives.<sup>160</sup> Professor Bentley, having worked with Kent, told us that the district authority and what is now the CCG “know each other much better than the county does [...] where there are already relationships and understandings and histories between the two,” so he said “it makes good sense to use that as the building block, to build upwards.”<sup>161</sup> The Royal Town Planning Institute cited another proposal for formally devolving power. It referred to former county councils that had become unitary councils partly on the basis of a “compact” to devolve a great deal more decision making, a model that the Institute suggested existing county councils could use to include districts.<sup>162</sup>

**70. District councils are responsible for many of the services that have a direct impact on the health and wellbeing of their residents. We accept that the omission of these lower tier authorities from Health and Wellbeing Boards and from participation in the Joint Health and Wellbeing Strategy was a potential cause for concern, but we have seen in practice that it has prompted some county councils to make their own arrangements to include district councils. This is entirely appropriate and welcome. County councils might develop a formal compact to devolve some decision making so that districts are recognisably involved in public health matters, or create local HWBs, forums or sub-groups to enable district councils to work more easily with local Clinical**

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<sup>156</sup> Ev 92

<sup>157</sup> Ev 151

<sup>158</sup> Q 58

<sup>159</sup> Q 246 [Cllr Ernie White]; Q 247 [Cllr Roger Gough]. Leicestershire County Council also had a local health forum in each district, localised public health programmes and regular visits by public health staff to district councils.

<sup>160</sup> Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)

<sup>161</sup> Q 276

<sup>162</sup> Q 161 [Richard Blyth]

**Commissioning Groups.** We encourage all county councils to develop agreed working arrangements with district councils.

### **Unitary authorities**

71. In our report, *Councillors on the Frontline*, we described how unitary councils had begun to implement their own brand of localism by devolving decision making, establishing area committees and giving ward-level councillors their own budgets.<sup>163</sup> During this inquiry, we were interested to know whether the changes in responsibility for health and wellbeing would have an impact on ward-level councillors. Duncan Selbie of PHE alluded to one means of engaging ward councillors, when he said: “I hope that being able to show what is happening to your people at ward level will enrich the conversation about what we mean by health”.<sup>164</sup>

**72. We consider that all upper tier councils, including unitary authorities, should set an example to central Government by demonstrating and embedding effective localism themselves. They can do so by devolving certain responsibilities and, where possible, budgets to councillors and committees at ward and area levels. All authorities should look to each other, including through the Local Government Association, for peer support and mentoring. They should also explore the powers and information currently at their disposal, through mechanisms such as the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, to describe the health situation at ward level and to include local councillors and, therefore, communities in decision making.**

### **Housing**

73. Housing, a district council responsibility in two-tier authority areas, has a profound effect on the health of local residents. The Chief Fire Officers Association told us, “poor housing conditions usually result in poor health outcomes for those individuals living in them.”<sup>165</sup> The Chartered Institute of Housing said that, under shadow HWBs, housing had “struggled to get its voice heard”,<sup>166</sup> but it acknowledged that its proposal to create “clear mechanisms linking public health function to the local housing authority” could be realised by placing a housing representative either on the HWB “or through a sub group”.<sup>167</sup>

74. We heard that local authorities had already found ways to work with the housing sector. Demonstrating the flexibility provided by the 2012 Act, Kent County Council noted that its prevention strategy was “being further enhanced in the new integrated commissioning arrangements, which sees a clear role for housing alongside services that promote health and wellbeing.”<sup>168</sup> Cllr Gough told us that Kent Housing Group, involving

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<sup>163</sup> Communities and Local Government Committee, Sixth Report of Session 2012–13, *Councillors on the Frontline*, HC 432, paras 20–22

<sup>164</sup> Q 3

<sup>165</sup> Ev w24, para 4

<sup>166</sup> Ev w52, para 3.6

<sup>167</sup> Ev w52, para 3.1

<sup>168</sup> Ev 145, para 9.2

the County Council, district councils and a neighbouring unitary council was already producing work linked to Kent's Health and Wellbeing Strategy,<sup>169</sup> while Oldham and Sheffield had both included housing representatives on their main HWB, Sheffield's being the Cabinet Member for Housing. Cllr Mary Lea explained that "housing [...] is so fundamental to health that we (the Health and Wellbeing Board) need a direct link in to the Cabinet Member and the housing services that his portfolio provides".<sup>170</sup>

**75. We acknowledge the importance of housing in determining people's health and wellbeing. It is important that this service is included in the 'voluntary' arrangements we have described. We suggest that councils explore ways to include housing in their work, either by establishing housing sub-groups of their main Health and Wellbeing Board or by addressing housing in their Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and when reporting on progress with public health outcomes.**

### The role of Clinical Commissioning Groups

76. CCGs will from April 2013 be responsible for commissioning £65 billion of secondary care, including elective hospital care, urgent and emergency care, rehabilitation and most community health services. These groups will comprise GPs, at least one registered nurse and a doctor who is a secondary care specialist. Some 211 had been established by January 2013.<sup>171</sup> CCGs whose boundaries fall within or coincide with a particular local authority will be entitled to one representative on the local HWB.<sup>172</sup>

77. The significance of the relationship between local government and the local NHS was described to us by Dr John Middleton, vice-president of the Faculty of Public Health, who said that, "if councils are to be strategic leaders of the health strategy, they will have to be able to understand and challenge what goes on in the (local acute) hospital on their behalf."<sup>173</sup> The HWB will be the forum in which councillors and GPs meet regularly, but, as Professor Chris Bentley explained there was some uncertainty about responsibilities. He described how one CCG had said to him: "So you are saying that the Health and Wellbeing Board is going to tell us what to do? We have been deciding what our plans are going to be." Professor Bentley had replied, "you are (part of) the Health and Wellbeing Board [...] it is not telling you what to do. You should be, as a group of people, making joint decisions and then taking away the findings to implement them."<sup>174</sup> We referred earlier in this chapter to how Kent County Council had built into its arrangements opportunities for local councillors and clinical commissioners to meet locally and regularly through HWB sub-committees. The Council explained that by adopting this approach councillors and GPs would collaborate on commissioning from start to finish: "The

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169 Q 252

170 Q 179 [Oldham], Q 181 [Sheffield]

171 See NHS Commissioning Board, [www.commissioningboard.nhs.uk/2013/01/23/wave2-auth/](http://www.commissioningboard.nhs.uk/2013/01/23/wave2-auth/).

172 Health and Social Care Act, section 195

173 Q 3

174 Q 280

commissioning strategies produced in this way will then be signed off by the upper tier Kent Health and Wellbeing Board”.<sup>175</sup>

### **Councillors and Clinical Commissioning Group Boards**

78. There is a general move to involve elected politicians in more health care decision making locally, and the Government has taken a less prescriptive approach to HWB membership. It therefore seems anomalous that a GP who is part of a CCG can be a member of their local HWB, but a local councillor is excluded from membership of a CCG Board.<sup>176</sup> A recent study of HWBs, *“Engagement with Clinical Commissioners”*, referred to this exclusion and to Department of Health guidance allowing two or more CCGs to be represented by the same person on an HWB, and suggested that it “is not hard to read into this a desire to protect CCGs from local political processes.” It added, “GPs and local councillors have much in common. They both run surgeries and they often share and feel a common concern for local issues and for the wider determinants of health”.<sup>177</sup>

79. Cllr Nick Forbes, leader of Newcastle City Council, raised “the importance of local democratic leadership in the process” and pointed out:

I have two deputy cabinet ministers who sit on our two CCG boards. They are able to relate the priorities of the Council to the CCG board and relate the priorities of the CCG Board back to the Council. Severing that link for no apparent, obvious purpose is a mistake.<sup>178</sup>

80. We asked Ministers why there was a bar on councillors sitting on CCGs. The Under-Secretary of State for Health, Anna Soubry MP, explained that it “was to remove the political influence in what should be clinical decisions.”<sup>179</sup> Ms Soubry said that in such situations, HWBs would be “the overseers, the checks and the democratic process”. Tim Baxter, head of the public health policy and strategy unit at the Department of Health, added that, if a CCG ignored the HWB, the NHSCB “can take action”.<sup>180</sup>

81. When we suggested that the new arrangements meant that CCGs would not be accountable to local, elected officials, Ms Soubry responded that health service decisions in the past had often been based on “political opportunism” and cited the commissioning of HIV services as one situation in which, “the politics then become terribly involved and muddled.”<sup>181</sup> We found little evidence to support this view. When we asked councillors

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175 Ev 144, para 5.4

176 As laid down in the National Health Service (Clinical Commissioning Groups) Regulations 2012 (SI 2012/1631)

177 Dr Michael Dixon and Professor Chris Drinkwater, *“Engagement with Clinical Commissioners”*, in *Getting Started: prospects for health and wellbeing boards*, The Smith Institute, p 39. The guidance they cite is “Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance”, Department of Health, July 2012. Local councillors are barred from sitting on CCG boards by virtue of the National Health Service (Clinical Commissioning Groups) Regulations 2012 (SI 2012/1631).

178 Qq 183, 184

179 Q 364

180 Q 368; as we noted in chapter 2, the Government has told us that under secondary legislation the NHSCB has powers to direct or dissolve a CCG where the (N)CB is satisfied that a CCG is failing to discharge its functions, or there is a significant risk of it failing to discharge its functions.

181 Qq 372, 375



whether they envisaged any political problems spending public health funds on, for example, sexual health services, Cllr Roger Gough, from Kent County Council, told us, “so far that has not been an issue.”<sup>182</sup> When we pointed out to the Ministers that councillors could sit on hospital boards, and suggested that there should be public accountability for overall resource allocation and service delivery, Ms Soubry was clear that “public accountability is through the health and wellbeing boards.”<sup>183</sup> In our view the exchange shows that the Department of Health may have further to go than the Department for Communities and Local Government when it comes to embracing localism. **We are concerned to ensure that the new responsibilities for health and, in particular, public health are not monopolised by senior councillors and the local authority executive; all councillors in an authority must play a part at all levels, including framing strategy. The role of the Clinical Commissioning Group involves the establishment of overarching priorities to improve the health of local people, not purely clinical decisions such as choosing which drugs and procedures should be used. While one purpose of health care reform is to remove politicians from day-to-day clinical decision making, the purpose of localism is to bring decision making closer to local people, to make it accountable to local people and to allow local people to develop the relationships that work for them locally. It is not clear to whom Clinical Commissioning Groups are intended to be accountable, and we were not entirely persuaded by Ministers’ arguments for not allowing councillors to sit on Clinical Commissioning Group Boards. *We do not intend to press for the inclusion of locally elected representatives on these boards; instead we recommend that they are not specifically excluded. In the spirit of localism, such issues should be left to local resolution.***

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182 Q 224

183 Q 379

## 4 Public health in practice

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### Tackling the causes of the causes of poor health

82. We have described the new arrangements for the promotion of health and wellbeing and for the integration of health, public health and social care. We have also examined the means by which local government and its partners in local and national health, in the community sector and among providers might assess residents' needs and create strategies to deal with them. These organisational matters will be important, but the approach that councils and their local health partners take to public health will be critical. It will not be enough for one "public health" department in isolation to commission services to deal with single issues such as obesity or smoking. Councils will need to focus all their policies and services on the social determinants of health—the social, economic and environmental reasons why people experience ill health or develop unhealthy behaviour—if they are to make an identifiable difference to the health and wellbeing of their residents. In this chapter we consider what this should mean in practice and how the impact of their work might be measured.

83. Neil Blackshaw, of Easton Planning, a consultancy with major public sector clients, explained, "The English health system has been dominated by the medical model of health throughout the evolution of the NHS."<sup>184</sup> In contrast,

the [social determinants of health] model states that a person's health status is a function of their social, economic and environmental situation [...] The failure to espouse this model wholeheartedly was the result of a combination of silo working and professional resistance and it has contributed to the persistence in inequities.<sup>185</sup>

84. Dr Nicholas Hicks, Director of Public Health in Milton Keynes, was concerned that despite public health functions moving over to local government, some local authorities might not recognise the way in which those functions could then be integrated with the council's existing responsibilities and services:

There is still a risk that too many people see public health as just preventive services, health improvement or health protection and do not necessarily see the whole strategic content [...] does the council really get its role as being the leader and responsible body for health in its community?<sup>186</sup>

Dr Mike Grady, principal adviser at the UCL Institute for Health Equity, agreed and raised the issue of resources:

early years education, our young people who are unemployed and not in training, our people who need support [...] and our older people [...] that kind of spend

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<sup>184</sup> Ev w6, para 10

<sup>185</sup> Ev w6, paras 5, 11

<sup>186</sup> Q 3



needs to shift into a public health agenda rather than provision (of specific public health services).<sup>187</sup>

He wanted to see an approach that went beyond “just ... commissioning” to one about empowering communities and creating greater social cohesion. He said that “the primary driver needs to be the empowerment of individuals and communities, and then a range of support services and commissioned services support that activity.”<sup>188</sup> We saw on our visit to Kent an example of integrated services in Gravesend town centre at the Gr@nd Healthy Living Centre, which incorporated services such as smoking cessation, a job club and youth counselling. We heard that such integration, currently taking place at one community centre, would need to be expanded by a local authority throughout its area and across its services. Sheffield City Council described this as the “place-shaping capacity of councils”,<sup>189</sup> and David Buck, from the King’s Fund, told us that

the Marmot review has been working quite hard with lots of local areas to try to embed its overall high-level policy-type advice in to what this can mean locally. I know the LGA is also working on this agenda [...] One of the critical roles is to make this meaningful for local decision makers.<sup>190</sup>

Professor Chris Bentley, an independent population health consultant, referred to this approach, which he described as a “whole system approach”, in relation to alcohol-related harm, telling us that it might include:

Population level inputs: licensing; bylaws on street drinking; controls on advertising; enforcement of trading standards/sales to minors;

Community level inputs: extended school education programmes; health trainers; community lifestyle initiatives; health champions

Service level inputs: Tier 1 – 4 alcohol services; social care wraparound services (debt management; housing support; job support).<sup>191</sup>

Dr Grady was confident that local government was “grabbing hold of this agenda”, and was not “being dragged back ... into lifestyle initiatives”—commissioning, for example, one education campaign to tackle one health issue, such as smoking. He said such initiatives “do not work and certainly do not work in the bottom 50% of the social gradient of health”.<sup>192</sup>

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187 Q 238

188 Q 235

189 Ev 127, para 1

190 Q 3

191 Ev 160

192 Q 232; the King’s Fund also explained that separate strategies to tackle different examples of unhealthy behaviour had not worked, because “unhealthy behaviours co-occur and cluster in population groups, particularly in the most disadvantaged populations,” and concluded: “Local authorities, with their greater knowledge of local communities—and their greater control over some of the economic and social conditions that shape behaviours—should be in a better position to do this than the NHS”, Ev 78.

### *Examples of local authority initiatives*

85. Witnesses gave us examples of how they hoped to use such an approach to begin to shape the conditions in which people live. On the example of dealing with alcohol-related harm, Newcastle City Council said that

instead of simply looking at alcohol treatment services, which is dealing with the problem too late, we are looking at the environment in which people think about and consume alcohol. That includes looking at the availability of it through not just pubs and clubs but also off-licences.<sup>193</sup>

On another health issue, obesity, Sheffield City Council explained that

we also want to look at some of our by-laws to see what we can do in terms of where food outlets are placed: are they near schools? Do we want some food outlets, takeaways and so on, in certain places?<sup>194</sup>

86. Decisions on appeal by Planning Inspectors have shown that in order successfully to refuse planning permission for a takeaway on the grounds of proximity to a school and the existence of a school's healthy eating policy, a local authority must also point to an over-concentration of takeaways in a certain area and to evidence of a link between childhood obesity and their proximity to schools.<sup>195</sup> Several councils, such as St Helen's, have now published supplementary planning guidance relating to takeaway establishments, putting in place a clear policy to exclude them from a certain distance around schools.<sup>196</sup>

87. In early January 2013, Westminster City Council and the Local Government Information Unit, in a joint report on the role of councils in public health, proposed several ways in which local authorities might embed healthy behaviour in their communities. One suggestion involved a link with welfare:

Relocalisation of council tax benefit [...] combined with new technologies provide an opportunity for councils to embed financial incentives for behaviours that promote public health. The increasing use of smart cards for access to leisure facilities, for instance, provides councils with a significant amount of data on usage patterns. Where an exercise package is prescribed to a resident, housing and council tax benefit payments could be varied to reward or incentivise residents.<sup>197</sup>

BMA member and GP Dr Lawrence Buckman called the idea "draconian and silly": "The best way [councils] can intervene is to stop restaurants and fast-food chains providing the kind of food that make people put on weight, and interfere with the way foods are sold in

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193 Q 170

194 *As above*

195 *Planning Use Class Orders*, Standard Note, SN/SC/1301, House of Commons Library, January 2013

196 *Planning Use Class Orders*, Standard Note, SN/SC/1301, House of Commons Library, January 2013

197 Local Government Information Unit and Westminster City Council, *A dose of localism: the role of councils in public health*, p 6

shops.”<sup>198</sup> The Westminster City Council and LGIU report, however, did include the proposal:

In areas identified as food deserts, where fresh and affordable foods needed to maintain a healthy diet are unavailable, councils could offer incentives to local shops that make such services available through social investment funds.<sup>199</sup>

When we asked Professor Chris Bentley for his assessment of the idea, he told us, “if they [Westminster City Council] are saying, ‘We have a range of other things we can do to support you to get yourself in a position where you can benefit from these interventions,’ I think that is perfectly sensible.”<sup>200</sup> He also suggested, in order to change behaviour across a community, some councils might benefit from more advice: “While central direction is not an option, there is a strong case for better guidance and developmental support on what will be needed to achieve population level change”.<sup>201</sup> When we put this point to the Health Minister, Anna Soubry MP, she cited smoking and how local authorities, “under the guidance of PHE, who can provide statistics, advice” etc, could identify a local ward’s incidence of smoking and then make a local decision to target smoking. In this way, she said, local councils could then “apply an order to make children’s playgrounds no smoking areas [...] work with the local school [...] and [...] make sure that all the pharmacies have got the right gear, that the GPs are stuck in on it and so on”.<sup>202</sup>

**88. Local authorities, if they are to grasp fully the opportunity afforded to them by the return of public health, will need to look beyond those services traditionally considered to be “public health”, such as health protection, health promotion and disease prevention, and tackle the causes of the causes of poor health, working with local partners and using all the powers, personnel and services at their disposal. The evidence we received makes it clear that people, particularly in vulnerable groups, are more likely to exhibit a range of unhealthy behaviours. Single initiatives targeting individual lifestyle choices, such as drinking or smoking, have been shown not to work, especially among people at the lower end of the social gradient of health. Authorities should be willing to take one step back from treatment to look additionally at by-laws, education campaigns and how to involve, for example, GPs, pharmacies or debt management and housing services in a more holistic attempt to deal with the multiple reasons behind complex health problems.**

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198 “Obese who refuse to exercise ‘could face benefits cut’,” *BBC News Online*, 3 January 2013 [www.bbc.co.uk/news/uk-england-london-20897681](http://www.bbc.co.uk/news/uk-england-london-20897681)

199 Local Government Information Unit and Westminster City Council, *A dose of localism: the role of councils in public health*, p 5

200 Q 290

201 Ev 164

202 Q 305

## Early years

89. Sir Michael Marmot, in his review of health inequalities in England, stated, “efforts to reduce health inequalities [...] must address [...] the quality of early years experiences.”<sup>203</sup> The review also noted:

What a child experiences during the early years lays down a foundation for the whole of their life. A child’s physical, social, and cognitive development during the early years strongly influences their school-readiness and educational attainment, economic participation and health.<sup>204</sup>

Professor Chris Bentley, agreed, “The key one is about early start, because if you miss children in the first five years of life, when their cognitive abilities are developing, it means they are playing catch-up for the rest of their lives.”<sup>205</sup> He was, however, concerned that “Health and Wellbeing Boards seem to be neglecting that.”<sup>206</sup>

Other witnesses indicated that HWBs were concentrating on early years interventions. Liam Hughes, the independent Chair of Oldham Shadow HWB, said he would like to “focus on the emotional wellbeing of very young children and also on early speech and language.” He added that over “a period of a few years we should be able to see those children more ready for school at age four and a half or five.”<sup>207</sup> Dr Mike Grady also pointed out that readiness for school could be measured:

If you look at the figures for Birmingham City Council in relation to readiness for school, what you will find is within three years they shifted that figure from 38% to 55% by having a coherent strategy, agreed joint priorities, integration of services and an absolute focus on what the health outcome was that they wanted to achieve.<sup>208</sup>

Cllr Mary Lea of Sheffield City Council said: “We think it is really important to focus on early life, nought to three, that age group. That is absolutely vital”.<sup>209</sup>

**90. Local authorities will of course wish to base their public health work on their Joint Strategic Needs Assessments, but we note how several councils have placed early years interventions—literacy, readiness for school and childhood obesity programmes—high on their list of priorities. We commend authorities to bear this in mind when making their decisions, given the importance of early years development in people’s later health and wellbeing.**

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203 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, p 39

204 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, p 60

205 Q 287

206 *As above*

207 Q 170

208 Q 232

209 Q 170

## Employment

91. The connection between work and health was emphasised by Westminster City Council, when it told us of the employment initiatives that it would seek to introduce:

Employment is one of the most evidence based determinants to a person's health and well-being [...]. Our Health and Wellbeing Strategy will help people to successfully return to work and retain work by supporting people with health conditions/disabilities and promoting quality work and health and well-being in the workplace.<sup>210</sup>

Such evidence might include a study of increased life expectancy in local authority areas between 1998 and 2007, which found: "Decreases in unemployment and increases in average income in an area explained, to a large extent, why some local authorities 'performed' better than others."<sup>211</sup> In Sweden, the National Board of Health and Welfare (NBHW) told us that it recognised three levels in public health: structural, involving a person's education, participation in society and economic circumstances; environmental, including people's workplaces and their local residential areas, and lifestyle, such as their drinking, eating and exercise habits. Bosse Pettersson, NBHW director, explained that to tackle the lifestyle factors, they had to work through the first two levels, because then they were able to see the connection between, for example, unemployment and smoking.

Cllr Nick Forbes, leader of Newcastle City Council, told us that his authority would focus at least some of its work on unemployment,<sup>212</sup> and Cllr Mary Lea, from Sheffield City Council, said:

We would like to see maybe more powers devoted to local government so that we can tackle more of the social determinants of poor health and inequalities. In particular, maybe we are looking at the Work Programme. That may be something that we would like to see devolved down to local authorities, because we think we can maybe make a better job of that than is currently happening.<sup>213</sup>

In our report, *Localism*, we noted how the Government's definition of the concept was sometimes stretched and contradictory, and concluded:

Some policy areas appear to have been granted an exemption from decentralisation. The priorities of the Department for Work and Pensions appear particularly resistant to the arguments for devolving power to local institutions, despite the eagerness of local authorities to be more involved in shaping the response to worklessness in their area.<sup>214</sup>

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210 Ev 120, paras 22, 23

211 Ben Barr, David Taylor-Robinson and Margaret Whitehead, "Impact on health inequalities of rising prosperity in England 1998–2007, and implications for performance incentives: longitudinal ecological study", *British Medical Journal*, 2012, ref: 335:e7831, p 1

212 Q 214 [Newcastle]; see also Ev 120, para 22 [Westminster] and Q186 [Sheffield].

213 Q 199

214 Communities and Local Government Committee, Third Report of Session 2010–11, *Localism*, HC 547, para 32

The Under-Secretary of State for Communities and Local Government, Baroness Hanham, pointed out, however, that on employment initiatives local authorities “already take that responsibility [...] supporting apprenticeship schemes and looking after people that are not well, and encouraging them back [to work]”.<sup>215</sup>

**92. We are pleased that local authorities are looking at the evidence and adopting an evidence-based approach to health and wellbeing. Evidence shows that being and staying in work has a significant effect on a person’s health and wellbeing; unemployment is one of the causes of the causes of poor health. It follows that a strategy to combat worklessness might be one of their public health initiatives from April 2013. This requires the Government and, in particular, the Department for Work and Pensions to adopt a more localist approach and to devolve more powers to councils, as we said in a report back in 2011. We note that local authorities already support apprenticeships and back-to-work schemes, but the Government should consider devolving to local government further measures, including elements of the Work Programme, in order to address at a more local level unemployment and, in turn, one reason why people may adopt unhealthy lifestyles.**

## Local authorities working with the Government

93. The Government, in its White Paper, *Healthy Lives, Healthy People*, stated:

Where the case for central action is justified, the Government will aim to use the least intrusive approach necessary to achieve the desired effect. We will in particular seek to use approaches that focus on enabling and guiding people's choices wherever possible.<sup>216</sup>

The Health Select Committee, when it examined public health in 2011, however, found:

While interventions that involved the Government “shoving people” (such as the ban on smoking in enclosed public places) were demonstrably effective, nudging, which was ill-defined (“a very flaky, slippery term”), was little supported by evidence [...] The recent report from the House of Lords Science and Technology Committee has since confirmed how thin the evidence base for nudging is, as well as the unevenness of evidence between different fields of behaviour change.<sup>217</sup>

94. We considered whether the local initiatives referred to in the previous section might, in some cases, require additional and complementary central Government action. Dr Nicholas Hicks, Director of Public Health in Milton Keynes, explained how a target to reduce inequalities in infant mortality had been

supported by concerted action nationally. There were public service agreements and every department bent its actions to that, supplemented by freedom and incentivisation of local authorities through local public service agreements.<sup>218</sup>

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215 Q 381

216 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, CM 7985, para 2.33

217 Health Committee, Twelfth Report of Session 2010–12, *Public Health*, HC 1048-I, para 277

218 Q 36



Dr Hicks explained that the target had been hit two years early and said that “we do have examples of how, by bending the totality of resources, not just this tiny sliver labelled public health, we can do something that is genuinely wonderful.”<sup>219</sup> Other witnesses told us they would be working to engage the Government. Cllr Mary Lea, of Sheffield City Council, said that one of her authority’s priorities was

to lobby Government in terms of some of the big health issues that we face: for example, obesity, how food is produced [...] manufactured [...] advertised and sold. I think there are some changes only the Government can make.<sup>220</sup>

On moving resources to prevention, Cllr Anthony Devenish, of Westminster City Council, was reluctant to call it “lobbying” but said

you have to communicate [...] you have to get your message across, and the value for money point [...] is that if we can prevent things through reducing binge drinking, that is going to help the NHS overall.<sup>221</sup>

In relation to alcohol-related harm, Newcastle City Council focused on the affordability of drink and was therefore “campaigning as a council for a minimum unit price of alcohol”.<sup>222</sup> The Health Minister, Anna Soubry MP, told us of her initial scepticism about a minimum price but revealed how she had subsequently met liver specialists and doctors who “frankly blew me away and completely convinced me that it is a thoroughly good idea.”<sup>223</sup> The Government’s consultation on the matter finished on 6 February 2013.<sup>224</sup> The Government is currently reviewing the results of the consultation.

95. Aside from consultation on proposed legislation, the Government has also introduced the “Public Health Responsibility Deal”, a voluntary agreement by which businesses commit, for example, to improving the health of their customers and staff, or to helping them to become more physically active.<sup>225</sup> The Department of Health has noted that many local authorities already run local Public Health Responsibility Deals to encourage such activity, and, working with the Local Government Association, local authorities, local businesses and other organisations, the Department is developing “a toolkit to support engagement of local businesses to take simple actions in the areas of alcohol, food, health at work and physical activity.”<sup>226</sup> On the next steps nationally in the Responsibility Deal process, Ms Soubry explained that a “bit of naming and shaming is going to happen, because we make it clear that, unless we begin to see substantial changes, we will consider legislation”.<sup>227</sup>

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219 Q 36

220 Q 170

221 Q 221

222 Q 170

223 Q 321

224 *A minimum price for alcohol?*, Standard Note, House of Commons Library, SN/HA/5021, 12 February 2013

225 Department of Health, “Public Health Responsibility Deal: Core Commitments”, [responsibilitydeal.dh.gov.uk/](http://responsibilitydeal.dh.gov.uk/)

226 Department of Health, “A toolkit for supporting engagement with local business”, [responsibilitydeal.dh.gov.uk/](http://responsibilitydeal.dh.gov.uk/)

227 Q 324

96. In Sweden, the NBHW told us that, on tobacco control, it had recognised the need for input on three levels: state level, which had set prices and an age limit on purchasing; regional level, which as the provider of primary and secondary care had introduced guidelines to ensure patients were ready for surgery; and municipal level, which had responsibility for enforcing the state's rules on price and age.

97. *Some public health issues, such as alcohol misuse and obesity, may require central Government leadership and action, including legislation, if a big difference is to be made to the health of local people. Central Government action will not be a panacea, but to effect change local authorities may require the support of complementary national-level initiatives to make the most of their own strategies, powers and influence. In the meantime, councils do have options available to them, including, setting up or expanding local Public Health Responsibility Deals, with local businesses, on which Government guidelines were published in January 2013. What is clear is that there is no single solution; multiple solutions will be required to deal with the multiple causes of unhealthy behaviour.*

### **Joined-up government**

98. In chapter 2, we cited Dr Mike Grady's point that to address the social determinants of health, HWBs would "need the right players in the right room to address the right issue".<sup>228</sup> We noted press reports on 8 November 2012 that the Cabinet sub-committee on public health, which had been established to enable work "across multiple departments to address the wider determinants of health",<sup>229</sup> was being disbanded. Explaining the decision, the Cabinet Office was reported as saying:

Public health issues will now be brought into the broader domestic policy committees rather than sitting with a separate subcommittee. This will allow public health issues to be discussed and decisions to be taken by a wider group of ministers from across government.<sup>230</sup>

When we asked the Government how and when public health issues had been discussed and decisions taken by that "wider group of ministers from across government", the Health Minister, Anna Soubry MP, replied, "I do not know of any,"<sup>231</sup> and Tim Baxter, from the Department of Health, said that "we have plans for engaging with the Home Affairs [Cabinet] Committee; The brutally frank answer is that we have not done so yet."<sup>232</sup> Ms Soubry did add later in the session that she "went to see Edward Timpson in the Department for Education to talk about [...] the lack of physical activity in too many of our youngsters".<sup>233</sup>

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228 Q 228

229 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, CM 7985, November 2010, executive summary, para 4

230 "Doctors dismayed as public health committee is scrapped", *The Guardian Online*, 8 November 2012, [www.guardian.co.uk/politics/2012/nov/08/doctors-dismay-public-health-committee](http://www.guardian.co.uk/politics/2012/nov/08/doctors-dismay-public-health-committee)

231 Q 326

232 Q 327

233 As above

99. Since the disbandment of the Cabinet sub-committee on public health, public health issues fall to be discussed and decisions taken in domestic policy committees. *We note also plans within the Department of Health to engage with the Home Affairs policy committee, and the discussions that the Department has already had with the Department for Education, which should be encouraged elsewhere in government.* Policy alignment nationally will assist councils' efforts to improve health and wellbeing locally and avoid the potential for mixed messages. Given the way in which local health issues span at least two Departments, Health and Communities and Local Government, local authorities need confidence in their contact with Government. *In the spirit of close working throughout government, both centrally and locally, we recommend that the Department of Health and the Department for Communities and Local Government set up a single point of ministerial contact to which local authorities can turn for support in their new health care role.*

## Measuring success

100. The Government, as part of its health reforms, has developed three frameworks from which bodies with responsibility for health can identify the outcomes they would like to achieve as a result of their work: the NHS Outcomes Framework, the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework. The Government explained that:

The purpose of developing three separate frameworks has always been to ensure focussed rather than blurred accountability and to recognise the different delivery systems and accountability models for the NHS, for public health and for adult social care [...]

the NHS Future Forum presented a model in which it should, in certain areas, be possible to set specific outcomes for the different sectors that contribute to broader outcomes that are shared between the different sectors. The Government supports this model [...]. However, the pace at which greater alignment of this type can be achieved will necessarily be constrained by current data and indicator availability.<sup>234</sup>

Dr Penny Toff, of the BMA, told us that the public health outcomes framework “as a way of monitoring what is going on locally” was “very sound”, although to encourage integrated working and to put aside “individual agendas” she considered “it would probably be helpful to have a more overarching national framework around integrated care.”<sup>235</sup> Tim Baxter, from the Department of Health, cited the public health outcomes framework as a systematic way of measuring success, highlighting its 66 “wide-ranging” indicators on “things like reoffending rates, school readiness, smoking prevalence, vaccination rates and premature mortality.”<sup>236</sup> We noted earlier in this chapter how improvements in school readiness rates could be a useful short-term measurement of success.<sup>237</sup> In that context, we also heard that the figure for NEETs (those not in education,

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<sup>234</sup> Department of Health, *The NHS Outcomes Framework, 2012/13*, [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131723.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf)

<sup>235</sup> Q 63

<sup>236</sup> Q 386

<sup>237</sup> See “Early years” section in this chapter, and Q 227 [Dr Mike Grady].

employment or training) would demonstrate “within a short period” whether an impact was being made.<sup>238</sup> The Royal Town Planning Institute was, however, keen to expand that indicator to include in the outcomes framework an overall assessment of worklessness rather than just of NEETS, and to include overcrowding and housing.<sup>239</sup>

101. Westminster City Council, while it found the absence of clear objectives from the Government “provided space for local authorities to determine local objectives which fit local needs,” noted:

Where the lack of national clarity may be problematic is balancing the local approaches to public health with the Department of Health’s approach to measuring the impact of the new arrangements.<sup>240</sup>

Professor Gabriel Scally, of the University of the West of England, told us that authorities would need to be able to measure their data alongside a range of comparators, nationally and internationally. For example, although in the south-west some areas were better than the English average, this did not provide a complete picture as “the overall position of England is so much worse than other countries.”<sup>241</sup> He concluded that “people must be allowed to act within the system in the interest of the population they serve”, whether the population of England or of a local authority.<sup>242</sup>

102. We also heard about the risks involved in assessing what works. Newcastle City Council, while acknowledging the importance of measuring health and wellbeing, and any changes in inequalities in health and wellbeing, stated that

there is a risk such measurement becomes an end in itself [...]. Measuring impact in the short-term can lead us to focus on individual interventions where there is a greater evidence base, rather than enable us to use our energy and resources to drive social change that will lead to sustained improvements for wellbeing and health for this and future generations.<sup>243</sup>

Dr Toff made a similar point, telling us about the lack of data on marginalised communities and when measuring, for example, childhood obesity levels, not to ignore “what is happening to groups that would not necessarily be included within those measurements.”<sup>244</sup> Liam Hughes, the independent chair of Oldham’s shadow HWB, said that a key indicator of success “should be the scale of the redirection of commissioning investment upstream into prevention.”<sup>245</sup> He accepted that “further upstream” into prevention, it would be difficult to draw a direct link between cause and effect, as any analyst would then be dealing with “the conditions of life rather than some preventive intervention”, but he cited work in Oldham on premature mortality, to which we referred

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238 Q 227 [Dr Mike Grady]

239 Q 135 [Richard Blyth]

240 Ev 120, paras 14–15

241 Q 64

242 Q 65

243 Ev 123

244 Q 69

245 Ev 125

in chapter 3, using the current figure for men dying and the direct interventions that might reduce it, as an example of good evidence and a targeted, measurable programme that the HWB was going to implement.<sup>246</sup>

103. Mr Hughes also drew our attention to the impact of external factors:

Many boards are concerned about the impact of major policy changes on health, especially the welfare reforms [...] for some of the most vulnerable people in our society, the combination of reduced income, more insecure housing and reduced support will work against the grain of health improvement.<sup>247</sup>

Sheffield City Council pointed out that measuring the impact of public health programmes on populations continued to be a challenge:

This is because public health initiatives take place in the context of continuing change within society, which in turn impacts on health [...]. Thus, for example, the current economic recession is likely to have far more extensive impact (negatively) on the health of the population than locally managed, relatively poorly resourced, public health programmes.<sup>248</sup>

It also explained that it would use its resources “to focus on interventions which are proven to make the biggest impact on well-being”.<sup>249</sup> Some examples that drive home its point are shown below. Professor Chris Bentley provided one example of a methodological intervention that could be easily measured. He noted in Birmingham the correlation between the incidence of people with heart disease and their non-registration with a GP and, extrapolating that evidence to people with other long-term conditions, explained that it was clear only half the people with such conditions knew they had them. He therefore suggested that all HWB partners could contribute to the solution by educating the public about the issue, by searching for the “missing thousands” of non-registered patients and by helping them to connect with the services available, explaining that as a result, “GPs will then be able to improve their own performance in relation to registering patients, and getting them on the best treatment”.<sup>250</sup>

**104. The transfer of functions from central to local government during the relocation of responsibilities for public health must not become an end in itself. Local authorities will need to provide within an agreed period evidence of an improvement in the health and wellbeing of their population. With these new powers comes the responsibility to deliver results, and local authorities will need to balance local and national objectives and short-term and long-term aims. Given the complex, multi-faceted nature of the social determinants of health, however, determining the success of general—population-wide—or specific initiatives will be difficult, time-consuming and may ultimately distract those working on them from making progress. Short-term success can be demonstrated relatively quickly, and without distracting from longer-term**

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246 Q 217

247 Ev 126

248 Ev 131, para 36

249 Ev 127, para 6

250 Ev 154

objectives, by, for example, improvement in readiness for school rates, the number of NEETs (those not in education, employment or training) in a local area and by all Health and Wellbeing Board members working to increase patient registration with GPs in order to identify those with long-term conditions and to prescribe treatment for them.

### **Assessment bodies**

105. The relationship between the national and the local in measuring success was also reflected comments on who should conduct the assessment. Cllr Alan Connett, from the District Councils' Network, referred to Healthwatch, scrutiny committees and ultimately the electorate as the bodies that should hold local authorities to account.<sup>251</sup> Cllr Steve Bedser, from the LGA and Birmingham City Council, said he was "reluctant to be held to account from day one, because in some local authorities we inherit very stark inequalities", but he also said "health scrutiny and Healthwatch are going to be very important in keeping some local temperature".<sup>252</sup> Dr Peter Carter, of the Royal College of Nursing (RCN), cited hospitals at the bottom of league tables which "feel quite persecuted by it, when it is often a reflection of the population they are serving [...] In the first few years [...] we need to be careful not to set unrealistic targets for local authorities, because this is about behavioural and lifestyle change."<sup>253</sup> Liam Hughes, from Oldham's shadow HWB, said that PHE was "conscious that the switch from top-down direction to sector-led improvement requires first-rate data and intelligence, the identification of blind-spots, and the will to take action about them." He added that PHE should therefore "be more of an ally and 'critical friend' than a regulator".<sup>254</sup>

106. **Good local authorities may already be tackling the difficult challenges posed by unhealthy people and communities, so in the short term at least it would be unfair and possibly counter-productive to start "naming and shaming" councils without taking into account historical and demographical factors. With Public Health England in its infancy it makes sense to restrict its role to that of critical friend. On matters of scrutiny and regulation, local authorities should not hide behind a national body such as Public Health England. We encourage them, in the spirit of localism, to take responsibility for these issues themselves, through overview and scrutiny committees and Local Healthwatch.**

### **Self-assessment**

107. Witnesses drew our attention to one aspect of measurement, self-assessment, as an effective means of both obtaining information about people and involving them in their own care. Caroline Abrahams, of Age UK, told us that, because older people when asked had included social contact in their definition of wellbeing, it was important to measure their levels of participation in society, adding, "you could do that through surveys [...]"

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251 Q 72

252 Qq 72, 74

253 Q 75

254 Ev 125



working with and through voluntary sector organisations.”<sup>255</sup> Paul Woodward, of Sue Ryder, agreed, telling us that its younger service users also had broad ambitions, to maintain their independence, spend time with their family and engage with the community, adding that “you could certainly look at that through surveys” and that he saw no way of measuring it “other than asking people whether they are actually getting it or not.”<sup>256</sup> This idea of making the most of the knowledge of service users as well as providers was, Dr Mike Grady told us, an element in the co-production of health and wellbeing which “encourages people and communities to participate in public services on an equal basis with professionals”.<sup>257</sup>

**108. Surveys—self-assessments—are a useful measure of wellbeing: they quantify the less specific but no less important objectives of independence and social participation, and they engage individuals in the development of their own wellbeing. Councils might make such surveys one aspect of agreeing their contracts with voluntary groups.**

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255 Q 143

256 Q 146

257 Ev 148

## 5 The national perspective

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### Introduction

109. The introduction of new bodies such as Health and Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs) will directly affect the architecture, provision and delivery of public health and health services in local areas, but the introduction of the two national bodies, Public Health England (PHE) and the NHS Commissioning Board (NHSCB), to which we have referred in previous chapters, will have a significant effect on local communities as well. We have dealt with the role of both bodies in evidence gathering, guidance and commissioning locally, but the two also have direct responsibilities for one significant area of public health: front-line health protection, dealing with infectious diseases, co-ordinating outbreak management programmes and responding to health emergencies such as flu pandemics. The arrangements for front-line health protection are another example of the complexity of the system from April 2013, which will include, for example, 39 Local Resilience Forums and 15 local PHE centres. In this chapter we consider how front-line health protection duties have been allocated and organised, the preparations locally and nationally for them and, in relation to the NHSCB, its central role in providing children's public health services and, in particular, screening and immunisation.

### Front-line health protection

#### *The role of Public Health England*

110. On the creation of PHE, the Government said that the rationale for a national public health agency was “to bring together for the first time the full range of public health expertise,” adding, “PHE will incorporate the functions of the Health Protection Agency (HPA), and thus will be responsible for front line health protection via its local centres which will support their local authorities.”<sup>258</sup> In its evidence to us the Government described the preparatory work which had been undertaken. It drew attention to the “factsheets” and a “resource pack” that it had issued on the Emergency Preparedness, Response and Resilience (EPRR) roles of local government, and said that work was underway to ensure everyone knew their role:

The new structures and organisations will work through partnerships of the 39 Local Resilience Forums (LRF), each with a lead DPH [...]. Initial responses will be led by the [Directors of Public Health], with PHE, in close collaboration with the NHS lead.<sup>259</sup>

111. Several witnesses expressed reservations about the preparations for, and effectiveness of, the new arrangements. The Chartered Institute of Environmental Health described a “transition from well established, effective safeguarding arrangements to something still

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258 Ev 166

259 As above

unclear and denuded of resources”.<sup>260</sup> The Association of Directors of Public Health (ADPH) warned:

There remains a risk that emergencies, outbreaks and epidemic situations, will not be properly managed or responded to, may quickly escalate, and the public will come to serious harm.<sup>261</sup>

The ADPH pointed out that numerous agencies that might be involved in a health protection incident and called for:

clear delineation of responsibilities for health protection at local, sub-national and national levels, including the [local authority], the [Director of Public Health], the NHS and the 15 centres of PHE.<sup>262</sup>

The arrangements for a co-ordinated response to a health emergency locally were also a concern for the Faculty of Public Health, which described the situation as “fragmented”, with responsibility spread across the local authority, the NHS and PHE.<sup>263</sup> Duncan Selbie, Chief Executive-designate of PHE, told us, however, that “the practical experience of outbreaks [...] is that 90% of these incidents are handled locally, and always will be.”<sup>264</sup> He added that, if a situation escalated, PHE would be responsible for ensuring that resources were in place, “so it is all about people and relationships at local level.”<sup>265</sup> He also said, “I will do everything I possibly can to make sure that people know whom to talk to from day one and we simply do not have that risk emerging”.<sup>266</sup>

112. Other witnesses described an inconsistent picture across the country. Some were more content than others with the new arrangements, and with their understanding of them. Dr Nick Hicks, Director of Public Health in Milton Keynes, told us he did not share the “anxiety” of other witnesses about local arrangements.<sup>267</sup> In contrast, Cllr Nick Forbes, Leader of Newcastle City Council, told us that:

the fundamental point I make is we do not know whom to talk to, because Public Health England does not exist yet, apart from in shadow form. So it is not just what conversation do we have, but who do we have it with? I do not know.<sup>268</sup>

Cllr Mary Lea, Sheffield City Council Cabinet Member for Health, Care and Independent Living, had three concerns:

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<sup>260</sup> Ev 79, para 3.1

<sup>261</sup> Ev w36

<sup>262</sup> *As above*

<sup>263</sup> Ev 86

<sup>264</sup> Q 20

<sup>265</sup> *As above*

<sup>266</sup> *As above*

<sup>267</sup> Q 22

<sup>268</sup> Q 212

- her council had just been informed of its responsibility for community infection control, and she told us that it "all happens in a few months, and we have only just found this out;"
- the treatment and management of TB, which had been under the control of the Primary Care Trust, was being split between the local CCG and PHE; and
- Sheffield's Director of Public Health "should know to whom to go to get some of the answers that we need to clarify these issues," but it was "proving very difficult for him to get the answers that he needs in order to advise us as a council".<sup>269</sup>

Cllr Steve Bedser of Birmingham City Council told us that he had been encouraging the NHS and local government to focus on relationship building and partnership, but

in this particular regard [...] we need unambiguous wiring diagrams [...] a clear line of sight from top to bottom of who is in charge, who is calling the shots, who is accountable, and we need to be satisfied as a health and wellbeing board that we properly understand that in our local context.<sup>270</sup>

Further witnesses told us they still had concerns about the co-ordination of a regional or national response to a health protection incident. Professor Gabriel Scally, from the University of the West of England, was:

not convinced that if we have a problem across a substantial part of the country, Public Health England would be able to provide enough staff to lead in every local area. I believe it should be the local director of public health and the local authority that leads that function, but that is not clear to me at all.<sup>271</sup>

Dr Peter Carter, chief executive of the RCN, wanted contingency plans made clear, and he wanted answers to the questions: "Who is responsible? When you press the hot button, who is the person on the spot that is going to be taking control?" Dr Carter concluded, "That is not clear at this stage, and that is not good".<sup>272</sup>

113. When we put these concerns to Tim Baxter, deputy director of the Public Health Development Unit at the Department of Health, he said that after a recent local government self-assessment process, "the general message was that people felt they were moving forward and they understood the new arrangements". He explained:

Four contingency exercises are being planned. I am not sure whether any of them have taken place yet, but they are planned to take place before the system goes live [...] I think people are clear about the general architecture. The point is more about nailing down exactly all the people in the local resilience architecture.<sup>273</sup>

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269 Q 212

270 Q 105

271 Q 104

272 Q 108

273 Q 300

114. In previous chapters, we have remarked on the need for local authorities to develop sound working arrangements with health partners based on trusted relationships, leadership, persuasion and influence, but, when it comes to protecting the population in the event of a health emergency, those involved need to know unambiguously what their role is, understand who is in charge and have in place clear lines of accountability. Despite the assurances of Public Health England and of the Department of Health, we heard from witnesses who were still unclear about the details of this vital new responsibility, including who would be in charge locally in the event of a regional or national outbreak. This is a worrying state of affairs so late in the transition process. *We therefore recommend that the Government sets out clearly and unambiguously the lines of responsibility, from Public Health England down to public health staff in local authorities, and confirms that Public Health England will have sufficient staff throughout the country to assist in the local and regional, as well as national, responses, in the event of a health emergency. We note that four contingency exercises have been planned before April 2013 but, to ensure that local authorities throughout the country are not only aware of, but practised in, the new procedures, we call on the Government to work with them to organise a continuing programme of such exercises.*

### ***The role of the NHS Commissioning Board***

115. While PHE would be responsible for “emergency preparedness including pandemic influenza preparedness (supported by local authorities)”, the NHSCB would be “mobilising the NHS in the event of an emergency”.<sup>274</sup> Professor Scally told us that “the good thing about the NHS system as it has operated in the past is it has been possible to mobilise staff very rapidly, and I fear the loss of that.”<sup>275</sup> Dr Penny Toff of the BMA was concerned that the new health protection

structures are very complex and not at all transparent to most people, and my main concern at the moment is what we are seeing as a result of that is huge variation [...] There is now a responsibility that will be placed on the NHS Commissioning Board’s local centres, which was not there before, to make sure that there is that capacity on the NHS side to respond to these emergencies [...] we will need to test out to see whether it works.<sup>276</sup>

Tim Baxter, from the Department of Health, told us that the task of ensuring people knew who the relevant people were in the NHSCB area teams and at the national level was “being dealt with”.<sup>277</sup>

**116. The inclusion of the NHS Commissioning Board and its 27 local area teams in the health protection system, with its role in mobilising the NHS in the event of an**

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274 NHS Commissioning Board Factsheet, [www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf](http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf)

275 Q 104

276 Qq 109, 110; according to an NHS factsheet on commissioning responsibilities, NHSCB local area teams will have a responsibility to co-operate with PHE and local authorities on outbreak control and to mobilise the NHS in the event of an emergency, NHS Commissioning Board Fact sheet for clinical commissioning groups, July 2012, [www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf](http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf), p 8.

277 Q 300

emergency, and combined with the 39 Local Resilience Forums and 15 local Public Health England centres, adds a further layer of complexity and introduces potential variation to the new arrangements, with all the attendant risks. Local authorities will need to be completely clear about whom they speak to in the NHS locally in the event of an emergency, so *we reiterate our recommendation that the Government and the NHS Commissioning Board ensure that these relationships are made unequivocally clear to public health staff in local government.*

### *The role of Directors of Public Health*

117. The Director of Public Health will have a pivotal role in the event of any health protection incident locally. Dr Penny Toff of the BMA emphasised the significance of their position, telling us, “it will be extremely important that they are given the resources and freedom to exercise that role in bringing the whole thing together locally, probably jointly with the local Commissioning Board”.<sup>278</sup> As we noted, Professor Scally was concerned about a perceived lack of clarity regarding the Director of Public Health’s role locally in the event of a regional outbreak that crossed local authority boundaries, but Ministers were keen to emphasise the responsibility of the Director of Public Health in specifically local emergencies. The Under-Secretary of State for Health, Anna Soubry MP, told us local politicians needed to ensure Directors of Public Health had the “power, respect and status within the local authority that they should have, given the job we want them to do,” and the Under-Secretary of State for Communities and Local Government, Baroness Hanham, told us that in the event of an outbreak of norovirus or of TB, for example, it was “important that the local authority, local government and the public health director are together”.<sup>279</sup>

### *Revised responsibilities*

118. In response to the Health Select Committee’s 2011 report, *Public Health*, the Department of Health stated:

Local authority Directors of Public Health, supported by Public Health England, will be responsible for ensuring that plans are in place to protect the health of their geographical population.<sup>280</sup>

Under guidance issued in August 2012, the Department of Health expected local authorities “to ensure that partners have effective [health protection] plans in place”.<sup>281</sup> The Faculty of Public Health told us, “There should be local responsibility with the Director of Public Health, beyond ensuring that plans are in place,”<sup>282</sup> but regulations introduced in February 2013 further clarified this DPH responsibility, providing only that each local

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278 Q 109

279 Q 300 [Anna Soubry MP]; Q 303 [Baroness Hanham]

280 Government response to the House of Commons Health Committee’s Twelfth Report of Session 2010–12, *Public Health*, CM 8290, para 67

281 Department of Health, guidance, “Health protection in local government”, [www.dh.gov.uk/health/files/2012/08/9739908HP\\_in\\_LG\\_factsheet\\_v4\\_29\\_August.pdf](http://www.dh.gov.uk/health/files/2012/08/9739908HP_in_LG_factsheet_v4_29_August.pdf) p 7. “Partners” include an NHS body, a Chief Constable, a fire and rescue authority, a district council, Public Health England, schools, social care services, voluntary bodies and businesses.

282 Ev 86



authority “shall provide information and advice” to local partners “with a view to promoting” the preparation of appropriate local health protection arrangements.<sup>283</sup> The Faculty of Public Health told us these new regulations appeared to translate the Director of Public Health’s function “into a purely advisory role, with no requirement for organisations to accept or act on the advice provided,” and the Faculty added that “escalation to Public Health England (the body to which a DPH would take any concerns) risks unnecessary delays in responding to emergencies and puts the public at risk”.<sup>284</sup>

119. Tim Baxter, from the Department of Health, told us that giving local authorities a similar duty to that of the Secretary of State—to protect the health of the population—“would not have worked”,<sup>285</sup> and when we asked him whether this meant the Health and Social Care Act 2012 was not quite as localist as we thought it might have been, he said there were a lot of situations in which it was “central Government’s responsibility to ensure that the population’s health is protected.”<sup>286</sup> Cllr Mary Lea, Cabinet Member on Sheffield City Council, told us it would “prove very difficult” for Directors of Public Health to ensure the safety of people in the city “when other people have the authority and resources for commissioning these services”,<sup>287</sup> but Mr Baxter emphasised that if any local body ignored the advice of the Director of Public Health, “they had better be pretty clear that they are doing it on the right basis”.<sup>288</sup>

120. **We acknowledge the legal issues, raised by the Department of Health, which might arise from giving local Directors of Public Health a similar duty to the Secretary of State to protect the health of the population, but our main concern is with the practicalities. Given the importance that the Government has attached to the role of the Director of Public Health, it must make sense to include them as fully as possible in ensuring, rather than simply advising on and promoting, adequate preparation for local health protection arrangements. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012 risk diminishing the authority of the Director of Public Health and creating delays while concerns about local preparedness are taken to Public Health England. We therefore recommend that the Government review these regulations, in order to enhance with identifiable authority the power, respect and status that the Government suggest should be accorded to Directors of Public Health.**

## Screening, immunisation and the NHS Commissioning Board

121. Strategic Health Authorities and Primary Care Trusts have been responsible for commissioning screening and immunisation programmes from secondary care providers, general practices and others. PHE does not formally take on its responsibilities until April 2013, but it is expected that some of its staff will be seconded to NHSCB local area teams,

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283 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, 2013/351

284 Ev 89

285 Q 336

286 Q 337

287 Q 209

288 Q 335

which will be responsible for “system leadership” and “co-ordination functions” and will commission screening and immunisation services.<sup>289</sup> Day-to-day management of these public health staff will be through the NHSCB local area team, but as holders of key public health posts the staff will be professionally accountable to and have their professional development needs met through PHE.<sup>290</sup>

122. Dr John Middleton, Sandwell PCT’s director of public health, had:

very little confidence in what I have heard described in relation to screening, immunisation and emergency planning around the NHS Commissioning Board.

He added:

The staff we have trained and developed in Sandwell who are involved in screening and immunisation on a daily basis are destined for Public Health England and to be seconded to the National Health Service Commissioning Board and managed by heads of public health commissioning with no qualification in public health necessarily. You would not invent that system if it was not for the extraordinary difficulties that the health reforms put us in.<sup>291</sup>

Professor Scally said that, initially at least, the “clear but informal view” was that the NHSCB did not want any public health staff and would deliver the services itself, and he said he found the “whole way in which this (the transfer of screening and immunisation services) has been pursued unsatisfactory in terms of its delay and its fragmentation”.<sup>292</sup> Responding to Dr Middleton’s points, Duncan Selbie, Chief Executive-designate of PHE, accepted that there was

an issue about screening and immunisation. I agree that we would not have invented this, but it is my job with others to make sure that we have a safe transit.<sup>293</sup>

Tim Baxter, from the Department of Health, acknowledged that “we did not redesign the whole health system with screening and immunisation in mind,” but he cited the introduction of a single national commissioner, evidence-based commissioning and the secondment of PHE staff to the NHSCB as representing “an improvement on the current arrangements”.<sup>294</sup>

123. Several witnesses expressed concern that the new arrangements, based on a national approach, would fail to take account of local diversity. Westminster City Council told us it wanted “to ensure that local diversity is fully considered in national immunisation and screening programmes,”<sup>295</sup> adding that with 30% or 40% population churn a year in some

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289 Department of Health, Letter to health organisation chief executives, 23 August 2012, [https://www.wp.dh.gov.uk/publications/files/2012/08/2900372\\_ImmScreening\\_PostApril2013\\_acc.pdf](https://www.wp.dh.gov.uk/publications/files/2012/08/2900372_ImmScreening_PostApril2013_acc.pdf)

290 Department of Health, Letter to health organisation chief executives, 23 August 2012, [https://www.wp.dh.gov.uk/publications/files/2012/08/2900372\\_ImmScreening\\_PostApril2013\\_acc.pdf](https://www.wp.dh.gov.uk/publications/files/2012/08/2900372_ImmScreening_PostApril2013_acc.pdf)

291 Q 23

292 Q 117. Under the £5 billion draft interim budget, £2.2 billion would have gone to local authorities and £2.2 billion to the NHSCB. The remainder would have gone to Public Health England.

293 Q 24

294 Q 296

295 Ev 121, para 32

wards a person could be on one list, not receive their screening, move and not appear on the list in their new area.<sup>296</sup> Cllr Nick Forbes, Leader of Newcastle City Council, cited Sure Start as an example of the “reach that local government has to communities in very different ways from the Health Service”, and he concluded that making screening and immunisation a responsibility of the NHSCB, rather than one of the local authority’s arrangements, missed “the local flavour” of what was needed in order to ensure consistency across the board.<sup>297</sup>

124. We noted above the division of TB treatment and management between local CCGs and PHE; TB screening and immunisation will be delivered by a third body, the NHSCB. The Health Minister, Anna Soubry MP, stressed the benefits of locating these services with the NHSCB’s 27 local area teams. She explained that local councillors and GPs would be able, through their HWBs, to “make their representations to the local NHS commissioning board [...] in a much better way because it is far more locally focused,” and that in this way public health delivery locally “could be hugely beneficial, drilling right down to communities and sometimes within wards”.<sup>298</sup> Sheffield City Council pointed out that while:

the DPH will have to be assured that screening programmes are working well locally [...] they will be commissioned by another organisation (PHE), working in a second one (NHS CB LAT) and from a variety of other organisations (local Foundation Trust, GPs etc.).<sup>299</sup>

Describing the situation in the north-west, Liam Hughes, independent Chair of Oldham’s shadow HWB, said that the 2012 measles outbreak on Merseyside showed just how serious the situation was and why people needed to take it seriously, and he added: “I do not think I am reassured. Although I know people are working as well as they can locally, personally I am not yet reassured”.<sup>300</sup>

**125. We heard serious concerns about the new arrangements for screening and immunisation, particularly the fragmentation of staff and organisations responsible for these services. We accept that local authorities will be able to work with the 27 NHS Commissioning Board Local Area Teams, but as we have already noted there are concerns about the ability of local government to influence the Board’s decisions. In addition, when it comes to screening and immunisation there are additional concerns about the number of bodies the Director of Public Health will have to work with, and the Board’s ability to reflect local diversity and to reach into local populations as effectively as local authorities can. We urge the Government and the NHS Commissioning Board to listen to local authorities, to respond to their calls for reassurance and we recommend that the Government reviews the arrangements with a view to devolving these services to public health staff within local government.**

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296 Q 205 [Cllr Anthony Devenish]

297 Q 208

298 Q 298

299 Ev 131, para 28

300 Q 208

## Childhood services

126. When we visited Sweden as part of our inquiry, we were taken to a project called the Familjens hus (Family house), part of a joint county council and municipality-run health and social care programme in the town of Norrtälje, north-east of Stockholm. The Familjens hus was an integrated health and social care centre providing services for families and children from nine months to 23 years old, including an open pre-school centre for children up to six years old, a young person's clinic and a meeting point for school nurses. The staff there also worked in and with schools on children's health programmes, including vaccinations.

127. In contrast in England, when the new arrangements start on 1 April, the “directors of public health will be the first public health officials in local government ever, or medical officers of health, who have had no responsibility [...] for childhood immunisation”.<sup>301</sup> As we noted, the division of responsibilities under the new arrangements for children's public health in England has been a cause for concern. Children's public health services for those aged 0 to five years will be commissioned by the NHSCB. Cllr David Rogers told the Health Committee's 2011 inquiry into public health, “it doesn't make sense for school nursing to be in one place and health visiting to be in another”.<sup>302</sup> Kent County Council also referred to that arrangement, when it told us:

From a children's services perspective a number of concerns have been raised, and in particular there will be challenges around interfaces and areas which require synergy e.g. Health Visiting and School Nursing.<sup>303</sup>

Health visiting, as part of the Healthy Child programme, will be commissioned by the NHSCB, while school nursing will be with local authorities. Cllr Forbes from Newcastle, when he raised the public health aspects of Sure Start, said that it provided “a great way” of reaching parents and people “who are most likely to slip through the traditional Health Service net—the people who might get one of the MMR vaccines, but not all three”.<sup>304</sup> The Government have stated, however, that these arrangements are “a time-limited approach” until 2015 “to ensure that the necessary steps are taken to meet the Government's commitment to increased health visitor numbers”.<sup>305</sup>

***128. Given the importance of early years interventions, and the reach that local authorities have into their communities, the Government should work with councils on devolving further responsibilities for children's public health, such as the Healthy Child programme, to local government—and guarantee at least that responsibility for health visiting will be transferred to local authorities in 2015, or when the target for increasing health visitors has been met, whichever is earlier. The Government should, as part of a general move to locate children's public health services in local government, also agree to a timescale for placing childhood immunisation services under the control of Directors of***

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301 Q 51 [Professor Scally]

302 Health Committee, *Public Health*, para 234

303 Ev 145, para 8.5. Health Visiting will be commissioned by the NHSCB; school nursing by local authorities.

304 Q 208

305 Government response to Health Committee, para 62; the measure is time-limited until 2015.

*Public Health, in acknowledgement of their previous responsibility for this area and of the pivotal position that they now occupy in local public health provision.*

## 6 Finance

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### Introduction

129. In February 2012, the Government produced a draft interim public health funding allocation for local authorities. This was updated in June 2012. In January 2013, the Government announced its final public health funding allocation.

130. In *Healthy Lives, Healthy People*, the Government set out its approach to financing the public health work carried out by local authorities:

It is time to prioritise public health. The Government will ring-fence public health funds from within the overall NHS budget to ensure that it is prioritised [...]. Alongside the shift of power from Whitehall to local communities we will allocate ring-fenced funds for public health to local authorities to enable them to secure better health and reduce inequalities, working with the NHS and other key partners in their areas.<sup>306</sup>

The Departments of Health and for Communities and Local Government, in their joint submission to our inquiry, provided further details of the proposed funding system:

From 2013–14 upper tier and unitary local authorities will be allocated ring-fenced public health grants to improve the health and wellbeing of local populations [...]. The Advisory Committee on Resource Allocation (ACRA), an independent expert committee that has overseen the formula used to allocate NHS resources for many years, is developing a formula for the allocation of resources to local authorities for public health.<sup>307</sup>

In preparation for 2013–14, the Departments also explained the draft interim public health funding allocation and the status of the funding process:

Baseline spending estimates for each local authority published in February 2012 estimated that in 2012–13 around £5.2 billion will be spent on the future responsibilities of the public health system, including £2.2 billion on services that will be the responsibility of local authorities [...] ACRA's interim recommendations (for 2013–14) were published on 14 June 2012.<sup>308</sup>

131. In this chapter we consider: first, the formula used in 2012 for funding local public health functions and its implications for local government budget preparations; second, the new formula produced in January 2013 and the Government's arrangements for redeveloping it; and, third, how those arrangements relate to the Health Premium, the Government's preferred method for incentivising authorities to tackle health inequalities.

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306 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, cm 7985, pp 26, 27

307 Ev 168, paras 39, 40

308 Ev 168, paras 39, 41



### *The draft interim allocation*

132. The ACRA, in its draft interim allocation, opted for a funding model based on the under-75 standardised mortality ratio (SMR), an approach that uses the population size of each local authority and the number of people dying before 75 years old as the indicator of relative need<sup>309</sup> to allocate the available budget. When the draft interim public health budget was published in February 2012, the Department of Health explained that “understanding baseline spend is just the first step in establishing future budgets, and further analysis will build on this,”<sup>310</sup> and in June 2012 it described how “an active period of engagement and consultation will take place following publication of ACRA’s interim recommendations”.<sup>311</sup>

133. The interim allocation prompted considerable criticism in the evidence we received. First, on the methodology, Core Cities, an organisation of England’s eight largest cities outside London, suggested that the use of standard mortality rates would “result in redistributing funds away from some of the most deprived areas in the country.” The NHS Confederation told us “the proposed funding formula would leave local authorities in the most deprived 30% of areas worse off, losing an average of £8 per resident, and those in the most affluent 20% of areas gaining by the same amount”.<sup>312</sup> Second, on the time taken to consult on the interim formula and devise a final funding settlement, Duncan Selbie, Chief Executive-designate of Public Health England (PHE), explained that, if

you asked [the Department of Health] what they had been spending on public health, they did not know because we did not ask. The first thing we had to do was establish the base line [...] It is not a satisfactory starting position, because we are not addressing what you should be spending, which is the formula, but what you are spending.<sup>313</sup>

Mr Selbie also cited two additional reasons for the length of the allocation process:

It was the first time we had ever gone through this exercise. We have to make sure that we are covering what is currently being spent—that is what the focus has been on—concurrently with the examination of a formula.<sup>314</sup>

134. Understandably, local authorities had to plan on the basis of the figures announced in 2012. (The final allocations were not published until January 2013.) Local authorities, their contractors and service providers were therefore compelled to develop commissioning plans and to set budgets for 2013–14 based on unknown but potentially significant changes in funding. Cllr Steve Bedser, from the Local Government Association, told us in oral evidence “it is now the end of November [2012], and we still have no idea of any notional

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309 The ratio was explained in a letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, pp 1,2. Available at <https://www.wp.dh.gov.uk/publications/>

310 “Baseline spending estimates for new NHS and public health commissioning published”, Department of Health press release, 7 February 2012, [www.dh.gov.uk/health/2012/02/baseline-allocations/](http://www.dh.gov.uk/health/2012/02/baseline-allocations/)

311 “Update on public health funding for local government”, Department of Health press release, 14 June 2012, [www.dh.gov.uk/health/2012/06/ph-funding-la/](http://www.dh.gov.uk/health/2012/06/ph-funding-la/)

312 Ev w 42, para 7.3

313 Q 32

314 As above

budget that is going to transfer across to us in April, which makes it quite difficult for us".<sup>315</sup> Cllr Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform at Kent County Council, explained in early December 2012 that there was "uncertainty about public health budgets and there is uncertainty about total budgets [...] that should be clarified sometime between now and Christmas, but it is extremely late in the day".<sup>316</sup> Kim Carey, Corporate Director, Adult Care and Support, at Cornwall Council, said: "We are flagging the budget transfer high on our risk programme, and it is becoming more of a risk the closer we get to the transfer of the service".<sup>317</sup> Cllr Ernie White, Cabinet Lead Member for Health on Leicestershire County Council, said that it was a problem not just for the public health budget, but for all the authority's partner organisations attempting to plan commissioning based on the Joint Strategic Needs Assessment: "They were all saying, 'We do not know our budget [...]' we really cannot get into a positive mood about sharing".<sup>318</sup>

### *The final allocation*

135. On 10 January 2013 the Department of Health published local authorities' individual public health budgets, explaining that it had decided to finalise allocations not just for 2013–14 but for 2014–15. The Department said that "providing a two-year budget will [...] give local authorities a clearer long-term understanding of their future funding as they prepare to take on their new responsibilities". It announced that the overall budget would rise to £2.66 billion in 2013–14—in contrast with the draft interim allocation for that financial year of £2.2 billion—and to almost £2.8 billion in 2014–15.<sup>319</sup> With the allocation, no local authority would receive less than a 2.8% increase in their funding when compared with the baseline year of 2010–11, and the maximum increase would be 10%.

136. When the final funding allocation was announced, Cllr David Rogers, Chairman of the Local Government Association's Community Wellbeing Board, welcomed it but said that

the biggest concern among councils was around the delay on the final funding decision. Today's announcement will give councils confidence that they have the money they need, but leaves a tight timescale of just three months to put plans in place to deliver on their statutory responsibilities for public health.<sup>320</sup>

**137. We welcome the increase—when compared with the draft interim allocation—in public health funding to local authorities. We recognise that to create a public health budget where none has previously existed, to finalise a formula and to consult with all those affected is not a task to be taken lightly or rushed, but the 11 months required to complete the final allocations process, with totals being announced on 10 January 2013,**

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315 Q 88

316 Q 238

317 Q 240

318 Q 237

319 "Ring fenced public health grants to local authorities 2013–14 and 2014–15 published", Department of Health press release, 10 January 2013, [www.dh.gov.uk/health/](http://www.dh.gov.uk/health/)

320 "Councils respond to extra funding for public health", Local Government Association press release, 10 January 2013, [www.local.gov.uk](http://www.local.gov.uk)

only 79 days before health responsibilities transferred from the NHS, left local authorities with a great deal of work to do in a short period. Local government understandably planned for the worst based on the interim February 2012 and June 2012 allocations, and, while the subsequent increases are welcome, the delay caused some problems for local authorities and their budgeting arrangements.

*138. Given that local authority public health budgets have now been set for 2013–14 and 2014–15, the Government has time to plan with local government a managed approach to allocating the budgets for 2015–16. We therefore recommend that the Government puts in place a timetable for publishing and consulting on the 2015–16 allocations with a view to finalising them by October 2014, so that commissioners and providers have at least six months in which to plan strategically the services that will contribute most effectively to local people’s health and wellbeing in 2015–16.*

### The revised formula

139. The revised formula was based on updated estimates of historical spending and on changes to the weighting applied in the interim allocation. ACRA based its final allocation on updated PCT estimates of their public health spending in 2010–11,<sup>321</sup> and the Department of Health explained that, although it would continue to use the standardised mortality ratio for those aged under 75 years as the basis for allocating funds, it would apply the ratio to smaller, more localised populations of between 5,000 and 15,000 people “to take account of inequality within local authorities as well as between local authorities”, weight the formula to “target funding towards areas with the poorest health outcomes”, and apply an age-gender adjustment “to those services with the highest proportion of public health spend which are also directed at specific age-gender groups”.<sup>322</sup> Tim Baxter, Deputy Director and Head of the Public Health Policy and Strategy Unit at the Department of Health, explained that with the SMR “you get the data down effectively to ward-level [...] You can then get very granular about identifying the most deprived parts of the population and directing more resource to them”.<sup>323</sup> The Royal College of Nursing (RCN) agreed with Cllr Steve Bedser, of the Local Government Association, about matching resources to need. Dr Carter saw a responsibility on local authorities to target the funding it was allocated: “One of the very good things is that we have rich data. What you [the local authority] need is a sophisticated local needs assessment, and then you target the resources where you think the greatest need is”.<sup>324</sup>

140. ACRA, in a letter to the Secretary of State in October 2012 detailing its preferred funding formula, acknowledged that in the medium term “a health outcome should not be the main driver of the formula,” and explained that:

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321 Department of Health, Exposition Book Public Health Allocations 2013–14 and 2014–15: Technical Guide, p 11 <https://www.wp.dh.gov.uk/publications/files/2013/01/Public-Health-Weighted-Capitation-FormulaTechnical-Guide-v0.13.pdf>

322 Department of Health, Exposition Book Public Health Allocations 2013–14 and 2014–15: Technical Guide, p 7 <https://www.wp.dh.gov.uk/publications/files/2013/01/Public-Health-Weighted-Capitation-FormulaTechnical-Guide-v0.13.pdf>

323 Q 353

324 Q 97

This is because a local authority which improves its health outcomes would be at risk of losing future public health funding and we believe this is a perverse incentive. ACRA will continue to work on a formula based more on the underlying drivers of need.<sup>325</sup>

ACRA also expressed “a desire to develop a more evidence based formula”.<sup>326</sup> When we asked Mr Baxter whether health outcomes should be the main driver of funding, given that a local authority which improved them would risk losing future funding, he accepted there was such a perverse incentive and said the formula would be reviewed.<sup>327</sup> In supplementary written evidence the Government said, however, that: “no specific timetable has been set for the next iteration of the public health allocations formula”.<sup>328</sup>

**141. We acknowledge that the current formula is an improvement on the interim model and allows local authorities to target pockets of deprivation in their areas. We note the perverse incentive in the medium term, however, of basing funding on improved health outcomes, given that areas which perform well risk having their funding reduced. Public health is not short of data, and it should be possible under the new arrangements to begin to base funding on observable trends in health locally and—using Joint Strategic Needs Assessments, for example—for local government to use its allocations in a more precise manner. This places a responsibility on councils and their Health and Wellbeing Boards to produce comprehensive and rigorous Joint Strategic Needs Assessments.**

*142. We recommend that the Government not only ensures the Advisory Committee on Resource Allocation makes good on its commitment to review the allocation formula, but clarifies the timetable for revising it—and whether this means a revised formula in time for the 2015–16 allocations. Just as local authorities need to know well in advance when budgets will be published, they require also some certainty about the formula that will be used to calculate them.*

### **The Health Premium**

143. The Health Premium is a cash incentive payable to those local authorities that make progress against public health indicators, including fewer children under 5 with tooth decay, more women breastfeeding their babies and fewer over 65s suffering from falls.<sup>329</sup> The premium would, in the Government’s view, “reward improvements in health outcomes, and incentivise action to reduce health inequalities”.<sup>330</sup> It was scheduled for introduction in 2015,<sup>331</sup> and the need to clarify the formula to be used in allocations from

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325 Letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, p 5 <https://www.wp.dh.gov.uk/publications/files/2013/01/DF-letter-to-SoS.pdf>

326 Letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, p 5 <https://www.wp.dh.gov.uk/publications/files/2013/01/DF-letter-to-SoS.pdf>

327 Qq 355–56

328 Ev 171

329 “Helping people live healthier lives”, Department of Health press release, 23 January 2012, [www.dh.gov.uk/health/2012/01/future-for-public-health/](http://www.dh.gov.uk/health/2012/01/future-for-public-health/)

330 Ev 168, para 41

331 “Health improvement funds delayed until 2015”, *The Local Government Chronicle Online*, 14 June 2012 [www.lgcplus.com/topics/health/health-improvement-funds-delayed-until-2015/5045970.article](http://www.lgcplus.com/topics/health/health-improvement-funds-delayed-until-2015/5045970.article)

2015–16 was therefore given greater urgency by the Government’s acknowledgement, in its supplementary written evidence, that any perverse incentive in the current formula would be

particularly marked were the current formula still in use alongside the Health Premium Incentive Scheme. We expect the first payments to be made under this scheme in 2015/16 and so this will also be a key year in the development of the formula.<sup>332</sup>

144. The Health Premium itself, as a stand-alone funding mechanism, was criticised during our inquiry. The RCN considered that the premium would be of little assistance to disadvantaged areas “that fail to make any progress as a result of the comparative greater disadvantage of their populace,” a problem that would be remedied only by weighting the public health allocation “to reflect the deprivation that an area experiences”.<sup>333</sup> Sheffield City Council said that the premium would “inappropriately and unfairly reward those areas where health is improving anyway, where arguably less public health resource is needed”,<sup>334</sup> and Professor Scally considered that the timescales involved in public health were too long to make the health premium “attractive”.<sup>335</sup>

**145. *The Government’s approach to public health funding leading up to and after 2015–16 seems confused and should be clarified. It says it has no timetable for modifying the current funding formula, but accepts that, given the impact of the Health Premium, the formula will need to be developed in 2015–16. Local authorities will need to know, first, when they can start planning their budgets for 2015–16, second, when the Government intends to redevelop the funding formula, and, third, that any system of reward will complement their main source of funding.***

**146. *The Government has acknowledged that the perverse incentive in the current funding formula would be particularly marked if it were still in place when the Health Premium was introduced. This suggests that the current funding formula and possibly the Premium need to be revised. A funding system which at the same time disadvantages and rewards improvements in public health cannot be fit for purpose. The Government has said that 2015–16 will be a key year in the development of the formula. We recommend that a parallel system of reward should not be implemented in the same year. It should be delayed until the funding formula has been redesigned.***

### **Demand-led services**

147. A number of witnesses drew our attention to demand-led services and, in particular, to the issue of mandated sexual health services. Dr John Middleton, Director of Public Health at Sandwell PCT and Vice-President of the Faculty of Public Health, said that, while basis of the formula could well be deprivation or mortality,

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332 Ev 171

333 Ev 106, para 5.8

334 Ev 131, para 37

335 Q 100



The problem is that, when you look at what is in the ring-fenced budget, it is not about premature mortality; it is about genitourinary medicine services, school nursing and drugs and alcohol services. We have used one formula potentially to describe a totally different set of problems and answers [...] In Westminster two-thirds of the budget goes on the GU medicine service, and they could spend all of the ring-fence in a very short space of time with those increases in activity.<sup>336</sup>

148. Cllr Anthony Devenish of Westminster City Council described an alternative method of charging for such services which the Council, along with other London local authorities, had submitted to the Department of Health.<sup>337</sup> This method used, instead of the under-75 standard mortality ratio, the index of multiple deprivation, which was “associated with high levels of public health needs such as drug and alcohol use, population churn and mandated sexual health services”.<sup>338</sup> Using demand-based allocations as a proxy for need, it was calculated that Westminster would receive an extra £4 million.<sup>339</sup> In the final allocation for 2013–14, it actually received only an extra £827,000.<sup>340</sup>

149. Those concerns were recognised in part. ACRA, in a letter to the Secretary of State, explained that concerns the SMR might not be suitably linked to the need for sexual health services were “valid”,<sup>341</sup> and Tim Baxter from the Department of Health acknowledged: “Sexual health services is an area that ACRA is going to have to continue to look at”.<sup>342</sup>

**150. The costs of demand-led services, such as sexual health provision, are increasing and in some cases could account for a considerable proportion of the public health ring-fenced grant from April 2013. It has been argued that the current formula fails to account adequately for the cost of these services, and we have received evidence detailing alternative funding criteria that might correspond more accurately to the care that local authorities have been mandated to provide. The Advisory Committee on Resource Allocation, while acknowledging these concerns, maintained that no immediate alternative appeared to work across the country. *We recommend that the Government and the advisory committee, as part of their commitment to keep this area under review, consider alternative formulas for calculating the overall ring-fenced grant, such as the index of multiple deprivation, and how such allocations might take better account of local circumstances.***

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336 Q 38

337 Qq 188, 189

338 HLTH B03, Letter from Central London Forward and London Borough of Hammersmith and Fulham local authorities to the Secretary of State for Health, 29 November 2012, [not published], appendix A, para 1

339 HLTH B03, Letter from Central London Forward and London Borough of Hammersmith and Fulham local authorities to the Secretary of State for Health 29 November 2012, [not published], appendix A, para 2

340 See Department of Health, “Public Health Grants to Local Authorities 2013-14 and 2014-15”, <https://www.wp.dh.gov.uk/publications/files/2013/01/Public-Health-Grants-to-Local-Authorities.pdf>.

341 Letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, p 3 <https://www.wp.dh.gov.uk/publications/files/2013/01/DF-letter-to-SoS.pdf>

342 Q 359



### ***Re-charging for non-residents' use of services***

151. Westminster City Council also told us about a need to allocate resources not only for its 200,000 residents, but for the 750,000 people who came into the city every day. Newcastle City Council faced similar pressures. Cllr Nick Forbes, Leader of the Council, said that “we suffer from a not dissimilar phenomenon [to Westminster’s], which is that the number of people who turn up and use Newcastle’s services is far higher than the number of Newcastle-based residents”.<sup>343</sup> ACRA did not recommend any adjustment in funding to account for non-resident populations’ use of sexual health services, preferring to encourage the development of a re-charging approach between authorities.<sup>344</sup> In its evidence the Department of Health said that non-residents’ use of services was significant only in the City of London and explained that local authorities could pool their budgets, as well as re-charge each other, to pay for these services.<sup>345</sup> In the face of the evidence from Westminster and Newcastle we are not persuaded that the Government’s approach is adequate. *We call on ACRA and the Government to work with local authorities on the issue of non-residents’ use of demand-led services. Given that many people work or go out in one borough and live in another, people’s use of services in this way should not be underestimated. Attempting to resolve that either by pooling resources or by re-charging has the potential to become complicated and contentious.*

## **Funding in the long term**

### ***Moving away from ring fencing***

152. Funding demand-led services highlighted the question whether in the long term public health funding should be ring fenced at all or, for example, relocated within a community budgets. These are general funds for a whole area and its people, rather than separate budgets for separate services such as health, transport and education. The RCN was concerned that

more than half of the Public Health money going to local authorities, has been identified as necessary spend for sexual health and substance misuse services, which are demand-led services. This presents real problems and significantly reduces the funding available to invest in prevention work on issues like obesity and smoking.<sup>346</sup>

153. David Buck, Senior Fellow, Public Health and Inequalities, at the King’s Fund, queried the use of a formula in the first place, saying that

if you have a given a pot of money and you give a local authority mandatory things to deliver, you should make an attempt to look at how much it costs to deliver services

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343 Q 190

344 Letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, p 4 <https://www.wp.dh.gov.uk/publications/files/2013/01/DF-letter-to-SoS.pdf>

345 Q 358 [Anna Soubry]

346 Ev 106–107, para 7.3

from a bottom-up perspective [...] a formula may be good approach to distributing what is left.<sup>347</sup>

This approach, of assessing the cost of a service before introducing a budget for it, was referred to by ACRA in its letter to the Secretary of State, when it said it would consider “a bottom-up costing, based on a model of what services might be offered to populations with different needs”.<sup>348</sup>

**154. *We urge local authorities and the Government to explore innovative approaches to funding public health services. One route might be to determine the actual cost locally of demand-led services and to separate funding for them from the rest of the public health budget. The remaining public health provision could then be determined using a formula, such as the standard mortality ratio, and either continue to be ring fenced or stand apart from the rest of the authority’s budget. Alternatively, the remainder might, as witnesses suggested, correspond to the remainder of the local authority’s overall budget and become in all but name a community budget.***

### **Community budgets**

155. During our evidence sessions, clinicians favoured and council representatives opposed ring-fencing the public health budget.<sup>349</sup> All agreed, however, that ring fencing would be important in the short term to protect investment in the fledgling public health system. Opponents wanted to remove the ring fence completely in the medium term so that local authorities might pool their public health resources, including those for demand-led services, along the lines of community, place-based budgets.

156. Those who favoured the eventual removal of the ring fence saw this step as fundamental to the new system if all local authority departments were to incorporate public health into their plans and services and to take full advantage of the relocation of public health to local government. Dr Nicholas Hicks, Director of Public Health in Milton Keynes, told us that, when a local authority’s entire budget was considered “public health” spending, the proportion required to fund demand-led services would diminish accordingly. He was

more interested in the total allocation in the community rather than the tiny percentage of that that is called the public health budget [...] sexual health services, substance misuse services and health checks [...] are all good things to do, but they are a small subset of public health and not the major mechanisms to tackle inequalities.<sup>350</sup>

157. Cllr Steve Bedser of the Local Government Association, warned that “if it (the funding) comes in a hermetically sealed bag labelled ‘public health’, the danger is that it

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347 Q 29

348 Letter from David Fillingham, Chair of ACRA, to the Health Secretary, 17 October 2012, p 5 <https://www.wp.dh.gov.uk/publications/files/2013/01/DF-letter-to-SoS.pdf>

349 The clinicians in favour were Professor Scally [Q 81], and Dr Carter [Q 84]; those against were Cllr Alan Connett [Q 82], and Cllr Steve Bedser [Q88].

350 Q 31

then does not properly integrate with all of the functions of local government [...] and bring alive all of the very real opportunities that exist within the transfer”.<sup>351</sup> Dr Mike Grady, of the UCL Institute of Health Equity, agreed that in the long term a transition from ring-fenced funding to place-based funding was logical:

the evidence supports it [...] the total-place pilots [...] were very good examples of greater efficiencies, savings, engagement of communities, and co-production of services with people and communities.<sup>352</sup>

The example of Total Place pilot budgets was cited also by Cllr Nick Forbes from Newcastle, who pointed to turf wars between adult social care, children’s social care and health service delivery, and concluded, “what we need is a total-place budget approach that looks at the whole system from a population and people perspective rather than an organisational perspective.”<sup>353</sup> The King’s Fund also explained that Total Place had shown “promising improvements for local populations,”<sup>354</sup> making the case for a joined-up, population-focused approach, given that separate strategies for obesity, smoking and alcohol had not connected with each other or to policies on health inequalities.<sup>355</sup>

158. We also heard how existing place-based budgeting system might be transposed on to public health. Newcastle City Council had found that multiple funding streams with different requirements did not help its service delivery, especially when investment made in one place resulted in savings elsewhere, and so the council had decided to pursue “the idea of a health and social care ‘city deal’—to give us more flexibility around both investment and re-investment,” and said that it was establishing a social care commission to investigate the idea.<sup>356</sup> Sheffield City Council also referred to its “successful City Deal recently agreed with Government” to promote and create opportunities for economic growth as an example of the powers it would require “to address the health and wellbeing problems which exacerbate benefit dependency, poverty, low incomes and productivity lags in our economies”.<sup>357</sup>

159. The final funding settlements made in January 2013 have, however, allowed for a form of budgetary integration. The Government explained that ACRA’s interim recommendations included “provision for pooling of the ring-fenced public health budget, including as part of a Community Budget,”<sup>358</sup> and the Government said that the grant conditions for the final settlement “specifically” allowed the money to be pooled with other budgets and across local authorities.<sup>359</sup> Tim Baxter from the Department of Health explained that the Department “very much” wanted to learn from “the community budgets

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<sup>351</sup> Q 90; Cllr Bedser also said the drawback of a ring-fenced approach was “it defines the limit of public health spend”, Q 89.

<sup>352</sup> Q 243

<sup>353</sup> Q 197

<sup>354</sup> Ev 77, para 19

<sup>355</sup> Ev 78, para 30

<sup>356</sup> Ev 123

<sup>357</sup> Ev 135, para 59

<sup>358</sup> Ev 168, para 40

<sup>359</sup> Q 348

[...] pilots looking at health and social care”.<sup>360</sup> He added that the “funding mechanisms are obviously very important but the shared objectives as to how the money is spent are the most crucial thing”.<sup>361</sup>

160. The Parliamentary Under-Secretary of State for Communities and Local Government, Baroness Hanham, accepted that “local government does not like ring-fenced grants” but drew attention to the role a Director of Public Health covering multiple local authorities might play in overseeing how resources were pooled,<sup>362</sup> and other witnesses also emphasised the pivotal position of the Director of Public Health, reaching across their local authority and out to the NHS, in order to safeguard public health money and to advise on its most appropriate use.<sup>363</sup> Both Departments placed some responsibility for developing a shared approach to resources on HWBs, explaining that as part of HWBs’ duties to encourage integrated working, “they will consider how the collective resources of the NHS and local government can combine to improve outcomes, for example through Community Budgets”.<sup>364</sup>

161. We agree with the Department of Health that, although funding mechanisms are important, shared objectives on how the money is spent are crucial. While the Department for Communities and Local Government recognises that local government does not like ring-fenced grants, we accept that, at least in the short term, some ring-fencing may be needed. But this should not become a permanent feature of the public health funding system in England. The Department of Health says it wants to learn from the Community Budget pilots on health and social care. *We urge the Department of Health to work with the Department for Communities and Local Government and to share that learning as soon as possible, in order to clarify what funding mechanism will be proposed for the financial year 2015–16 and beyond—with a view to removing the ring fence and moving to community budgets. In addition, we urge the Government and, in particular, the Department of Health to recognise that if public health is to become an overarching priority for all local authority departments, it will require an overarching budget which reflects that approach. If the evidence from the completed Total Place and ongoing Community Budgets pilots continues to point to their effectiveness, we recommend the Government provides local authorities with community, place-based, budgets for the direction of resources at people and places rather than at organisations.*

162. There is also a role for Health and Wellbeing Boards to play, given their duty to encourage integrated working, by devising joint strategies that allow local authorities to use existing levers in the final funding settlement to pool public health budgets with those of other departments and across authorities, thereby demonstrating to central Government how shared resources can improve outcomes. In this endeavour, Directors of Public Health will remain central to the budgeting process if and when the ring fence is removed.

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360 Q 348

361 Q 352

362 Qq 349, 350

363 See, for example, Q 76 [Dr Penny Toff] and Q 87 [Dr Peter Carter].

364 Ev 167, para 26

## 7 Conclusion

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163. There is an undeniable logic behind the return to local government of a responsibility for public health. Local authorities have an important opportunity to take the lead in tackling poor health in their areas. To make an impact they will need to focus to a large extent on the social determinants of health, including education, housing and employment.

164. These changes in responsibility are part of a complex set of reforms, bringing together National Health Service and local government organisations. The complexity raises questions of accountability. The purpose of localism is not only to bring decision making closer to local people, but to make it accountable to local people. Locally, Health and Wellbeing Boards will be pivotal, but how and whether the Boards are accountable, apart from through the election of their councillor members, is unclear. Similarly, the accountability of Clinical Commissioning Groups and the NHS Commissioning Board, whose commissioning will have a significant impact on the health and wellbeing of local people, is opaque. The Government should clarify how all these bodies can be held to account locally for the decisions they take. Local accountability will encourage engagement, and we are concerned to ensure that these reforms do not end up the preserve of senior councillors, clinicians and chief officers. The majority of councillors in an authority must have influence over health improvement in their area, not least if local residents are to feel that they, too, have some control over the conditions in which they live, grow and work.

165. On localism, the Department of Health has further to go than the Department for Communities and Local Government. The new arrangements for screening and immunisation services have been criticised as complex, fragmented and restrictive. They are the responsibility of the NHS Commissioning Board, which may not reflect local diversity or reach into local populations as effectively as local authorities. Early years interventions are important to later health and wellbeing, and, with the NHSCB also responsible for children's public health, the Government will need to work with councils to move more of these services and, in particular, childhood immunisation services into local government under the control of Directors of Public Health.

166. The new local health system will need to rely on leadership, relationships and influence, but the new arrangements for protecting the population in the event of a health emergency will require those involved to know unambiguously the roles that they and others will play. Worryingly, local authorities were unclear who would be in charge locally in the event of an emergency across the country, and the Government needs to set out clearly everyone's lines of responsibility. The local Director of Public Health should also be more than an adviser on emergency arrangements, and always report directly to the local authority chief executive.

167. The increase in ring-fenced public health funding is welcome, but when it comes to the 2015–16 settlement the Government will need to give local authorities more time to finalise their budgets. The funding formula includes a perverse incentive that may penalise success, while the Health Premium, to be introduced in 2015, would do the opposite and appears unfit for purpose. Local authorities will need to know, first, when they can start planning their budgets for 2015–16, second, when the Government intend to redevelop the funding formula, and, third, that any system of reward will complement their main source

of funding. Finally, ring-fenced public health funding may be required in the short term, but, if public health is to be reflected in every local authority service, it will need a budget that ignores service boundaries, a community budget that deals with people and places, not organisations.



# Conclusions and recommendations

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## The transfer of public health responsibilities back to local authorities

1. We welcome the return of public health responsibilities to local government and in particular:
  - the introduction of Health and Wellbeing Boards (HWBs), which will count local councillors among their members and, in many cases, senior councillors as their Chairs;
  - the transfer of directors of public health and their teams from the NHS to local authorities;
  - the opportunity for local councils to focus all their activities, from education to housing, on the health and wellbeing of their local residents.

These changes are part of a complex set of reforms across local government and nationally. Local authorities and, in particular, Health and Wellbeing Boards will have to work hard to involve local people in their work, and we expect that the operation of the new arrangements will be reviewed by a select committee in two years' time. (Paragraph 13)

## The role of Health and Wellbeing Boards

2. We conclude that the successful operation of Health and Wellbeing Boards is crucial to the new arrangements. Boards should aim to be creative by including where possible those individuals with responsibility for the social determinants of health, including those working in education, planning and economic development. The obvious danger with the new Boards, however, is that the initial optimism surrounding their establishment and first year or two in operation will falter and go the way of previous attempts at partnership working that failed and became no more than expensive talking shops. To succeed, Health and Wellbeing Boards will need to work on the basis of relationships and influence, and this will depend on both people and structures. This can be a strength, as it will, for example, allow for local discretion over Board membership, but also a weakness, because a Board will have few demonstrable powers with which to require council departments, clinicians and the local arms of national bodies to adhere to its strategic priorities, as set out in its Joint Health and Wellbeing Strategy. Local authorities will need to rely not only on the organisations and structures that they create, but on the relationships that they develop with individuals and groups if they are to grasp this opportunity and work effectively with these partners. This is the right approach but could make demands on local authorities' leadership and relationship-building skills. (Paragraph 22)
3. Local authorities should use the limited central prescription on their Health and Wellbeing Board membership in combination with their influence across the local community, to work with a range people and bodies most closely linked to their areas' health needs and objectives. They might do this either by including them on

the main Board or by creating a range of other relationships. These can be informal, through the cultivation of partnerships with, for example, the voluntary sector, or formal, with the development of Health and Wellbeing Board sub-committees, partnership bodies, and community groups. (Paragraph 23)

## The priorities of Health and Wellbeing Boards

4. Health and Wellbeing Boards have been given a substantial mandate to encourage integrated working between the NHS and public health and social care services. They also need to maintain a strategic and balanced outlook on their new responsibilities, focusing on promoting the health of their local population, rather than becoming exclusively preoccupied with the detail of health and social care commissioning and integration. Given that people are living longer and the cost of health care is rising, Boards will need to draw on the public health, clinical and social care expertise of their members to promote healthy and independent living among all age groups, young and old, if they are fully to take advantage of the opportunity provided by their creation to embed health promotion and disease prevention in all local services. (Paragraph 27)

## Accountability

5. Given the Health and Wellbeing Board's pivotal role in the new local health system, as the forum for local government, the NHS, the public and providers, each Board must be held accountable for its work. But it is unclear whether HWBs will be held responsible for health outcomes in an area. We have heard differing accounts from Communities and Local Government and Health Ministers as to how or, indeed, whether they will be. Accountability clearly cannot take place just through the election of the Board's local councillors, and this seems to be an area of real confusion. The questions are, what are HWBs to be accountable for, given their lack of powers; and, what sort of accountability is appropriate: democratic, procedural or financial? We were concerned also by the suggestion that the Director of Public Health, a member of the Board, would inform the scrutiny committee if the Board were performing poorly. This would place Directors of Public Health in an invidious position, and we therefore do not consider this to be a satisfactory or robust mechanism to hold Boards to account. *We recommend that the Government clarifies the procedures for holding Health and Wellbeing Boards to account, including the role it expects local overview and scrutiny committees to play and the role of the Director of Public Health, given their position as a Board member. Directors of Public Health should also report directly to the local authority's chief executive, and we urge the Government to reassert its understanding of this point, too.* (Paragraph 31)

## Healthwatch

6. We have heard about the importance of people having a voice in the development of local services, but Local Healthwatch, the organisation intended to give people such a voice locally, has not been established consistently throughout the country. Its development has been variable, and the establishment of strong and properly resourced Healthwatch bodies must be made a priority as local authorities and their

Health and Wellbeing Boards take on their new responsibilities in April 2013. *We call on Healthwatch England and the Government to work with local authorities to ensure that a Local Healthwatch representative is available to take part in the deliberations of every Health and Wellbeing Board throughout the country by the end of the year.* (Paragraph 33)

## **The position of national organisations in guiding and advising Health and Wellbeing Boards**

7. Health and Wellbeing Boards are an innovation. While there are some guidelines in place, there is no template to follow and all HWBs are different. They will, however, need advice, guidance and evidence of best practice, as county councils and municipalities in Sweden have found. The job of providing this material will be in part for the renamed National Institute of Health and Care Excellence, which will have a remit to work more closely with local authorities, including from April 2013 on quality standards for social care. There will also be a role for Public Health England, as yet undefined. With its staff and resources derived in part from the NHS, it may not initially have the capacity or expertise to advise local authorities. Local government should therefore look not only to NICE and Public Health England, but to itself. As the reforms bed in, local authorities should seek out support and improvement among themselves, including, for example, through the Local Government Association's Knowledge Hub resource. (Paragraph 36)

## **The relationship between NHS Commissioning Boards and Health and Wellbeing Boards**

8. The NHS Commissioning Board, as the commissioner of primary care and significant public health services, will have a major influence over the way in which health care is prioritised locally, but its status in relation to Health and Wellbeing Boards is unclear, its interaction with other health bodies is complex and it lacks local accountability. We do not wish to prescribe membership of Health and Wellbeing Boards, and we recognise that, for now at least, Health and Wellbeing Board members will have to work together to establish constructive relationships with as many relevant bodies locally as possible. We therefore urge Boards to work closely with their NHS Commissioning Board Local Area Teams at all times, not simply when discussing their Joint Assessments, Joint Strategies and the NHS Commissioning Board's own commissioning plans. The best way to address these concerns would be to work face to face with the NHS Commissioning Board on a regular basis. (Paragraph 41)

## **Local accountability**

9. There is no requirement for the NHS Commissioning Board and its Local Area Teams to adhere to a Health and Wellbeing Board's Joint Health and Wellbeing Strategy, and there is no mechanism to hold them to account for their actions. In effect, the co-ordination of local strategies will rely on the pragmatism of local bodies, including the NHS Commissioning Board's Local Area Teams. The Health and Social Care Act 2012 includes a duty on the NHSCB to "have regard" to the Joint

Health and Wellbeing Strategy, but what this means in practice is unclear. *We call on the Government to set out in detail what Health and Wellbeing Boards can do if the NHS Commissioning Board subsequently fails to commission services consistent with these strategies. We also ask the Government to clarify what the duty on the NHSCB to “have regard” to a Joint Health and Wellbeing Strategy means in practice.* (Paragraph 43)

### The NHSCB’s role in holding other bodies to account

10. *Health and Wellbeing Board meetings should be attended by a representative of the NHS Commissioning Board when Clinical Commissioning Group commissioning is under discussion. Indeed, they should be attended by a representative of the national body, given its prominent role in local health matters, whenever required.* (Paragraph 45)
11. We are grateful to the Government for clarifying that the NHS Commissioning Board can direct a Clinical Commissioning Group if it fails to discharge its functions of working with local authorities to develop a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy. We urge Health and Wellbeing Boards to refer cases to the NHS Commissioning Board and it, where necessary, to make full use of this power to direct. But this does not deal with the action that can be taken if a CCG fails to take account of a Joint Health and Wellbeing Strategy in its commissioning. *We ask the Government to clarify what action can be taken if a CCG fails to commission services in accordance with a local Joint Health and Wellbeing Strategy.* (Paragraph 46)

### The development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

12. The importance of the Joint Strategic Needs Assessment should not be underestimated, as it will form the basis for the Joint Health and Wellbeing Strategy, one of the more critical health promotion measures any local authority will be involved with in terms of potential impact. The significance, resources and expertise attributed to both the assessment and the strategy will have a major bearing on the success of an individual authority’s local health care work, and that of the local NHS, at least in the short term. The Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy must not therefore be viewed as tick-box forms to be produced and filed; they must be living, breathing documents to which all local health partners willingly contribute and adhere. Local authorities should look to innovative approaches, such as we saw in Kent, to use their assessments and strategies as an opportunity to devolve power and to identify local-level activity through which they can improve health and wellbeing in specific places, among certain groups of people and throughout their local area. (Paragraph 49)

### Data sharing and information management

13. Any joint assessments and strategies will only be as good as the information on which they are based, but there is ignorance and misunderstanding of the current

information-sharing arrangements. *If strategies are to be based on sound evidence, the Government must involve the Information Commissioner in clarifying what data local authorities and the NHS can share. This should be done by the end of this year, so that authorities have time to use any new guidance in the development of assessments and strategies for 2014–15.* We recommend that Public Health England publicise widely guidance on how local authorities can manage their data and information. (Paragraph 53)

### Building relationships with other sectors

14. Health and Wellbeing Boards will need to make themselves accessible to, and work closely with, the voluntary and community sectors and other providers not only to deliver services, but to draw on the valuable statistics and information that these groups can supply. *We expect that local authorities, the Local Government Association and the Government itself will draw lessons from the four pilot areas establishing the readiness of these sectors.* These lessons must be disseminated as soon as possible, so that, first, local government can work out how to create structured arrangements with the potential partners, including through community sector boards, and, second, each has a defined role in the creation of Joint Assessments And Strategies. (Paragraph 57)

### Collecting and analysing information

15. Local authorities will need to collect more data on the people for whom they provide services, and link that data to the development of strategies. There is, however, a lack of specialist analytical staff in local authorities to turn those data into strategies. *We recommend that local authorities and the Government keep under review the role of staff in Commissioning Support Units to ensure they are sufficiently public-health focused and councils have access to an adequate number of public health analysts. They should also consider how staff from Public Health England's local centres might assist in any local analysis.* (Paragraph 60)

### Communicating information

16. Conveying to different audiences—chief executives, councillors, providers and local residents—in clear and simple terms ‘the story’ of public health in their area will be vital if individuals are to engage in the improvement of their own wellbeing. This may amount to talking about population health in terms of enabling people to live longer lives of greater quality, and devising campaigns that highlight the role clinicians might play in identifying a particular health need. The way in which information from the Joint Strategic Needs Assessment is communicated to people will play an important part in maintaining the momentum gathering behind Health and Wellbeing Boards and in ensuring that they succeed. There will be a significant role for the Director of Public Health, who will be able to present ward-level data to ward-level councillors, and councils will themselves need to instigate training to ensure their councillors take advantage of these new arrangements. (Paragraph 64)



17. Given that Health and Wellbeing Boards will be required to use their influence to ensure their health and wellbeing strategies are transformed into commissioned services, they will need to learn how to capture the imagination of councillors, commissioners and their communities. Local authorities, the Local Government Association, the District Councils' Network and Public Health England should develop the skills required to communicate public health issues and ensure locally elected representatives, Board members and public health staff have access to such training when required. In order to convey to colleagues and residents what their local needs are, and how the Board intends to deal with them, local authorities should seek a Plain English Campaign endorsement of their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. (Paragraph 65)

### Engagement of councils and councillors

18. District councils are responsible for many of the services that have a direct impact on the health and wellbeing of their residents. We accept that the omission of these lower tier authorities from Health and Wellbeing Boards and from participation in the Joint Health and Wellbeing Strategy was a potential cause for concern, but we have seen in practice that it has prompted some county councils to make their own arrangements to include district councils. This is entirely appropriate and welcome. County councils might develop a formal compact to devolve some decision making so that districts are recognisably involved in public health matters, or create local HWBs, forums or sub-groups to enable district councils to work more easily with local Clinical Commissioning Groups. We encourage all county councils to develop agreed working arrangements with district councils. (Paragraph 70)

### Unitary authorities

19. We consider that all upper tier councils, including unitary authorities, should set an example to central Government by demonstrating and embedding effective localism themselves. They can do so by devolving certain responsibilities and, where possible, budgets to councillors and committees at ward and area levels. All authorities should look to each other, including through the Local Government Association, for peer support and mentoring. They should also explore the powers and information currently at their disposal, through mechanisms such as the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, to describe the health situation at ward level and to include local councillors and, therefore, communities in decision making. (Paragraph 72)

### Housing

20. We acknowledge the importance of housing in determining people's health and wellbeing. It is important that this service is included in the 'voluntary' arrangements we have described. We suggest that councils explore ways to include housing in their work, either by establishing housing sub-groups of their main Health and Wellbeing Board or by addressing housing in their Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and when reporting on progress with public health outcomes. (Paragraph 75)



## Councillors and Clinical Commissioning Boards

21. We are concerned to ensure that the new responsibilities for health and, in particular, public health are not monopolised by senior councillors and the local authority executive; all councillors in an authority must play a part at all levels, including framing strategy. The role of the Clinical Commissioning Group involves the establishment of overarching priorities to improve the health of local people, not purely clinical decisions such as choosing which drugs and procedures should be used. While one purpose of health care reform is to remove politicians from day-to-day clinical decision making, the purpose of localism is to bring decision making closer to local people, to make it accountable to local people and to allow local people to develop the relationships that work for them locally. It is not clear to whom Clinical Commissioning Groups are intended to be accountable, and we were not entirely persuaded by Ministers' arguments for not allowing councillors to sit on Clinical Commissioning Group Boards. *We do not intend to press for the inclusion of locally elected representatives on these boards; instead we recommend that they are not specifically excluded. In the spirit of localism, such issues should be left to local resolution.* (Paragraph 81)

## Local authority initiatives

22. Local authorities, if they are to grasp fully the opportunity afforded to them by the return of public health, will need to look beyond those services traditionally considered to be "public health", such as health protection, health promotion and disease prevention, and tackle the causes of the causes of poor health, working with local partners and using all the powers, personnel and services at their disposal. The evidence we received makes it clear that people, particularly in vulnerable groups, are more likely to exhibit a range of unhealthy behaviours. Single initiatives targeting individual lifestyle choices, such as drinking or smoking, have been shown not to work, especially among people at the lower end of the social gradient of health. Authorities should be willing to take one step back from treatment to look additionally at by-laws, education campaigns and how to involve, for example, GPs, pharmacies or debt management and housing services in a more holistic attempt to deal with the multiple reasons behind complex health problems. (Paragraph 88)

## Early years

23. Local authorities will of course wish to base their public health work on their Joint Strategic Needs Assessments, but we note how several councils have placed early years interventions—literacy, readiness for school and childhood obesity programmes—high on their list of priorities. We commend authorities to bear this in mind when making their decisions, given the importance of early years development in people's later health and wellbeing. (Paragraph 90)

## Employment

24. We are pleased that local authorities are looking at the evidence and adopting an evidence-based approach to health and wellbeing. Evidence shows that being and

staying in work has a significant effect on a person's health and wellbeing; unemployment is one of the causes of the causes of poor health. It follows that a strategy to combat worklessness might be one of their public health initiatives from April 2013. This requires the Government and, in particular, the Department for Work and Pensions to adopt a more localist approach and to devolve more powers to councils, as we said in a report back in 2011. *We note that local authorities already support apprenticeships and back-to-work schemes, but the Government should consider devolving to local government further measures, including elements of the Work Programme, in order to address at a more local level unemployment and, in turn, one reason why people may adopt unhealthy lifestyles.* (Paragraph 92)

### Local authorities working with the Government

25. *Some public health issues, such as alcohol misuse and obesity, may require central Government leadership and action, including legislation, if a big difference is to be made to the health of local people. Central Government action will not be a panacea, but to effect change local authorities may require the support of complementary national-level initiatives to make the most of their own strategies, powers and influence.* In the meantime, councils do have options available to them, including, setting up or expanding local Public Health Responsibility Deals, with local businesses, on which Government guidelines were published in January 2013. What is clear is that there is no single solution; multiple solutions will be required to deal with the multiple causes of unhealthy behaviour. (Paragraph 97)

### Joined-up government

26. Since the disbandment of the Cabinet sub-committee on public health, public health issues fall to be discussed and decisions taken in domestic policy committees. *We note also plans within the Department of Health to engage with the Home Affairs policy committee, and the discussions that the Department has already had with the Department for Education, which should be encouraged elsewhere in government.* Policy alignment nationally will assist councils' efforts to improve health and wellbeing locally and avoid the potential for mixed messages. Given the way in which local health issues span at least two Departments, Health and Communities and Local Government, local authorities need confidence in their contact with Government. *In the spirit of close working throughout government, both centrally and locally, we recommend that the Department of Health and the Department for Communities and Local Government set up a single point of ministerial contact to which local authorities can turn for support in their new health care role.* (Paragraph 99)

### Measuring success

27. The transfer of functions from central to local government during the relocation of responsibilities for public health must not become an end in itself. Local authorities will need to provide within an agreed period evidence of an improvement in the health and wellbeing of their population. With these new powers comes the responsibility to deliver results, and local authorities will need to balance local and

national objectives and short-term and long-term aims. Given the complex, multi-faceted nature of the social determinants of health, however, determining the success of general—population-wide—or specific initiatives will be difficult, time-consuming and may ultimately distract those working on them from making progress. Short-term success can be demonstrated relatively quickly, and without distracting from longer-term objectives, by, for example, improvement in readiness for school rates, the number of NEETs (those not in education, employment or training) in a local area and by all Health and Wellbeing Board members working to increase patient registration with GPs in order to identify those with long-term conditions and to prescribe treatment for them. (Paragraph 104)

### Assessment bodies

28. Good local authorities may already be tackling the difficult challenges posed by unhealthy people and communities, so in the short term at least it would be unfair and possibly counter-productive to start “naming and shaming” councils without taking into account historical and demographical factors. With Public Health England in its infancy it makes sense to restrict its role to that of critical friend. On matters of scrutiny and regulation, local authorities should not hide behind a national body such as Public Health England. We encourage them, in the spirit of localism, to take responsibility for these issues themselves, through overview and scrutiny committees and Local Healthwatch. (Paragraph 106)

### Self-assessment

29. Surveys—self-assessments—are a useful measure of wellbeing: they quantify the less specific but no less important objectives of independence and social participation, and they engage individuals in the development of their own wellbeing. Councils might make such surveys one aspect of agreeing their contracts with voluntary groups. (Paragraph 108)

### Front-line health protection

30. In previous chapters, we have remarked on the need for local authorities to develop sound working arrangements with health partners based on trusted relationships, leadership, persuasion and influence, but, when it comes to protecting the population in the event of a health emergency, those involved need to know unambiguously what their role is, understand who is in charge and have in place clear lines of accountability. Despite the assurances of Public Health England and of the Department of Health, we heard from witnesses who were still unclear about the details of this vital new responsibility, including who would be in charge locally in the event of a regional or national outbreak. This is a worrying state of affairs so late in the transition process. *We therefore recommend that the Government sets out clearly and unambiguously the lines of responsibility, from Public Health England down to public health staff in local authorities, and confirms that Public Health England will have sufficient staff throughout the country to assist in the local and regional, as well as national, responses, in the event of a health emergency. We note that four contingency exercises have been planned before April 2013 but, to ensure that*

*local authorities throughout the country are not only aware of, but practised in, the new procedures, we call on the Government to work with them to organise a continuing programme of such exercises. (Paragraph 114)*

### The role of the NHS Commissioning Board

31. The inclusion of the NHS Commissioning Board and its 27 local area teams in the health protection system, with its role in mobilising the NHS in the event of an emergency, and combined with the 39 Local Resilience Forums and 15 local Public Health England centres, adds a further layer of complexity and introduces potential variation to the new arrangements, with all the attendant risks. Local authorities will need to be completely clear about whom they speak to in the NHS locally in the event of an emergency, so *we reiterate our recommendation that the Government and the NHS Commissioning Board ensure that these relationships are made unequivocally clear to public health staff in local government. (Paragraph 116)*

### Revised responsibilities

32. We acknowledge the legal issues, raised by the Department of Health, which might arise from giving local Directors of Public Health a similar duty to the Secretary of State to protect the health of the population, but our main concern is with the practicalities. Given the importance that the Government has attached to the role of the Director of Public Health, it must make sense to include them as fully as possible in ensuring, rather than simply advising on and promoting, adequate preparation for local health protection arrangements. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012 risk diminishing the authority of the Director of Public Health and creating delays while concerns about local preparedness are taken to Public Health England. *We therefore recommend that the Government review these regulations, in order to enhance with identifiable authority the power, respect and status that the Government suggest should be accorded to Directors of Public Health. (Paragraph 120)*

### Screening, immunisation and the NHS Commissioning Board

33. We heard serious concerns about the new arrangements for screening and immunisation, particularly the fragmentation of staff and organisations responsible for these services. We accept that local authorities will be able to work with the 27 NHS Commissioning Board Local Area Teams, but as we have already noted—there are concerns about the ability of local government to influence the Board's decisions. In addition, when it comes to screening and immunisation there are additional concerns about the number of bodies the Director of Public Health will have to work with, and the Board's ability to reflect local diversity and to reach into local populations as effectively as local authorities can. *We urge the Government and the NHS Commissioning Board to listen to local authorities, to respond to their calls for reassurance and we recommend that the Government reviews the arrangements with a view to devolving these services to public health staff within local government. (Paragraph 125)*

## Childhood services

34. *Given the importance of early years interventions, and the reach that local authorities have into their communities, the Government should work with councils on devolving further responsibilities for children's public health, such as the Healthy Child programme, to local government—and guarantee at least that responsibility for health visiting will be transferred to local authorities in 2015, or when the target for increasing health visitors has been met, whichever is earlier. The Government should, as part of a general move to locate children's public health services in local government, also agree to a timescale for placing childhood immunisation services under the control of Directors of Public Health, in acknowledgement of their previous responsibility for this area and of the pivotal position that they now occupy in local public health provision.* (Paragraph 128)

## The final funding allocation

35. We welcome the increase—when compared with the draft interim allocation—in public health funding to local authorities. We recognise that to create a public health budget where none has previously existed, to finalise a formula and to consult with all those affected is not a task to be taken lightly or rushed, but the 11 months required to complete the final allocations process, with totals being announced on 10 January 2013, only 79 days before health responsibilities transferred from the NHS, left local authorities with a great deal of work to do in a short period. Local government understandably planned for the worst based on the interim February 2012 and June 2012 allocations, and, while the subsequent increases are welcome, the delay caused some problems for local authorities and their budgeting arrangements. (Paragraph 137)
36. *Given that local authority public health budgets have now been set for 2013–14 and 2014–15, the Government has time to plan with local government a managed approach to allocating the budgets for 2015–16. We therefore recommend that the Government puts in place a timetable for publishing and consulting on the 2015–16 allocations with a view to finalising them by October 2014, so that commissioners and providers have at least six months in which to plan strategically the services that will contribute most effectively to local people's health and wellbeing in 2015–16.* (Paragraph 138)

## The revised funding formula

37. We acknowledge that the current formula is an improvement on the interim model and allows local authorities to target pockets of deprivation in their areas. We note the perverse incentive in the medium term, however, of basing funding on improved health outcomes, given that areas which perform well risk having their funding reduced. Public health is not short of data, and it should be possible under the new arrangements to begin to base funding on observable trends in health locally and—using Joint Strategic Needs Assessments, for example—for local government to use its allocations in a more precise manner. This places a responsibility on councils and



their Health and Wellbeing Boards to produce comprehensive and rigorous Joint Strategic Needs Assessments. (Paragraph 141)

38. *We recommend that the Government not only ensures the Advisory Committee on Resource Allocation (ACRA) makes good on its commitment to review the allocation formula, but clarifies the timetable for revising it—and whether this means a revised formula in time for the 2015–16 allocations. Just as local authorities need to know well in advance when budgets will be published, they require also some certainty about the formula that will be used to calculate them.* (Paragraph 142)

## The Health Premium

39. *The Government's approach to public health funding leading up to and after 2015–16 seems confused and should be clarified. It says it has no timetable for modifying the current funding formula, but accepts that, given the impact of the Health Premium, the formula will need to be developed in 2015–16. Local authorities will need to know, first, when they can start planning their budgets for 2015–16, second, when the Government intends to redevelop the funding formula, and, third, that any system of reward will complement their main source of funding.* (Paragraph 145)
40. *The Government has acknowledged that the perverse incentive in the current funding formula would be particularly marked if it were still in place when the Health Premium was introduced. This suggests that the current funding formula and possibly the Premium need to be revised. A funding system which at the same time disadvantages and rewards improvements in public health cannot be fit for purpose. The Government has said that 2015–16 will be a key year in the development of the formula. We recommend that a parallel system of reward should not be implemented in the same year. It should be delayed until the funding formula has been redesigned.* (Paragraph 146)

## Demand-led services

41. *The costs of demand-led services, such as sexual health provision, are increasing and in some cases could account for a considerable proportion of the public health ring-fenced grant from April 2013. It has been argued that the current formula fails to account adequately for the cost of these services, and we have received evidence detailing alternative funding criteria that might correspond more accurately to the care that local authorities have been mandated to provide. The Advisory Committee on Resource Allocation, while acknowledging these concerns, maintained that no immediate alternative appeared to work across the country. We recommend that the Government and the advisory committee, as part of their commitment to keep this area under review, consider alternative formulas for calculating the overall ring-fenced grant, such as the index of multiple deprivation, and how such allocations might take better account of local circumstances.* (Paragraph 150)

## Re-charging for non-residents' use of services

42. *We call on ACRA and the Government to work with local authorities on the issue of non-residents' use of demand-led services. Given that many people work or go out in*



*one borough and live in another, people's use of services in this way should not be underestimated. Attempting to resolve that either by pooling resources or by re-charging has the potential to become complicated and contentious. (Paragraph 151)*

### Funding in the long term

43. *We urge local authorities and the Government to explore innovative approaches to funding public health services. One route might be to determine the actual cost locally of demand-led services and to separate funding for them from the rest of the public health budget. The remaining public health provision could then be determined using a formula, such as the standard mortality ratio, and either continue to be ring fenced or stand apart from the rest of the authority's budget. Alternatively, the remainder might, as witnesses suggested, correspond to the remainder of the local authority's overall budget and become in all but name a community budget. (Paragraph 154)*

### Community budgets

44. *We agree with the Department of Health that, although funding mechanisms are important, shared objectives on how the money is spent are crucial. While the Department for Communities and Local Government recognises that local government does not like ring-fenced grants, we accept that, at least in the short term, some ring-fencing may be needed. But this should not become a permanent feature of the public health funding system in England. The Department of Health says it wants to learn from the Community Budget pilots on health and social care. We urge the Department of Health to work with the Department for Communities and Local Government and to share that learning as soon as possible, in order to clarify what funding mechanism will be proposed for the financial year 2015–16 and beyond—with a view to removing the ring fence and moving to community budgets. In addition, we urge the Government and, in particular, the Department of Health to recognise that if public health is to become an overarching priority for all local authority departments, it will require an overarching budget which reflects that approach. If the evidence from the completed Total Place and ongoing Community Budgets pilots continues to point to their effectiveness, we recommend the Government provides local authorities with community, place-based, budgets for the direction of resources at people and places rather than at organisations. (Paragraph 161)*
45. *There is also a role for Health and Wellbeing Boards to play, given their duty to encourage integrated working, by devising joint strategies that allow local authorities to use existing levers in the final funding settlement to pool public health budgets with those of other departments and across authorities, thereby demonstrating to central Government how shared resources can improve outcomes. In this endeavour, Directors of Public Health will remain central to the budgeting process if and when the ring fence is removed. (Paragraph 162)*

# Formal Minutes

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**Wednesday 20 March 2013**

Members present:

Mr Clive Betts, in the Chair

Bob Blackman

Simon Danczuk

Mrs Mary Glendon

James Morris

Mark Pawsey

Andy Sawford

Heather Wheeler

Draft Report (*Role of local authorities in health issues*), proposed by the Chair, brought up and read.

*Ordered*, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 167 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Eighth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 29 October, 7, 21 and 26 November, 12 December 2012, 7 and 21 January, and 11 and 25 February 2013).

[Adjourned till 4.00 p.m. on Monday 25 March

# Witnesses

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## Monday 19 November 2012

Page

**David Buck**, Senior Fellow, Public Health and Inequalities, The King's Fund, **Graham Jukes**, Chief Executive, The Chartered Institute of Environmental Health, **Dr Nicholas Hicks**, Milton Keynes Director of Public Health and Programme Director for Public Health to the NHS Commissioning Board, **Dr John Middleton**, Vice-President, UK Faculty of Public Health and Director of Public Health, Sandwell PCT and **Duncan Selbie**, Chief Executive designate, Public Health England

Ev 1

## Monday 26 November 2012

**Cllr Steve Bedser**, Chair, Community Wellbeing Board, Local Government Association, **Cllr Alan Connett**, Executive Lead for Health and Wellbeing, District Councils Network, **Professor Gabriel Scally**, Director of WHO Collaborating Centre for Healthy Urban Environments, University of the West of England, **Dr Penelope Toff**, co-Chair, Public Health Medicine Committee, British Medical Association,, and **Dr Peter Carter**, Chief Executive, Royal College of Nursing

Ev 15

**Caroline Abrahams**, Director of External Affairs, Age UK, **Richard Blyth**, Head of Policy and Practice, Royal Town Planning Institute, **Andy Murdock**, External Relations and Policy Director, Celesio UK, and **Paul Woodward**, Chief Executive, Sue Ryder Care

Ev 27

## Monday 3 December 2012

**Cllr Anthony Devenish**, Cabinet Member for Public Health and Premises, Westminster City Council, **Cllr Nick Forbes**, Leader, Newcastle-upon-Tyne City Council, **Liam Hughes**, Independent Chair, Oldham shadow Health and Wellbeing Board, and **Cllr Mary Lea**, Cabinet Member for Health, Care and Independent Living, Sheffield City Council

Ev 35

**Kim Carey**, Corporate Director of Adult Social Services, Cornwall Council, **Cllr Roger Gough**, Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council, **Dr Mike Grady**, Principal Adviser, University College London Institute of Health Equity, and **Cllr Ernie White**, Cabinet Lead Member for Health, Leicestershire County Council

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## Monday 7 January 2013

**Professor Chris Bentley**, Independent Population Health Consultant

Ev 54

## Monday 21 January 2013

**Anna Soubry MP**, Parliamentary Under Secretary of State and **Tim Baxter**, Deputy Director, Public Health Development Unit, Department of Health, and **Baroness Hanham CBE**, Parliamentary Under Secretary of State, Department for Communities and Local Government

Ev 60

## List of printed written evidence

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Department of Health and Department for Communities and Local Government	Ev 165, Ev 169
District Councils Network	Ev 93
Dr Mike Grady	Ev 146
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## List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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Second Report	European Regional Development Fund	HC 81 (CM 8389)
Third Report	The work of the Local Government Ombudsman	HC 431 (HC 615 & HC 650)
Fourth Report	Pre-appointment hearing for the Chair of the Audit Commission	HC 553
Fifth Report	Mutual and co-operative approaches to delivering local services	HC 112 (CM 8547)
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Seventh Report	The Committee's response to the Government's consultation on permitted development rights for homeowners	HC 830

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First Report	Local Authority Publications	HC 666 (HC 834)
Second Special Report	Local Authority Publications: Government response to the Committee's Sixth Report of Session 2010–11	HC 834
Second Report	Abolition of Regional Spatial Strategies: a planning vacuum?	HC 517 (CM 8103)
Third Special Report	FiReControl: Government response to the Committee's Fifth Report of Session 2009–10	HC 835
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Ninth Report	Taking forward Community Budgets	HC 1750
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Fourth Special Report	Preventing violent extremism: Government response to the Committee's Sixth Report of Session 2009–10	HC 1951
Eleventh Report	Financing of new housing supply	HC 1652 (CM 8401)



# Oral evidence

## Taken before the Communities and Local Government Committee on Wednesday 21 November 2012

Members present:

Mr Clive Betts (Chair)

Bob Blackman  
Simon Danczuk  
Bill Esterson

James Morris  
Mark Pawsey  
John Stevenson

### Examination of Witnesses

*Witnesses:* **David Buck**, Senior Fellow, Public Health and Inequalities, The King's Fund, **Dr Nicholas Hicks**, Milton Keynes Director of Public Health and Programme Director for Public Health at the NHS Commissioning Board, **Graham Jukes**, Chief Executive, Chartered Institute of Environmental Health, **Dr John Middleton**, Vice President, UK Faculty of Public Health and Director of Public Health, Sandwell PCT, and **Duncan Selbie**, Chief Executive designate, Public Health England, gave evidence.

**Q1 Chair:** Can we begin this session with declarations of interest? Members have their interests in the register of interests. I point out at the very beginning that I am a vice-president of the Local Government Association, and I put that on the record so you know where I am coming from in that respect. I welcome all of you to the first evidence session in our inquiry into the role of local authorities in health issues. For the sake of our records, could you begin by saying who you are and the organisations you represent?

**Dr Middleton:** I am John Middleton, vice-president of the UK Faculty of Public Health and director of public health for Sandwell in the West Midlands.

**Dr Hicks:** My name is Nicholas Hicks, director of public health in Milton Keynes. I also spend three days a week of my time as a consultant to the NHS Commissioning Board.

**Graham Jukes:** I am Graham Jukes, chief executive of the Chartered Institute of Environmental Health.

**Duncan Selbie:** I am Duncan Selbie, chief executive designate of Public Health England.

**David Buck:** I am David Buck, senior fellow in public health and health inequalities at The King's Fund.

**Q2 Chair:** There are five of you and no doubt you will all have your own views on things, but if your views coincide with those of one of your colleagues you do not have to repeat them in detail. If you just say you agree, it helps us to move the business forward so that we can deal with all the questions we need to in a reasonable time. All of us here probably have local government interests but have not been particularly exposed to the issues around the reforms in public health, because it is a new transfer back to the local authority arena, but in terms of that fundamental, perhaps you would give us your view about the significance of the transfer of the role back to local councils. It did not seem to me that the average councillor would feel very much ownership of any of this, looking at the various proposals, accountabilities and responsibilities that we have in front of us.

**Duncan Selbie:** I have been in the health service for over 30 years and have worked with the public health community in various different ways, for example in psychiatry 10 years ago. It is inconceivable how you could offer care and access to treatment without working across local government and the health service. The opportunities to get into health outside treatment and early intervention are so much greater working through local government than where we have been for the last number of years.

My own experience of meeting elected members around the country suggests there is optimism and positivity. They have been saying to me that this is about the responsibility coming back home. The leader of Newcastle City Council described their priorities in three themes: creating jobs, decent neighbourhoods and tackling inequalities. One of the leaders in the Greater Manchester conurbation described how the next phase of economic strength in that area would only be possible by improving the health of the population. In Sheffield, they talked about spending £1.5 billion and being able to scale up 44,000 households, but not knowing quite what to do and looking to the public health movement to Sheffield City Council as their R and D function. I am sure that is not the case everywhere, but as I travel round the country I meet a great deal of optimism about this.

**Graham Jukes:** Public health is coming home. Local authorities were the originators of many of the public health interventions that created huge improvements in the health of the nation. Post-1974, when medical officers of health moved out of local government and into the NHS, many local authorities have forgotten the roots of public health improvement; it is about infrastructure and all the things that local authorities do so well. In many respects public health has become synonymous with public ill health, and we ought to be trying to get in front of the curve, as many commentators have said, to start addressing the causes of the causes of ill health, and that is through prevention. Local authorities are in the best place to do that. I am not sure many local authorities and councillors understand the history of public health

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provision in this country, or indeed where it can go to now. A lot of work needs to be done through the LGA and other mechanisms to make sure councillors understand not only the history but also the future.

**Dr Middleton:** We would certainly want to see health as an issue of civic pride for councillors. Life expectancy ought to be an important thing they want to achieve for their residents. It should be unacceptable if their life expectancy is not as good as it is in other parts of the country or in other parts of their council. The issue is to get councils to appreciate health as a matter of civic pride and necessity and what they should expect for their citizens.

**Dr Hicks:** It is important to recognise how fast health has been improving. In the 10 years between 1997 and 2007, expectation of life for men improved by over three years. That is 37 months in 10 years; in other words, expectation of life has been improving by over three months for each year, which is remarkable. During that period my perception working locally has been that although local government has always had many of the levers for improving health—education, housing, transport and so forth—it has not always had the confidence to use those levers to improve health, or seen that as one of its core aims. The great opportunity of these reforms is for councils to put the improvement of the health of their population and the narrowing of inequalities right at the core of their purpose in being there. If we can achieve that, it would be fantastic.

**David Buck:** I would reinforce much of what my colleagues have said. This gets to the core of what local government thinks of itself and what its purpose is. It feels to me that at the heart of it is primarily its stewardship of wellbeing, of which health is clearly one aspect. They are separate concepts, and there are some interesting issues about health and wellbeing boards. If you focus on health versus wellbeing, you will not necessarily choose the same things to focus on. Maybe we can get into that debate later.

When we talk to local councillors, they really get it. They want it and they are incredibly enthusiastic about it. It also particularly opens up opportunities for good conversations and joint working between GPs and local councils, which has often been hard in the past. Both of them come from a space where they are talking about small areas—their wards and patches. That conversation between the NHS and councillors has often been difficult before, because it has been primarily a relationship between the PCT, a much higher-level body, and local councillors. There are some real opportunities, particularly with GPs and local councillors as they come to the health and wellbeing board, through the CCG role. It is a good question about the average councillor. The councillors I see are the ones who are enthused, not the ones outside the health and wellbeing board remit, so it is a good challenge and good question to us.

**Q3 Chair:** It is a simple question. In five years' time, when someone comes along and says to a council, "You're responsible for public health and all these inequalities. What have you done about it?" They will say, "Well, we're not really responsible. The leader and some of our senior officers may be a bit involved

in that, and we have Public Health England, commissioning groups and the NHS Commissioning Board." They all have their fingers in the pie. It is desperately difficult to explain the system to anybody. You could explain it all, but you are probably only five out of 10 people in the country who have any understanding of it. Isn't the problem for the public that if something is not understandable it is not really accountable?

**Graham Jukes:** There is an issue about timing, transition and transformation. As we go into this next phase—public health will go to local government on 1 April—we are very much at the planning stage. There have been lots and lots of discussions about that. As we start to get the health and wellbeing boards firmly established, JSNAs beginning to drive the agendas for local authorities and the necessity particularly for district councils to be involved and engaged in the creation of local JSNAs to set strategies, we will see the emergence of a very clear understanding about roles and responsibilities, but we are not there yet. Once it is established, we need to provide the tools and information for councillors to understand their new role.

**Dr Hicks:** When I spoke before I said that if we can get councillors to put health at the heart of their purpose, that is a great prize, and it is, but it is an "if". There is still a risk that too many people see public health as just preventive services, health improvement or health protection and do not necessarily see the whole of the strategic content. One of the tests is looking at an existing council plan, which sets out the council's ambition, and asking whether it wants the health and wellbeing board to help them deliver that plan, or whether they see the arrival of their leadership role for health as changing the council plan, so the council plan becomes much more focussed on health as a whole. As to that, there will be some questions about the relationship between the health and wellbeing board and the council. Which one drives which? Does the health and wellbeing board come up with one view and the council plan then reflects it, or do they look at it and say, "We'd rather do something else"? For me, one of the key tests of your question is: does the council really get its role as being the leader and responsible body for health in its community?

**Dr Middleton:** I would not want the Committee to believe that the five people assembled before it understand fully what this system is all about. There are large chunks of the system that are in flux and are still being devised and determined, and there are considerable risks in that. As to what councils need to do, we describe three domains of public health: health protection, which is about keeping us safe from infectious disease, communicable disease and major emergencies; health improvement, which is all the policies of the council and how we promote health and keep people healthy; and the domain of healthcare-related public health, where the analysis of what goes on in your local acute hospital is every bit as important as those other two elements. If councils are to be strategic leaders of the health strategy, they will have to be able to understand and challenge what goes on in the hospital on their behalf. Similarly, they

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will have to be able to support clinical commissioning groups by providing public health advice so that what goes on in primary care can be as effective as we would advise.

**David Buck:** There are three additional things that will help. One is that we know from most experience that local authorities are much better at engaging with their local communities than perhaps the NHS is. The experience I have had with health and wellbeing boards is that they have been getting all their systems in place, working out who is on them and the links between the JSNA and the health and wellbeing strategy. They are now starting to ramp up around public engagement, both with the public directly and more broadly with councillors. That is coming on stream, but we are asking a lot of health and wellbeing boards to do an awful lot of things. There is a danger that they are becoming Dr Johnson's elixir—they will sort out all the problems locally, including health issues. We have to be careful about loading them up and expecting too much of them too quickly, but I think local authorities are much better at public engagement and that will come through.

Secondly, it is good to have Duncan here, and Public Health England and NICE, explaining the evidence about the things local councillors have control of through their political role in local areas, and how that translates to what they can do about it. That is a critical role for Public Health England. We welcome that, and working with NICE to work more closely with local authorities as well as the NHS. For instance, yesterday a big report came out, admittedly from the States, showing that the impact of being out of work in your 50s and 60s on mortality was as great as smoking; putting people out of work is an economic development and is a critical role of the council. Similarly, there is recent work on the role of isolation, particularly for the very elderly. That impact is as big as smoking and health behaviours. Public Health England is in a very good position to make the most of that linkage.

I know that the Marmot review has been working quite hard with lots of local areas to try to embed its overall high-level policy-type advice into what this can mean locally. I know the LGA is also working on this agenda. It is by no means perfect; we need to keep working hard on this, and time is of the essence. There are things in place, and I welcome Duncan's role in particular. One of the critical roles is to make this stuff meaningful for local decision makers.

**Duncan Selbie:** I agree with that.

**Chair:** I thought you might.

**Duncan Selbie:** As to the pursuit and spread of knowledge and holding mirrors up at ward level there is meaning for councillors about what is going on in their community, we heard about the improvements overall in survival rates, but we also know that the gap between rich and poor has been getting wider. The reasons for this are not so much about what the NHS does, which we are familiar with in acute hospitals, but about the determinants: whether you have a job and something to do, self-esteem, a home that is not damp and where you feel safe and, crucially, whether you have someone who cares about you enough. That is why social isolation is such a

killer. I hope that being able to show what is happening to your people at ward level will enrich the conversation about what we mean by health. The folk who have been hearing the messages about smoking, alcohol, diet and exercise have been acting on them and living longer and without a burden of disease for longer. For those who have not been hearing those messages, the gap has been getting wider. The way we will address those is by action at a local level, how priorities are set and how people come together. We will be seeking to share the evidence about what works, not telling people what to do but opening up possibilities.

**Q4 Simon Danczuk:** I want to concentrate for a moment on the workforce. The BMA said that "reforms have left the public health workforce in limbo for over two years, with many uncertain as to where they will be employed in April 2013—or even whether they will be employed at all." Is it a fair assessment by the BMA?

**Dr Middleton:** Absolutely. The position of many public health staff is still not determined. There is a programme through which migration to local authority public health and the NHS Commissioning Board is laid out, but there are still many people who have not been aligned as yet. There is still a due diligence process to be gone through in councils. There are posts, for instance, in policy analysis, community development and certain other areas where councillors will say, "We already do that, thank you." There is considerable risk and uncertainty for public health staff. Potentially, there will be 50 vacant directors of public health posts by April next year according to the ADPH survey. We are seeing a loss of public health staff through the recent mutually agreed resignation scheme. In my own district of Sandwell we have lost one third of our public health workforce in the last two months.

**Q5 Simon Danczuk:** In brief, what do you think is going to happen?

**Dr Middleton:** It is a period of serious risk and uncertainty. I think that we will come through it positively. The cadre of trainees in specialist positions is an excellent and outstanding bunch of people and they will graduate through the ranks, but there will be a very uncomfortable period when a large number of vacancies for directors of public health in particular is the reality.

**Q6 Simon Danczuk:** What are the biggest potential risks?

**Dr Middleton:** A real risk is that people who do not have leadership in public health do not value it and do not see what it is going to do for them.

**Graham Jukes:** If I may comment on a slightly different angle, what has just been commented on is the transfer of public health staff from PCTs and the existing structure into local government. That is denying the large public health workforce already out there that is not part of this process but needs to be integrated into it. Over the last nine to 12 months there has been considerable concentration on issues to do with pay and rations in the transfer process but not

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enough concentration on the wider public health workforce that is going to make this work far more effectively. One of the concerns raised at a meeting in Nottingham earlier this week was that there is an expectation that local authorities will take on the role of training and nurturing public health staff as they transfer in, but that is not the culture of local government. There is a culture gap around not only the existing workforce employed in local government who have public health functions but the new staff coming in, so there is a mismatch that will need to be addressed. We also need a full audit of the full public health workforce, because it is not just those who are transferring who deliver these services. From what we can see, there is no auditing going on at this moment, in fact I invite Duncan, who I only met outside, to take that on as one of the key functions—to understand what the wider public health workforce is and what training is required to support growth in the future.

**Q7 Simon Danczuk:** Duncan, tell us everything is going to be okay.

**Duncan Selbie:** I hope so. I am obviously a popular chap. My ambition and hope is that it is not this number that are public health thinkers but the entire workforce, so we have public, or the public's, health organisations three, five or 10 years down the road. I have to recognise the personal uncertainty and, for some, trauma of the extended period of time, but it is getting to a point where certainty is starting to come into the system. About half of the workforce as we have conventionally understood it are moving into local government. For some weeks there has been an agreement in place about the transfer of staff; 152 authorities have just done a self-audit and the LGA can talk themselves about what they have discovered. But broadly it is positive. It is a period of transition and uncertainty, but it should begin to settle.

About 5,000 staff are going into local government and 5,000 are coming into Public Health England. That is all under way as well. Ninety-five per cent of those staff are coming in under what we call a lift and shift arrangement, which essentially is taking them from 70 sender organisations—forgive the language—such as the Health Protection Agency and the National Treatment Agency for Substance Misuse. They are coming into Public Health England. All of them have certainty. They would say they are not quite sure what that is going to mean for them—to whom they are accountable. Is it going to affect them day to day? Of course it is going to affect the day-to-day job, because we are trying to transform the whole. It is not just about what they used to do and then moving into a new organisation where they continue to do what they have always done, or moving from public health teams embedded in PCTs and into local government and carrying on as though nothing has ever changed. I recognise that we are going to have to invest in this. Factually, the LGA, from the work just completed, believes there will be 19 vacancies for directors of public health come April, so six out of seven will have substantive directors of public health in post. The other 19 will have acting arrangements. There will not

be a situation where we go into next year and do not have somebody in charge in every part of England.

**Dr Hicks:** I have never seen, or been involved in, change on this scale, so I am not quite sure what one would expect. I think you would expect a degree of anxiety and discomfort. I agree with John that there is a lot of anxiety and discomfort, and it is not just about the period up to the transfer. If you look at my crew, they would accept there is a TUPE transfer process that will take them in, but they do not know what is going to happen beyond that. They are anxious about that and what it means, not so much regarding the content of their work but their terms and conditions and what will happen there, and given that no one can give them a straight answer at the moment, you can understand why.

**Q8 Simon Danczuk:** David, do you have anything to add?

**David Buck:** Not much. We get to some of the cultural issues and differences between the NHS and the way it has traditionally worked and the way the local authorities have worked, and also the role of Public Health England versus local authorities. The Government have been very explicit that they will be taking as many hands off as they can in terms of how that is organised locally, so it is not surprising there will be quite a lot of variation. The promise is that there will be more innovation and maybe variation in services and how people work and so on, but less variation in outcomes and fewer inequalities. That is the aim of the game, but through that process things are going to be very different. To reiterate, there are certain parts of the country that we know have more problems than others. London will probably be in a particular situation, but it also affects the unique characteristics of London and sharing resources across boroughs and so on, including public health staff. Part of this is the transition; part is the real concerns John talked about, but we would expect some of those because we are changing the culture of how we work. I am not really qualified to talk about individual areas as much as the other panellists.

**Q9 Simon Danczuk:** The UK Healthy Cities Network raises a concern about staff from the NHS moving to local government and “working in a politically-led environment”, but health is nothing if not political. Should there be cause for concern there? Are there potential problems with these people moving into a political environment?

**Dr Middleton:** Yes of course, health is political, and arguably the reform that moves public health practitioners into the local authority should harness and make a positive out of that. I am not naïve enough to think there will not be difficulties about it. Nevertheless, the best practitioners and managers will harness the political interest to the best benefit for the public's health. There are concerns in relation to the different cultures. Evidence base is not necessarily a political concept. Nevertheless, we all need to learn from it and increase the quality of decision making. Moving public health is not supposed to make things easier; it is supposed to make them better.

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**Q10 Simon Danczuk:** Duncan, the Government say that one of the functions of Public Health England is to develop the public health workforce. Briefly, how do you intend to do that?

**Duncan Selbie:** Wherever the workforce happens to be, whether it is in Public Health England or local government or embedded in a clinical commissioning group, we have a responsibility to ensure that at undergraduate and postgraduate level and in continuing professional development for all staff, there is a framework for education and training, and research and science is brought to bear right across it. It is our job to ensure that people have access to education at every stage and learn together. Through that we will probably best address some of the cultural issues that have been raised.

**Q11 Bob Blackman:** One of the key areas is going to be the directors of public health; their role is vital in the whole exercise. Many of the people moving across and taking on this role will be used to making decisions and getting on with the job. But this job is a bit different, isn't it? It is influencing people—trying to influence behaviour and local authorities. Duncan, do you have any concerns that the scope of this role might be difficult to fill in certain cases?

**Duncan Selbie:** We could not carry on as we were. We have a situation where we have widening gaps and experts in public health who are not as visible as they need to be; they are embedded in a health system that essentially is concerned with what goes on in hospitals. We recognise that we need to get out of that and into a system that thinks more widely about it, so it could not continue as it was. That means directors of public health and public health specialists going into local government are going to be in an environment they are not familiar with; there will be political leadership in a direct way that they are not familiar with. The opportunities will be immense, but they will be more accountable than they have ever been before. It will not be a matter of reporting what is not right; it will be about, "What are you doing to help make it right?" This is a very different ask.

**Q12 Bob Blackman:** People are being appointed to these jobs in an acting capacity at the moment. As time goes on there will be more people in those roles, but the key issue is whether they have the skills and capabilities now; and if not, what is being done to skill them? Simon is talking about the workforce; I am talking about the key role of the director.

**Duncan Selbie:** I have a particular responsibility, which I fully recognise and accept, to bring forth the leadership. We expect 133 directors of public health to move into 152 local authorities. I have got about 170 people leading on facing the regions and the national folk, including some academic input as well. With those 170 people, irrespective of who the employer is, it is my responsibility to make sure we are learning together, supporting and challenging one another and coming together regularly. This does not happen at the moment. Undoubtedly, a number of the folk already have those skills. We have some fabulous people out there.

**Q13 Bob Blackman:** You are happy that you have a programme in place to get everyone skilled up to do this key role.

**Duncan Selbie:** That is what we will have in place.

**Q14 Bob Blackman:** Others are itching to get in on this subject.

**Graham Jukes:** I had the privilege of being part of a Department of Health leadership programme, which has now sadly ceased. Most of the current DPHs have been through some sort of leadership programme. The issue for me is about where they are in the tiers of local government.

**Q15 Bob Blackman:** I was going to ask about that specifically. One of the concerns is that, according to the Government, they should be—I agree with this—reporting to the chief executive and not the director of adult social services, but that seems to be the structure in certain local authorities. Do you have a concern about that?

**Graham Jukes:** We are the victims or benefactors of localism, and it is really a question of how local authorities wish to construct their particular structures and where the DPH sits in that. It is conceivable that DPHs in some authorities will be third tier. How will that influence the public health programmes and health and wellbeing board decision making, if that is in fact the case? But there are also joint appointments. Currently, there are examples where environmental health practitioners have been appointed as directors of public health in a joint appointment process. One of our prominent members in Newham, who is a director of public health and also an environmental health practitioner, is very used to the local authority political environment and dealing with the intricacies of the debate and discussion that surround the democratic process. That is something leadership training will address. It is about how individuals will find themselves in the firmament of the structure and learn to influence those making decisions down the line, and clearly the cream will rise to the top.

**Dr Hicks:** I feel quite strongly about this. In 2002 I was appointed joint director of public health across the health service in a unitary authority. The role is as you describe it; it is to be an influencer, and it is too easy to focus on just a public health budget. Your aim is to get the whole of the health service budget and local government budget, plus the organisations beyond, used in a way that supports and promotes health and reduces inequalities.

To be an effective influencer you need a platform of power, and that comes in a variety of different forms: your own personal attributes; your professional and technical skills and knowledge; but you also need managerial power and an ability to deliver your home organisation. If you are employed by the council and are out and about in the town and cannot deliver your organisation, nobody is going to believe you. I do not think you can do that if you are third tier or seen as someone below it with the same status as a corporate director. If you have got corporate directors and somebody else sitting below them, they know you do not run the organisation—game over.

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**Dr Middleton:** In moving into local authorities, they won't know what they don't know, and the need for the senior public health person to be at the chief officer's table reporting to the chief executive is absolutely essential. Directors of public health need standards, resources and powers. One of the aspects of these reforms that worries me and some of my colleagues is the notion of assurance—that we will somehow float over the whole system and say it is all okay. Is it a warm glow you feel when the hospital tells you it is doing the right thing, or is it a critical inspection of what is going on, be it in infection control, screening or any of the other areas? To me, it feels that directors of public health need to have both the resource and the power to deliver those.

As to standards, councils are used to working in a peer-led environment and sector-led improvement. As a faculty of public health, we are keen to support that process. The whole system needs to work at a sufficient level. If I as a local authority officer find that the neighbours are not doing as well as they need to on TB, genitourinary medicine or drug control, those problems are my problems too. If I have a wonderful town planning service that does safe walking and cycling and those routes stop at the border, we will not get the best for public health, so we need standards across authorities.

**Q16 Bob Blackman:** You have mentioned London. I am aware that different authorities that are not adjacent are appointing joint directors with joint teams across very different geographical areas. Do you have any concerns about that type of arrangement, where they are sharing resources and potentially dissipating the effort within those boroughs?

**Graham Jukes:** I do have concerns about geographical issues to do with how these appointments are being arranged, because that will lead not only to inefficiencies but different types of issues in relation to the policy of adjacent and adjoining local authorities. That needs to be managed in the right way.

**Q17 Bob Blackman:** So if two adjacent authorities do this, it would not be an issue.

**Graham Jukes:** It would not be a problem.

**Q18 Bob Blackman:** But if they are doing it with a wide difference geographically, it would be a problem.

**Graham Jukes:** Yes, it would be.

**Duncan Selbie:** When we are thinking about the future, we must not have a rosy picture about our past. We have not had 152 brilliant leaders in public health with influence and access and getting it all done. That is a big part of why we are making these changes. I am much more concerned about the director of public health being on the top team rather than to whom he is accountable. In statute they are chief officers and are accountable to the chief executive; they have direct unfettered access to members. It is about how they have influence across everything.

To revert to London, I am seeing them tomorrow afternoon. If we had been seeing each other on Friday, I could have given you a very clear view. It is precisely about whether we are getting this right, not

just on day one but what happens subsequently. Not just in the last year but over a number of years there has been history about the capability of public health in London. My issue is less about adjacency and more that they share all of their functions. If two boroughs adjacent to each other share all of the corporate functions, that is fine. There are choices. We have been very clear that we are not telling local government how it should organise, but it needs to be infiltrating everything. If you have one borough doing everything separately from another but sharing a single director of public health, I would be more concerned. Does that make sense?

**Bob Blackman:** Yes, absolutely.

**Q19 James Morris:** To follow up Bob's point, I represent part of the Black Country and Dr Middleton will know some of that area well. I know there have been discussions between Sandwell metropolitan borough and Dudley about sharing a public health director. Surely, there is a strong rationale in an area like the Black Country for a director of public health who may straddle all four of the local authorities in that area, because one of the advantages is that a strategic needs assessment of the health of the Black Country, given its geographical composition and population make-up, would make a huge amount of sense, wouldn't it?

**Dr Middleton:** Should I answer that, and do I declare an interest and leave the room? There was a discussion of a Black Country DPH and of a shared DPH. There was a realisation that even a shared DPH would potentially be an impossible job, with two health and wellbeing boards, two scrutiny committees, two council management teams and three or four clinical commissioning groups extending into Birmingham, because of Sandwell's relations with Birmingham. In the end it was a practical consideration that it could not be done. That may be a consideration for other local areas where they do consider that. For instance, in Greater Manchester they have all committed to their separate directors of public health, but then they commit to sharing other functions like information, intelligence, health protection and so on. Having that leader and senior position for each council is certainly what I think should happen, but I am conscious that for some localities and some parts of London that is not simply practical, so there has to be a local discussion on that.

**Graham Jukes:** We are on a journey; it does not start on 1 April, so we are moving forward. One of the big challenges will be to create cohesive plans that address inequalities in health in local communities, which are no respecters of boundaries. There are boundaries that go through various things. The challenge for DPHs, health and wellbeing boards and local councils is to marshal their resources, understand the problems of their respective communities and try to find strategies to deal with them. That is a significant challenge and one that I think the people chosen for this job will be up for. It is up to Public Health England and organisations like my own and others sitting round this table to support that process.



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**Q20 Simon Danczuk:** Duncan, I am worried about frontline health protection, whether it is an E. coli outbreak as happened in Germany or a Legionnaires' outbreak as happened in Edinburgh. I am not the only person who is worried. Concerns have been voiced about considerable and unacceptable uncertainty about the health protection function and that arrangements are unclear, are denuded of resources and filled with risk. That is what reputable organisations are saying about it. How do you respond to that?

**Duncan Selbie:** I have to recognise what people are saying. Let me tell you what is happening. All of the Health Protection Agency is moving entirely, as it is now, into Public Health England, so the experience of people at local level will not be disturbed by these changes. Directors of public health, with everything that has been said this afternoon, are asking what it is going to mean and who will be doing what. The practical experience of outbreaks, whether it is measles, food poisoning or something going wrong on a petting farm, is that 90% of these incidents are handled locally, and always will be. Public Health England from now through to April and beyond will be the responsible people for making sure that the resources, when something escalates, are there, so it is all about people and relationships at local level. I will do everything I possibly can to make sure that people know whom to talk to from day one and we simply do not have that risk emerging.

**Q21 Simon Danczuk:** On 2 April there is absolutely nothing to worry about. You are saying to me and others who have raised concerns that if something goes wrong you will be ready and it will be dealt with.

**Duncan Selbie:** We will be ready.

**Graham Jukes:** These controls are already in place. Environmental health officers in local authorities deal with E. coli, Legionnaires' disease, problems with public and private water supplies and outbreaks. They rely upon the support of the HPA, now Public Health England. There is concern about the shape of local government in terms of the cuts it is having to bear and the austerity measures, but largely it will not be as a result of the changes that are taking place; it will be about how local authorities can respond to those challenges and what responses they can get from Public Health England and others as we move into the new structure.

**Q22 Simon Danczuk:** Nick, you have an interest in the NHS Commissioning Board in terms of public health. Are you also comfortable with all the contingency arrangements?

**Dr Hicks:** I can speak as the DPH in Milton Keynes rather than for the commissioning board. My experience on the ground is that we already have good relationships with the environmental health personnel and other colleagues in the council, and we have excellent support from the Health Protection Agency. There is new clear guidance about how the system should work in future, and already the directors of public health, local authorities and the Health Protection Agency have well developed conversations and plans. I believe the personal relationships will stay

very similar for now. We have one detail that is a geographical change; we have to work out how we relate to the Thames Valley and a different Public Health England centre, but I have no doubt that that work is manageable and is being managed. I do not share the anxiety that has been reflected to you.

**Q23 Simon Danczuk:** John, are you comfortable that we have cross-boundary working across local authorities at sub-regional level?

**Dr Middleton:** I have every confidence in what Duncan Selbie describes from Public Health England, and very little confidence in what I have heard described in relation to screening, immunisation and emergency planning around the NHS Commissioning Board. I come back to the word "assurance". The staff we have trained and developed in Sandwell who are involved in screening and immunisation on a daily basis are destined for Public Health England and to be seconded to the National Health Service Commissioning Board and managed by heads of public health commissioning with no qualification in public health necessarily. You would not invent that system if it was not for the extraordinary difficulties that the health reforms put us in.

As to health protection, we need to emphasise that there is a whole preventive infrastructure in place in local authorities, as Graham described, but there has been a very successful infrastructure for infection control in primary care trusts. The district infection prevention control officers have an excellent story of reducing healthcare-acquired infection. These are not things where the Health Protection Agency historically has done a great deal of hands-on work. These are ecological problems. If pharmacists prescribe loperamide, GPs prescribe antibiotics, care homes do not clean their mattresses more than once every 15 years and hospitals do not record the data on clostridium difficile, potentially these send infections spiralling around our communities, and we need to be able to see that preventive work carried on in local authorities.

**Q24 Simon Danczuk:** I was reassured until you spoke.

**Duncan Selbie:** John conflated two things: screening and immunisation is a separate matter, which we can touch on if you wish. You were asking about health protection. My categorical assurance to the Committee is that there is no cause for anxiety or concern about managing this in a safe way. In the Health Protection Agency we have a world-class organisation; it is rated internationally, and we are very good at it. It is coming into Public Health England in its entirety. We have embedded public health teams in every local authority, and we have been very careful about getting guidance out. That helps, but what matters is relationships. Those conversations will be going on, and watch what happens on 2 April. It is not going to be any different from 31 March. There is an issue about screening and immunisation. I agree that we would not have invented this, but it is my job with others to make sure that we have a safe transit, but do not conflate the two things; they are not the same.

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**Q25 Mark Pawsey:** I want to ask about funding and ring-fencing, but I start off with health inequalities. The Advisory Committee on Resource Allocation has set out its interim proposals. Mr Jukes, your institute is very critical and has said that, "For a local authority with high levels of deprivation and poverty, a formula which does not explicitly distribute the grant funding by reference to such matters will see its ability to address health inequalities decline over time." You are critical of the funding method, but you also go on to say that "the forecast £2.2 billion available for local authorities is insufficient by 50% ... and public health services ... are in danger of being set up to fail". You are critical of both the amount of money being allocated and way it is being distributed. How would you change things if you were given a blank piece of paper?

**Graham Jukes:** I would provide more money.

**Q26 Mark Pawsey:** That is very easy.

**Graham Jukes:** It is a very easy answer. If I may, I will just sidestep that question with a broader one. The money we are talking about here is about the transfer of the functions. At our conference on Monday, the Minister was very kind to say that the funding base would be provided very soon, so we are expecting that certainly by the end of this month, if not early next month.

**Q27 Mark Pawsey:** So is the figure I have given wrong?

**Graham Jukes:** We do not know what the figure is. At the moment those are estimates. The Minister will be publishing those figures, and once we know what they are, we can comment further.

**Q28 Mark Pawsey:** Whatever it is, it is too small, as far as you are concerned?

**Graham Jukes:** If it is of that order, it will be. But the broader issue I want to touch upon is that of local government. I made a comment earlier about the preparedness and readiness of local government not only to receive these functions but carry on doing their normal work. Within the last three years local government has lost 30% of its resources. In environmental health terms that is about 8% of the resource base. There is concern that further spending reviews will add to that burden, which means that coming into local government is a function that needs resource and investment and an existing workforce and structures that are being diminished as we speak. Different structures and systems are emerging. We have a bigger problem here, which is not just about the amount of money but where we put our investment and focus on workforce planning, and how we invest in that for the future. It is a bit trite to say it is not enough, because it will never be enough. The real question we ought to be asking is what we need to do with that money, how it will be effectively used and how we will tackle that.

**Q29 Mark Pawsey:** What are the views of the others on dealing with inequalities?

**David Buck:** When we looked at this issue, there were three or four core things. One is: is the amount of

money right? You would expect the Department to have worked out what amount of money is required, as opposed to counting how much PCTs have spent in the past. I am not sure whether or not the Department has done that, but that is critical. A formula, even if it is perfect, depending on your views on the formula itself, will redistribute only a given pot; it will not tell you how much you are supposed to spend. It is a real shame that the Department does not seem to have done that work. If it has, it has not made it public. You are quite right that, as far as we know, possibly £2.2 billion will go into local authorities. The rest of the pot, about £3 billion, is still the domain of the NHS and the NHS Commissioning Board in particular. We have not talked that much about the NHS Commissioning Board today, but clearly it has a massively significant role, particularly in screening and immunisation and so on. The relationship between Duncan and the commissioning board is a critical one. None the less, there is a question about the amount. I do not know whether or not it is right, and it is hard to say. One would hope the Department would have taken view on that and made that public as it was doing this work, but it has not as far as I am aware.

As to the formula itself, if you are going to choose a formula, the standardised mortality ratio under 75 is, I am sure, admirably simple compared with the NHS and local government formula. That has a lot going for it. There are real issues about that in the sense that a standardised mortality ratio under 75 probably tells you a lot about the experience of people in a local authority area over time who are now dying before 75. It tells you a lot about past problems in local authorities, but there is a real question about whether it tells you about the current problems in local authorities, particularly in areas with younger populations and behaviour problems, behaviour change, unhealthy behaviours and so on. There is a question about the variable itself. It may need to be supplemented by others. Others have suggested deprivation or some healthy behaviour-type indicators, which we now have through the public health outcomes framework.

The additional question is whether a formula approach is the right way to go. Our thinking as it has developed is that, if you have a given pot of money and you give local authority mandatory things to deliver, you should make an attempt to look at how much it costs to deliver those services from a bottom-up perspective. If you have a defined standard and an equitable standard, going to your point about inequalities, and money is left over, a formula may be a good approach to distributing what is left. SMR is a good stab at that, but there are cases for changing it. Because of the mandatory services, we should be after a formula plus, not simply a formula, and how you allocate resources should be driven by the system you have designed, and similarly for the ring-fencing question.

**Q30 Mark Pawsey:** I will come back to ring-fencing in a minute, but I would first like the views of the other panel members on inequalities.

**Dr Middleton:** I was a party to discussions about deprivation versus the use of mortality for the

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formula, and therefore I hold up my hand as part of the responsibility for that. All of the evidence of Marmot suggests that mortality is strongly related to deprivation. You could choose a deprivation measure or take the mortality measure. The problem is that, when you look at what is in the ring-fenced budget, it is not about premature mortality; it is about genitourinary medicine services, school nursing and drugs and alcohol services. We have used one formula potentially to describe a totally different set of problems and answers that we need.

**Q31 Mark Pawsey:** But does the formula deal with inequalities or exacerbate them in your view?

**Dr Middleton:** At this point it is the simplest and most straightforward answer that we can have to the question of inequalities as a pragmatic solution.

**Dr Hicks:** My answer is similar to John's. It goes back to what your definition of "public health" is. At the beginning we talked about the public health budget for a community. My aim as a director of public health is to get the totality of that money being spent, so in practice I am more interested in the total allocation in the community rather than the tiny percentage of that that is called the public health budget. That budget is used for specific services. If I look at my local authority, the three biggest items are sexual health services, substance misuse services and health checks. They are all good things to do, but they are a small subset of public health and not the major mechanisms to tackle inequalities. I would like the total formula coming into my population across the health service, police, local authority grants and all the rest of it to reflect the needs of my community. I would agree with the two other speakers that lots of these measures are highly correlated, so why not pick the simplest? The standardised mortality ratio for people under 75 seems a nice simple method and avoids lots of other complications.

**Q32 Mark Pawsey:** I want to come back to the services. Mr Selbie, what is your view of inequalities?

**Duncan Selbie:** I want all the money everyone has got for this, but I have a megalomaniac's view of it and want to own all of it. I want to comment on why we are in the position of not knowing what we have been spending. It reflects that all of us have conflated health and the NHS for so many years. I want to return to that. It is important that we do not see the NHS as about health; it is a contribution, but it is all the other things we have talked about that matter. If you ask the Department of Health what is being spent in A&E or in aortic aneurism surgery, or something going on in a hospital, they will be able to tell you precisely. If you asked them what they had been spending on public health, they did not know because we did not ask. The first thing we had to do was establish the base line. What have people been spending beyond the mandatory services? It is not a satisfactory starting position, because we are not addressing what you should be spending, which is the formula, but what you are spending. It was the first time we had ever gone through this exercise. We have to make sure that we are covering what is currently being spent—that is what the focus has been on—concurrently with the

examination of a formula. The first thing we have committed to is that local government will not have less than is currently being spent, and that commitment is for next year.

**Q33 Mark Pawsey:** Are you satisfied that is being done? Mr Jukes is not.

**Duncan Selbie:** We have been out several times. This has been an iterative process, and it is not yet complete, but we are committed to ensuring—I hope I have been very clear about it—that what has been spent by PCTs on public health will be transferring into local government intact. Then there is a conversation about growth, and that will be announced when the Secretary of State is ready. It will be some time before Christmas.

**Q34 Mark Pawsey:** This money is to be ring-fenced. How does that sit with the principles of localism? Mr Buck has lots of confidence in local authorities because he tells us they engage so much better and, on that basis, they should be able to spend money better, but we are ring-fencing it and determining what should be done with it. How does that sit with localism?

**Duncan Selbie:** I want more money to go into this, because the prevention agenda is where we will get in early, and it will save the country. It is an economic decision as much as anything else. This is the starting position; it is not the next conversation, or even the last one. What we are saying to local government is that we will make sure it will get what is currently being spent by the NHS. It will not get less than that. We will see what we can do about growth, and there is a conversation to be had about the pace of change. We have said there are five matters that are mandated, including the health check Nick talked about; the sexual health service; the provision of advice to CCG. We have not mandated drug services, for example, and about a quarter of the funding going into local government will be for drug services. You cannot say the mandated services are everything that has been spent on the public; it is part of it.

**Q35 Mark Pawsey:** Mr Buck, are you happy to see this level of mandated services, or do you have more confidence in councils to react to their own individual circumstances?

**David Buck:** I have a personal view, which is probably not the Fund's view.

**Q36 Mark Pawsey:** Give both of them.

**David Buck:** Maybe it is the Fund's view; I am not sure. I completely accept Duncan's point that we have never measured public health spend before. It is a very difficult thing to do. The fact that PCTs were just left to spend whatever they wanted on public health is a bad thing and we are moving to a better position. The other positive thing to say about inequalities is that, as far as I understand, the formula will be based on very small area estimates of inequality rather than local authority-wide. For instance, we know that Westminster overall is a very wealthy authority but it has very small pockets of deprivation. That did not really get reflected in its allocations under the old

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system and it will do under the new one. That is a positive move for inequalities. PCTs spent basically what they wanted. Some of the forward-thinking ones invested a lot in public health; some of them did not invest very much at all. We can have a debate about the formula itself and whether it is formula plus baseline or whatever, but the critical thing is the transition to what the formula implies. We know that is very different from where the money is at the moment, so the transition to the formula is going to be the critical issue. Because there is likely to be very little growth in public health budgets, it is going to be hard to move to where the money should be from a fair basis, which is England-level need, versus possibly taking money out of, or certainly not giving extra money to, authorities that have probably invested more in the past. There is a real issue about transition. Either you are unfair to local authorities who have put in a lot of money in the past or unfair to the need as a whole, and that is a tricky thing for the DH, Public Health England and the Minister to decide.

**Duncan Selbie:** Which is why it is taking us some time.

**Dr Hicks:** You are not going to tackle inequalities with £2 billion nationally; it is the totality that makes a difference. Over the last decade there have been examples of where things have improved. You can measure inequalities in different ways. You can measure either a slope or the gap between two different bits of a population. An example of where things have gone well is that a national target was set for the reduction of inequalities in infant mortality. That was supported by concerted action nationally. There were public service agreements in which every department of state bent its actions to that, supplemented by freedom and incentivisation of local authorities through local public service agreements. I do not think it is widely understood. That target was hit two years early. Everyone said it could not be done, and combined action nationally, co-ordinated with appropriate local incentives, produced a fantastic result. We got infant mortality down to the lowest levels we had ever seen and the inequality reduced, and the national target was hit two years early. We do have examples of how, by bending the totality of resources, not just this tiny sliver labelled public health, we can do something that is genuinely wonderful.

**Q37 Mark Pawsey:** Dr Hicks, I think it was you who spoke about the difference between preventative work and the fact that might get squeezed because of the amount of demand-led services, such as perhaps sexual health. How do we deal with that tension? Where should the priorities be, or should we leave that to local authorities?

**Dr Hicks:** This is now personal opinion. I could not conceive of not providing comprehensive health services that are both preventative in nature but also respond to demand. Personally, I would like to see the same for substance misuse services too. There are difficult trade-offs to be made against other preventative areas. I do not think there is a single right answer. Personally, I would make sure there are

services that need to be provided, just as you need to provide education services, and hold people to account for providing those services but still allow a lot of local discretion for people to design them. I like the idea of holding people to account for outcomes. The strength with which you hold people to account is also important.

**Q38 Mark Pawsey:** Has the Advisory Committee on Resource Allocation got this tension right? Does it need to go back to the drawing board, or are you broadly happy with where it has set things?

**Duncan Selbie:** It has yet to report, so this is the stuff of the next few weeks. Can I just comment briefly on Nick's point? One of the things we could do so much better, to go back to the earlier point about the spread of knowledge, is understand how people are approaching this in different parts of the country and with what impact; that is, making sure others know about those who are able to do better with this. It is not just about how much we are spending but how well we are spending it. If we take sexual health services and the way these are managed and distributed and who is providing them, there are many different ways of doing it. Some are more efficient and some cost less and some cost more. We will be able to make sure people are aware of what works at what cost and what their options might be. It is less about whether or not they have it and more about how they go about ensuring it.

**Dr Middleton:** In response to your question about the overall allocation, if we simply reallocate the pot we have, we will disadvantage those who have spent more against their level of need now. As we have with health service allocations in the past, my understanding is that we are looking at the formula to move people or not, as the case may be. There are other real problems with the ring-fenced budget not specific to the ring-fence: the level of investment we are talking about, £2.2 billion, and the risks around GU medicine, which is growing by 3% or 4% a year. For my PCT an extra £400,000 a year was nothing out of £500 million, but my local authority is extremely concerned about £400,000 out of £20 million. This is an area of risk that local authorities are very concerned about. In Westminster two-thirds of the budget goes on the GU medicine service, and they could spend all of the ring-fence in a very short space of time with those increases in activity.

**Q39 Bill Esterson:** John, I was going to ask about the impact on local authorities of this additional service and their ability to manage it. If you look at the LGA graph of doom, everything excluding social care and waste management by 2020 will have lost 90% plus of its moneys. If what you have just said is right, there will be pressures on the remaining 10% to fulfil the public health function. Social care is a demand-led service, which already puts that under pressure. There are additional demand-led services. Can local authorities cope with this?

**Dr Middleton:** I raise it because I see it as a major risk. Whether or not, as we have had in the context of NHS investment, you can have some kind of shared risk programme for that, clearly it is something that

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adds to demand-led services. The additional complication for local authorities, which also impact on providers, is moving back to resident-based payments versus responsible population base. I do not think our providers are geared to that, so either there will be a shortage of service or people with invoices that they are trying to get paid.

**Dr Hicks:** The straight answer is that I do not know whether or not they can cope, but I hope there are other benefits of public health expertise going into local government. For example, I like to think that we have a scientific as well as political approach to our work. There are things we could help about improving efficiency and value for money that comes from social care, for example. I see very little data about the effectiveness of individual interventions. I do not know whether intervening one step lower prevents three people going to a more expensive and severe level. I hope we can work with colleagues in social services and others to apply those sorts of approaches that have been relatively familiar as a process within health services.

**Graham Jukes:** There has to be investment in getting ahead of the curve. It was Derek Wanless who coined that phrase. The problem is that the unaffordability of the current NHS system of services and transfer of public health into local government gives an opportunity for us to start to address some of the preventative care issues from a housing and whole-place perspective. I certainly do not think the existing amount of finance will be enough to get us to that place. I want to look into the future once we are past the recessionary process we are currently in and build a system within local government that can respond to some of the more inherent issues to do with people's health. We have to play a long game here; we have to build and invest in structures that will help us address inequalities in health over a much longer period of time.

**David Buck:** I do not think we should fool ourselves that preventative public health is going to save vast amounts of money very quickly. Public health certainly can be cost-effective and in some circumstances save money, but most of public health—I would imagine other panellists would agree—is about delaying costs. We will all get old and pass away from something. One of the successes of the NHS is that we are now seeing a much older population that is very frail, which then leads to high costs later in life. It is almost another epidemiological transition, with increasing rates of dementia and so on. That is part of the success of the NHS as a treatment organisation and, in the past, in terms of public health intervention. We should not sell public health as saving the NHS, because I do not think it necessarily will, but it is a good thing in and of itself and we should do those public health things cost-effectively. To go back to ring-fences—I apologise that I did not answer your question—our view is that they are more appropriate when what you have to deliver is very specific. If you have to deliver a specific service to a particular standard, you know what you are delivering. You are already interested in delivering processes, so doing things to people rather than outcomes per se, and you have a lot of clarity about what needs to be

done. You are not particularly concerned about innovation. If there is a ring-fenced budget, you can add it up and know how much to spend on it; it is an obvious service that you have to deliver. Ring-fences in our opinion are less appropriate when you expect and want more localism and innovation, so you want variation. It is the outcomes you are interested in that are really important, not how you get to them, and you expect local areas to deliver them in the way that is fit for them with no specific configuration of services. You are not specifying that, but also critically you have strong accountability to the funder, which in this case in this transfer is the Secretary of State for Health's budget.

As to where we are with the current system, we would argue that you should design your system and then decide whether you need a ring-fence, rather than decide to have a ring-fence and design the system. Clearly, there are elements in current public health service where we are moving to that latter system. These reforms are the direction of travel, but we are not there yet, which means there is some debate about ring-fencing. We may be moving to letting go of ring-fencing, but clearly there are some public health services, particularly health protection, which are very much specific and mandated; they have to be there. You cannot slice away at the edges, because if you get rid of the edges the whole thing collapses. On the question of ring-fencing, you need to design the system first and then decide to what extent you need a ring-fence, not the other way round.

**Q40 John Stevenson:** If in a perfect world you get your funding formula right, your ring-fenced funding and public health directors in place, to go back to one of our earlier questions about the political element, is there not a danger, particularly in the present environment, that there will be tremendous pressure coming from local politicians, probably chief executives and so on, to allocate the funds in that ring-fenced budget in a slightly different way so that it is more in tune with what the politicians want than necessarily the public health director wants?

**David Buck:** I am sure there is. We have not talked too much about the outcomes framework today, but accountability for them, both locally and nationally, is critical. Duncan talked a little about accountability as well as focusing on understanding and the incredible science around public health. It is also critical to get the accountabilities and then the outcomes right. From our perspective, we are not as concerned about how you get to the outcomes as long as you get there and you have accountability for them. That is an easy thing to say and a hard thing to do.

**Duncan Selbie:** The point and purpose is political leadership at a local level working out what matters and having the resource to address it. I agree about the ring-fence and where we have come from. It was a concern that at the initial stages we needed to get some protection of the public health moneys, but the point is to get to a stage later, and soon, where that would not be so very necessary. We have matured again.

**Dr Hicks:** All the way through we have had the comment that everyone has recognised the

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opportunity and how fantastic it will be when local government has put health right at the centre of what it does. I am sure that will happen in lots of places. It is also worth asking the question: what if there were places where that did not happen and they did not see health as the most important thing in life? If one is honest and stands back to look at the history of public health, many of the biggest advances have come by bloody-minded people challenging strong vested interests in their local communities, whether it be the Factories Act or slum clearance. What if you had a community where the main source of income was a tobacco factory, and the health and wellbeing board came up with fantastic tobacco control plans? One can imagine the scenario where people are voted in by those whose livelihoods depend on tobacco sales. In that community perhaps the money was disappearing and substance misuse services disappeared. It is worth asking ourselves: what is the protection for people in those sorts of areas? Much as I would like to think I could win every political battle, in reality I know that is absolutely not the case. There will be things on which I and perhaps others feel strongly where in the politics we lose the battle. As well as being rosy and very optimistic about the opportunities, there will be places where the opportunities are not realised and things go in the opposite direction. We do need to ask ourselves how we intervene and hold people to account in those circumstances.

**Dr Middleton:** For many years in the NHS I believed that we were arguing our case in each round of development and prevention would win out in the end, and I did not want a ring-fenced budget for it. In about the last year in the NHS I became convinced that ring-fencing was essential. The justification for our move to the local authority was the lack of success of public health being recognised in the NHS. We need a ring-fenced budget protected for the foreseeable future, perhaps an expanded one, and in that great future with local authorities recognising the value of health, we will have a much bigger ring-fence created by local authorities.

**Q41 John Stevenson:** Moving on to the health and wellbeing boards, they have been widely welcomed, but there is concern that they do not necessarily remove the barriers to joined-up care; some boards are moving at a faster pace than others and some will get left behind, and obviously some will be very successful. The danger is that the initial enthusiasm for them will wane as time passes and realities of life kick in. How are you going to deal with that?

**Graham Jukes:** As to success so far, some research has recently been carried out, which we released on Monday, indicating that most health and wellbeing boards were structurally being set up reasonably well. The issue is about how health and wellbeing boards co-ordinate with their respective councils at the top tier of local government and how they are engaging with district councils below that. We are starting to see parallel structures being created with local health and wellbeing boards and local JSNAs. They are starting to tease out the issues within local government. In terms of the structure, shape and direction of health and wellbeing boards, we are

seeing those established well. The statistic that comes to mind is that 95% of all local authorities have those well in place as shadow mechanisms. The challenge is how those health and wellbeing boards are properly informed by their constituent parts, and how that cascades down into policy and strategy delivery. As colleagues said, it is about the outcome at the end of the day. If health and wellbeing boards are not being properly advised—from a professional and parochial perspective, environmental health practitioners are not represented on health and wellbeing boards because they are largely at district council level—there is lack of influence there. Putting that professional parochialism to one side, I see health and wellbeing boards being set up reasonably well at this moment.

**Dr Middleton:** For once, I can be completely upbeat about something. Health and wellbeing boards are being embraced. They have the benefit of having some continuity with the health and wellbeing boards that have been in place since 2007 in many cases. They also have the benefit of being the least prescribed part of the Health and Social Care Act. There is a lot of scope for local determination of what they look like. They also have the benefit that they are the glue; they are the central point. They are the only coherent part for many local authorities, and they are the engine room through which health strategy can be delivered. It is a body we need to support and develop.

In Sandwell it is chaired by the leader of the council, and that top-level seriousness that is going into the health and wellbeing board is extremely crucial. We have seen it at least as a meeting of commissioners; it is not yet a commissioning body, but we will need to pool more budgets potentially, not fewer. We will certainly need to share our parallel investments in alcohol, drugs and so on, and it is a forum we want to support.

**Q42 John Stevenson:** Clearly, you are an enthusiast and see them as a positive thing, but is there a danger that some councils will take more interest in them than others, and therefore you could end up with a two-tier system?

**Dr Middleton:** It is. As I said earlier, there needs to be a minimum expectation across the board about what is acceptable and necessary to deliver a safe public health system. There are real concerns and tensions in county councils and districts. There will be different solutions in different councils, so it will not be one size fits all, but there has to be something and that is what we need to monitor.

**Q43 John Stevenson:** Does a two-tier system concern you at all?

**Duncan Selbie:** Yes. I am sure I should reciprocate and say something really miserable, but I do not feel able to. That is the essential message. When we talk about real life, there will be differences around the nation and it will wax and wane a bit, but we are all seeing health and wellbeing boards as the front line where these big engines come together—the commissioning board and local government responsibilities—to make sure we have got one set of priorities and not competing ones. We have to believe this is going to be better than anything we have had



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before, but of course there will be differences in commitment and in just how effective these organisations are.

**David Buck:** I will be positive about this as well. We have seen a lot of enthusiasm on the boards we have helped to develop, both on public health and broader issues as well. They are essentially all natural experiments, so we will see a lot of variation in terms of the structure, the number of people on them and, therefore, the decisions they take, if they do end up taking decisions. The ones we are working with are starting to think, “Are we really commissioners, doers, checkers or inspirers? Is it our role to set the long-term vision? Is it our role to do some short-term fixes year on year?” The answer is yes to all of those in certain parts of the country. We have to keep our eye on how that is going, and we intend to do another survey soon about that. We will see a lot of variation around services. The critical thing is that that does not translate into a lot of negative variation around outcomes. That is where localism and accountability for outcomes come together. We probably need to do a bit more thinking about that. The concern is that outcomes start to drift. Duncan and the Government have been very clear that Public Health England is not a performance manager in the way the Department of Health used to be, and sector-led improvement is the way to go, but I do have some concerns about how we support the real tail of possible poor performance. That may come about because of greater localism. That is an obvious risk of localism, but there are many benefits as well.

We are generally very positive about health and wellbeing boards. We have to be careful about expecting too much of them too early. Although we have been talking about them for ages, they are still not there. When the money starts to hit and they take those really big decisions, we have to think about how it is working. We have seen some great health and wellbeing boards with a shared vision locally, which is fantastic; they are starting to get their plans and leadership right. It brings together GPs and councillors, which is critical, but some of them are not thinking about the money. They agree everything and so on, but they have not put the resources alongside it. I am not sure how representative that is, but that is the thing on which they have to focus next, and we have not talked about the wider context.

**Q44 James Morris:** I want to pick up one point about the health and wellbeing boards. The King’s Fund raised a concern. If they are to be a commissioning body, will that detract from integration of care? Do you have any views on whether that is a danger with health and wellbeing boards?

**Dr Hicks:** If they are a commissioning body, that would promote the integration of care. If you have all the commissioners in the community sitting together round one table and they have decided to commission something together in a common policy and spend their budget in a co-ordinated way—John mentioned the pooling of budgets—particularly if they ask for a set of outcomes rather than processes, the way the providers respond would have to be more integrated, for example on the basis that they are all being held

to account to deliver a set of outcomes for the frail elderly.

**Q45 James Morris:** Mr Buck, you raised the issue that, because of the potential exclusion of providers from health and wellbeing boards, this might create some problems.

**David Buck:** What is right locally is right locally, but about one-quarter of health and wellbeing boards according to my survey earlier in the year had providers on the board. Other health and wellbeing boards will deal with it in different ways. Some have provider forums, for instance, as a way of separating the commissioning from provision and the potential conflicts of interest. There is variation. Personally, it is good to get everyone around the table, but obviously there are some conflicts, which I do not think have been necessarily sorted out.

The other issue about health and wellbeing boards that we have not touched on very much is the role of the NHS Commissioning Board. That is the big player with the big money around the table. We have had some concerns in our survey that people were not convinced they would be able to influence the NHS Commissioning Board locally around health and wellbeing. That is a real pressure. For me, that takes us back to the issue of accountability. Going back to the history of the NHS, CCGs are looking very closely at the commissioning board in terms of whom they follow. We have the commissioning outcomes framework between the NHS outcomes framework and the CCGs. It is very strong accountability up to the NHS Commissioning Board. The public health outcomes framework is explicitly different from that; it is much more about transparency. There is a concern that health and wellbeing boards will not really get the commissioning board input into local decisions.

**Q46 James Morris:** Mr Selbie, you wanted to make a final point.

**Duncan Selbie:** I was going to draw a distinction between the commissioning of integrated care and how we involve providers, not just statutory ones but the voluntary sector, in the design. When we talk about commissioning, what really matters is that you involve the provider in all its different forms in the design of what you are seeking to commission and separate that from the commissioning, so you have dealt with the conflict. You do not deal with the conflict by excluding them; you get them involved in the design.

**Q47 Chair:** That leads on to the final point. The NHS Confederation has been concerned about the eight different commissioners of child health services. There are many views around the table at the health and wellbeing boards. If you then bring in providers, schools and police and crime commissioners, will you not get to a situation where nobody is going to make a decision about anything? They will just sit down and talk for a couple of hours.

**Duncan Selbie:** That is the point. If you say you cannot be involved because you might be conflicted, it means that 90% of the folk cannot be in the room. I am drawing a distinction in terms of how you

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involve folk in the design. What does “good” look like? Then it is a matter of what the subsequent commissioning looks like.

**Q48 Chair:** But you have eight different organisations involved in commissioning child health services.

**Duncan Selbie:** You are picking a particular area.

**Dr Hicks:** There is a lot of anxiety about that specific issue. I was part of the Children and Young People’s Health Outcomes Forum. There are people talking about ways in which that can be overcome. For example, most places have either a children’s trust or the remnants of one as some sort of children’s partnership. I know there are certainly places where people think that group, which brings together interested parties and children, can have a relationship with the health and wellbeing board as a sub-committee. Some people are suggesting delegating to that body the production of the joint strategic needs assessment and a joint health and wellbeing strategy for children. If you have all your children round that area, including representation from the commissioning board, CCGs and local authorities, you are in a very strong position. You have one needs assessment, one plan and all the commissioners. If they present their money, effectively you have a

co-ordinated budget. All you need to do is apply to the commissioner because you now have an integrated service by bringing everyone together. If all people are conscious of that risk, there are ways it can be mitigated locally.

**Dr Middleton:** An additional positive is that the fact commissioning for drug and alcohol misuse, vulnerable young people and so on is coming into the local authority on the back of public health is an opportunity to bring the safeguarding of children closer to a public health agenda. In dealing with issues of domestic violence, new migrant populations and all these things there is a chance of a more co-ordinated approach by local authorities, but the overall issue of eight separate commissioners is a problem. The NHS Commissioning Board doing the nought to fives until 2015–16 suggests that we do not trust local authorities with that kind of commissioning, and that is a mistake.

**Chair:** There are issues we will want to come back to. One of the things we have heard about today is the real opportunity for some good innovation and progress, and the concern that probably we will have a problem with those authorities that do not really get it. That may be something we have to follow up in due course. Thank you very much indeed to all of you for coming to give evidence to us.

## Monday 26 November 2012

Members present:

Mr Clive Betts (Chair)

Bob Blackman  
Simon Danczuk  
Bill Esterson

Mark Pawsey  
John Stevenson

### Examination of Witnesses

*Witnesses:* **Councillor Steve Bedser**, Member, Community Wellbeing Board, Local Government Association, **Dr Peter Carter**, Chief Executive, Royal College of Nursing, **Councillor Alan Connett**, Executive Lead for Health and Wellbeing, District Councils' Network, **Professor Gabriel Scally**, Director of WHO Collaborating Centre for Healthy Urban Environments, University of the West of England, and **Dr Penelope Toff**, Co-Chair, Public Health Medicine Committee, British Medical Association, gave evidence.

**Q49 Chair:** We welcome all of you to our second evidence session of the inquiry into the role of local authorities in health issues. Thank you very much for coming to give evidence this afternoon. For the sake of our records, please say who you are and the organisation you represent. That would be helpful to us.

**Dr Toff:** Dr Penelope Toff. I am Co-Chair of BMA's Public Health Medicine Committee, and Consultant in Public Health Medicine and Deputy Director of Public Health from NHS Brent.

**Professor Scally:** Gabriel Scally. I am currently Professor of Public Health and Planning at the University of the West of England, where I am Director of the WHO Collaborating Centre for Healthy Urban Environments, and I am a former Regional Director of Public Health.

**Councillor Alan Connett:** Councillor Alan Connett; I am lead spokesman on health and wellbeing for the District Councils' Network. I am a member of Teignbridge District Council and Devon County Council.

**Dr Carter:** I am Peter Carter, Chief Executive of the Royal College of Nursing.

**Councillor Steve Bedser:** Hello, I am Councillor Steve Bedser. I am here representing the Local Government Association Community Wellbeing Board, and I am the Cabinet Member for Health and Wellbeing on Birmingham City Council.

**Q50 Chair:** You are most welcome. There are five of you; it is quite a large panel. If you find yourself agreeing with something someone else has said, an indication that you agree without repeating everything is helpful to move us along, because we have quite a wide-ranging area that we would like to cover with you. With regard to the proposals for the transfer of the public health role to local government—or the reintroduction of public health to local government, as some people remind us, given the history of it—what do you think is wrong with the current arrangement? Is it essentially that the NHS has marginalised public health and hopefully the changes will bring it back to centre stage?

**Councillor Steve Bedser:** I am hesitant to criticise the NHS for the history of the last two or three decades, but it is very clear that the return of public health to local government, and indeed there are environmental

health colleagues who will say the joining up of the public health family into local government, is something we welcome. If you think about the functions of local government and take a social view of the determinants of health, so understanding that people's health status is driven by their housing, education and employment status, it makes tremendous sense for the function of the public sector that is responsible for driving the public health agenda and reducing health inequality to sit alongside all of the other services that have an opportunity to affect people's life chances and health status, rather than being conjoined with the bit of the system that is dealing with people once it is too late in public health terms, i.e. fixing people once they are ill. It is a welcome opportunity. If you think about the range of views associated with the Health and Social Care Act, it is quite significant that this is one that enjoys perhaps the most unified support.

**Dr Carter:** If I could complement that, we had and still have significant reservations about the Health and Social Care Act. However, we think this part really makes sense. Eons ago it was ill-advised to have taken this away from local government, and I think it gives a wonderful opportunity to give public health the profile and focus that is needed. As Councillor Bedser says, the health service is under huge strain at the moment. That is not a criticism of the health service; it is a fact. In some areas the NHS has done well over the years, but we could do much better on the preventative aspect of the nation's health.

**Councillor Alan Connett:** From our point of view the benefit of return is that there will be a more holistic approach to public health. Our view generally about the new arrangement is that the significant contributor, the district councils, do not receive a parity of esteem. Nonetheless, it is much better that all the parties are working together rather than seeing it in isolation as an NHS priority.

**Professor Scally:** I have long supported public health returning to local government, although I wish it were happening under more auspicious conditions than at present. However, it is not a full return to public health. When you look at the allocation of responsibilities, a substantial amount of those responsibilities are going to the National NHS Commissioning Board and to Public Health England, which is an integral part of the Department of Health,

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and being centralised in the civil service, so it is not a full transfer.

**Q51 Chair:** Would you have transferred the lot then?

**Professor Scally:** I think there is a discussion to be had, which we may well come to, about infectious disease and emergency planning and so on. I think it is a matter for regret that the directors of public health will be the first public health officials in local government ever, or medical officers of health, who have had no responsibility, for example, for childhood immunisation. That responsibility will be with the NHS Commissioning Board. There are serious problems around the allocation of resources and functions, but in general I think local government provides very many welcome opportunities.

**Dr Toff:** I agree with much of what has been said. The problem to date has been that, although there were many joint appointments of directors of public health, there was not always the joint working that should have gone on with local authorities, which could have really made a difference to the wider determinants of health. However, where those relationships were working well, we have some really good examples of the kind of work that can be done, and the move into local authorities should make that much more achievable.

I agree with the comments about fragmentation. We do not want to go from a situation where we had some fragmentation to one where we have even more, so we need to guard against that. I also think there were advantages for some directors of public health and public health teams within the NHS in that they had a certain amount of independence, and that lent credibility to the advice that they gave. It is very important that they are positioned in such a way in local authorities that they do retain that independence and use it to the best of their ability.

**Q52 Chair:** Just to pick up one issue there, you mentioned that some areas have already got good working relationships and various partnerships. Would it be possible to just carry on building those rather than the organisational changes that we are now faced with?

**Professor Scally:** Primary care trusts are disappearing and a lot of their functions with them. It would be very difficult to see a DPH operating, for example, within clinical commissioning groups. Secondly, there has been a significant breach in co-terminosity around the clinical commissioning groups and local government areas, so I think there would be difficulties continuing.

**Q53 John Stevenson:** We have talked about public health originally being part of local government, then in turn part of the NHS, and now it is returning to local government. Quite clearly there are cultural differences between how things were conducted under the NHS and how they will be, or have been in the past, under local government. The BMA have expressed concerns that some local authorities see public health as any activity that improves the health

of the population rather than as a distinct health speciality. Should we be concerned about that?

**Dr Toff:** There is a concern because at the moment there is not a full and meaningful understanding of what public health is as a specialty. There are public health services that are in many cases already provided to some extent by local authorities, which can be extended and improved upon in terms of serving the population's health. We have to distinguish between those and public health services provided by public health specialists currently, and the huge breadth that those services cover across the different domains of public health. Most local authorities are more aware of the work done in health improvement, often because there has already been collaboration in those areas, than they are of the work that is done at local level in health protection and in supporting the commissioning of healthcare services.

**Dr Carter:** I do not think the clash of culture will necessarily be a problem. Sadly, one of the things that have bedevilled the NHS over many decades has been the perpetual reorganisation. NHS staff are used to working with different organisations and different architecture every few years. The biggest issue for us is that, by transferring across, we want to make sure there is not a brain drain and people with skills feel disinclined to come across. Particularly in relation to nursing staff, we need to ensure there is parity in terms of pay, pensions, and terms and conditions, but culturally our members overall think this is a very sensible move.

**Q54 John Stevenson:** Do you see it as a more stable environment?

**Dr Carter:** If it is allowed to mature, bed in, and is not subject to another reorganisation, this would be a sensible way forward for us. Local elected councillors tend to be people who have lived in the constituency and have a long-term perspective. Ultimately if it is allowed to bed in, there could be a much more stable and sensible approach to planning.

**Councillor Steve Bedser:** If you look at it objectively, the people who currently work in public health are going through a period of significant organisational change. I have had experience both of working in the health service and as an elected member. They are two very different cultures. At an individual level, people react to that differently. Some people will embrace the change and find it exciting, and others will be very worried. Mixed in with that, across the public sector, is a judicious amount of concern about job security, but I do not think there is a fundamental problem with making the transition. I have not heard the concern about public health being seen as about health inequality rather than a speciality. It is a sizeable resource that is transferring across, and I would be very concerned if people were not looking at that objectively as something that would be about driving health improvement and reducing health inequality, because that is the job we need to do. In my local authority we have got an 11-year gap in life expectancy between the rich and the poor. If public health is not going to play its part in helping the local

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authority close that gap, then I struggle to understand what its purpose is.

**Q55 John Stevenson:** Professor Scally, you have expressed some concerns about the position of the public health function within local authorities. What are your concerns there? Do you feel that it will be dominated by other aspects of local government, or do you feel that people coming from the NHS will be seen as a threat by the current employees of the local government?

**Professor Scally:** On the latter, I do not think so; I am not concerned about that. Although just to address that one point, I do think there is an enormous amount more that should be done to spread public health skills across local authorities. In the South West, where I was regional director of public health, we had paid for 57 or 59 people, nearly all of them from local authority backgrounds, to do diplomas or masters in public health. I know, as a director of public health, if I am having discussions with transport officials or leisure services officials, it is so much easier if they understand what public health is about in the first place. So I think there should be more widely spread public health skills.

My concerns about the transfer relate to the power and influence of the director of public health and his or her team, and their station within local authorities. We will see of course when it actually happens on 1 April where the location is, but I hear far too many reports of directors of public health potentially ending up as third in line, reporting to other directors, such as directors of adult social care, and being seen as part of that. Some directors of adult social care are making a very deliberate play to take over public health. After all, it is all about wellbeing, is it not? I know when those issues have been raised, the point has been made about the size of budgets. I do not regard that as a good basis for planning the structure of organisations when it comes to dealing with health, so I am concerned about their positioning.

**Q56 John Stevenson:** Where do you think it should be placed?

**Professor Scally:** I did attempt to prosecute my view on this, but I did not get very far. We should have a properly staffed office of the director of public health in each local authority, and it would report directly to the chief executive, or the executive leader of the council. It would not be in competition for the resources of the big budget holders and would be seen as a source of professional expertise across the council's business.

**Q57 Mark Pawsey:** There is a pretty universal acceptance that the return of public health to local authorities is a good thing. I particularly want to pick up with Councillor Connett, if I may, the omission of district councils from the health and wellbeing board. I am a former councillor on a district council and meet with my colleagues regularly. I think they are feeling a little bit left out, after all they are responsible for environmental health, housing and planning. Do you

regard the omission of district councillors as a significant one?

**Councillor Alan Connett:** Yes, I do. The District Councils' Network has done research, and district councils feel that they have not been able to engage as fully. Certainly, over the past 12 months, more councils are feeling more engaged. There has been a change from about 64% to 86% in councils now feeling that they are engaged. A lot of the statutory responsibilities actually sit with district councils; as you were saying, planning, housing and some of the economic development activities play a fundamental role in delivering better public health. I called it earlier the lack of parity of esteem: not having a dedicated seat at the table is reducing the opportunity for the public sector to work fully in delivering the requirements of the Act.

**Q58 Mark Pawsey:** Do you think that the Government's objectives are less likely to be met because of that omission? Professor Scally spoke about the need for the director of public health to be able to engage with professionals responsible in those sectors. Do you think that informal links will be made or do you think the omission from the health and wellbeing board is a really serious one and will stop us achieving what we want to achieve as a consequence?

**Councillor Alan Connett:** I think it makes it harder to achieve. Your words were "less likely". I would not disagree with that; I think it makes it harder to achieve. In most places I suspect there will be very good informal links, but that is not the same as being part of a decision-making process. Given the role that districts have, that seems to be an omission.

**Q59 Mark Pawsey:** Councillor Bedser, this will not concern you terribly because you are not from a two-tier authority, but have you got a view about it?

**Councillor Steve Bedser:** It is an observation, and Alan I were talking about this before we came to give evidence. I will leave Alan to speak for himself on behalf of district councils, because it is not a world I directly inherit. All health and wellbeing boards will inherit a degree of complexity. In my own situation we have got devolved structures that have given us 10 districts and four clinical commissioning groups. I am chair of the health and wellbeing board, and if we had everybody who wanted to be around that table, we would be holding our meetings in a stadium rather than a committee room.

We have all got different types of complexity to understand and embrace. If I was the chair of a health and wellbeing board in a county situation, I would not understand the opportunities and the challenge if I did not proactively engage my colleagues and representatives from district councils, so it is a measure of the quality of the partnership and leadership that is given by the health and wellbeing board. I think the external scrutiny and some of the peer and mentoring support that the Local Government Association will give to authorities that are perhaps struggling to implement the new structures is about that critical frank challenge to ask,

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“How are you involving other partners in two-tier situations?” or indeed, in my own situation, “How are you getting proper localism embedded into a unitary structure?”

**Professor Scally:** Health and wellbeing boards are a really interesting topic. I was the director of public health in Northern Ireland—chief administrative medical officer in Northern Ireland—and I arrived in England in 1993, just in time to see the last of the joint planning committees between health authorities and local authorities. In my limited experience of those, some of them worked extraordinarily well but some worked extraordinarily badly, resulting in pitched battles about the use of resources and who would pay for which particular aspect of care. I am extremely worried about health and wellbeing boards when you read the remit that the Department of Health has consulted on. It is largely about the commissioning of services, and you have to get well down the first page of that very short document before you come across health and wellbeing in its broadest sense.

**Q60 Mark Pawsey:** So do you consider public health itself is not a big enough priority on health and wellbeing boards in the first place?

**Professor Scally:** I personally think the construction of health and wellbeing boards is largely to do with the NHS and adult social care interface. In all my experience of working in the NHS and the Department of Health, that is where the concern lies. There is a great desire, for perfectly legitimate reasons, that there should be a very good working relationship around those issues, but I do fear that public health concerns and the overall health of the population will lose out. That is built upon by the fractured nature of the responsibilities. As you so accurately pointed out, district councils control many of the important determinants of health, including being the place where our separated brethren in environmental health reside.

**Dr Carter:** Yes, this is where we have some concerns. These things are not hardwired enough. We are not quite sure where the accountability lines are. Of course, a lot of it is to do with relationships and partnerships; that has always been the case and always will be. What you need is more detail, particularly on the accountability.

I would just briefly go back to Mr Stevenson’s point, and I agree with Professor Scally: in terms of the accountability of directors of public health, we feel very strongly that they should be accountable to chief executives because of the nature of the role. If they are third in line, you will lose the focus that is badly needed, particularly in England with the types of issues that we are seeing to do with health inequalities and the health of the nation.

**Q61 Mark Pawsey:** Dr Toff, do you have a view about the omission of district councils?

**Dr Toff:** It is not my particular area of expertise. I think the director of public health is probably quite key in this, because one way into this is through the joint strategic needs assessment. Whatever

arrangements are made, it is really important that all the localities are considered within that, and all of the differing local needs. Clearly, even though the recommendation from the King’s Fund is ultimately you do not want to have a huge core team there because the health and wellbeing board is probably not going to function well under those circumstances, you do have to find a very clear mechanism for the input of the district councils and all the other groups who you also need to take into account.

**Q62 Mark Pawsey:** I put it to you then that, if the health and wellbeing boards are about preventative work as the substantial priority, it might be more important for district councillors to be there than members of the clinical commissioning groups, who will get involved particularly when people become ill. The key objective of public health is to prevent people from becoming ill. Are the priorities wrong? Should the councillors be there instead of the CCGs?

**Dr Toff:** I do not think they should be there instead of the CCGs; both aspects of this are important. If you do not get the prevention right, the CCGs are going to struggle to deliver their part of the equation. The input from the directors of public health in particular needs to be seen as absolutely key here on both sides of that, from the point of view of the JSNA and the health and wellbeing strategy.

As another member of the panel has said, at the moment it is not clear how health and wellbeing boards will be held to account for that, and for including all the aspects that they need to include, and also for the public health input into the commissioning of services. They will be very key in that respect on health and wellbeing boards so that the boards have credibility in the eyes of the CCGs.

**Q63 Simon Danczuk:** Should objectives for public health be defined by central Government or locally?

**Dr Toff:** The public health outcomes framework that we have at the moment as a way of monitoring what is going on locally is a very sound framework. It covers a huge range of areas, and some of that is based on the very successful work of the health profiles that predated it, but it is not exclusive. Clearly there are other things that need to be taken into account, and other sources of data and mentoring that need to be looked at.

In terms of the health and wellbeing boards agenda, particularly around integrated care, in order to reinforce the positive working together and the putting aside of individual agendas that will be required, it would probably be helpful to have a more overarching national framework around integrated care and what should be achieved.

**Q64 Simon Danczuk:** Are there any other views on that?

**Professor Scally:** I think it needs to be both, and more than both. Identifying ways in which the health of the population can be improved needs to be a responsibility right across civil society. I can give you a very practical example of that. We have had data sets produced for some years now, and very recently,



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looking at the health of local areas and comparing them with the health of England as a whole. Large parts of my region, the South West, were completely useless because the health of the South West is very good. Many of our local authorities had nearly all of their indicators better than the English average. How dispiriting or difficult is it for a direct of public health to have that sort of report? It missed out on the fact that for many of those same indicators, the overall position of England is so much worse than other countries. So I think it requires national and local analysis and strategies, and the mixture of both should be able to address the health needs.

**Q65 Simon Danczuk:** Supposing they clash though, Professor?

**Professor Scally:** If they clash, they clash, and you work out how they clash. I have spent the last five or 10 years of my professional life trying to frustrate the Government's ambition to reduce health inequalities in this country. The target was set as the difference between the top 10% of local authority areas and the worst 10%. We did not have any in the worst 10% and we had some in the top 10%. So the best I could do, as a regional director of public health, to help the achievement of that target was do nothing, or in fact make the health of the territories I was responsible for worse. I was not going to do that. Our local authorities were not going to sit back and do nothing in order to achieve such a daft target. So it has to be a mixture of both, and people must be allowed to act within the system in the interest of the population they serve, whether it is the population of England as a whole or the population of a local authority.

**Q66 Simon Danczuk:** Alan, do you want to comment?

**Councillor Alan Connett:** I would, Chairman. I share some of what Professor Scally says, but also within my own county of Devon there are quite significant health inequalities, and Devon must be able to respond to that. I personally feel, for the sake of labouring the point, that what we are missing here is an opportunity for the districts to be engaged on that. Ultimately life expectancy is lower in the north of Devon compared with the south of Devon; health and local authorities in the county as a sector need to be able to address that. I think the primary situation is for the local authorities to set their objectives.

**Dr Carter:** The common theme is that if you just rely on a local, federated approach, you will struggle. Equally, if you try to do this from Whitehall, you will struggle. You need some overarching principles. I travel all over the country in this job and I see huge differences. We need some overarching architecture. There are some common denominators, but you need to be able to say to local authorities, "You need to develop what is right for your area, otherwise you will really struggle."

**Councillor Steve Bedser:** I would echo some of that sentiment. I come from an area where 40% of our population are among the 10% most deprived in the country. The narrative of health inequality is very useful, but I recognise the merits of both national and

local levers in focusing on outcomes. If we focus on the wiring diagrams or who is or is not in charge, we waste energy. We should be focusing on what makes a difference. Using a framework like Marmot to interpret your local situation, and then locally determine what needs to be done to make improvement, is a very helpful concept.

**Q67 Simon Danczuk:** In terms of what we should measure, should it be based on a particular aspect of public health, such as obesity, or should it be more general, such as healthy life expectancy? We could just measure happiness or something like that. Should it be precise or more broad and general? Any views?

**Dr Toff:** I just wanted to come back on your previous question.

**Q68 Simon Danczuk:** Are you going to answer this as well?

**Dr Toff:** As I said, the overarching outcomes around healthy life expectancy and reducing inequalities are the right ones, and it is important that the outcomes framework is based on evidence and what we know makes a difference. It is important for that reason, so I hope that answers that question.

Going back to the previous issue, there is a real problem around the lack of data that we have for marginalised and vulnerable communities. It will be very important locally to try to ensure that we do include those groups, in terms of the engagement of the health and wellbeing board and more broadly across the different areas of local government and public health, to make sure that we do engage properly with local communities and the local population. That can present a challenge in some areas, because different groups have different ways of engaging and require different communication strategies.

**Q69 Simon Danczuk:** Should we be measuring precise issues such as obesity, or more general things?

**Dr Toff:** I am trying to say that we can measure, for example, levels of childhood obesity, but we have to be very careful that when we are making measurements we do not fail to look at what is happening to groups that would not necessarily be included within those measurements.

**Councillor Steve Bedser:** I think the question you are asking is one best answered by the health and wellbeing boards. If you think about the shadow boards that are in place, and take the model of group dynamics, they are still very much forming and storming. We are going through a process of norming and performing, and actually having those contextual debates about what we are trying to do and what we are measuring through the local lens of what seems important. Drawing on the experience of Birmingham, deciding to focus on issues such as smoking and childhood obesity have been very helpful for achieving some of the other things that have been referred to in previous questions about engaging the right partners, setting the right cultural tone and helping people manage the transition from NHS to local authority. I think you should be very worried if

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any one of the panel was able to answer that question definitively now, because the process of understanding the right answer is part of the development.

**Q70 Simon Danczuk:** Before I move on to my final question, Professor, do you want to say anything?

**Professor Scally:** Yes, I do. I think this is a really important question, particularly the happiness issue. The WHO definition of health is a state of complete physical, mental and social wellbeing. It is in the preamble to the WHO Constitution, and I think is an absolutely correct formulation. It is a great pity that we are so reductionist in so many ways. I would point you towards Bhutan as a place to which I know Members of Parliament travel occasionally.

**Q71 Chair:** We are already looking at it.

**Professor Scally:** It would seem to be a good place to go, because they operate on the basis of gross national happiness. They have a very well constructed index, which comprises a huge range of indicators, including challenging things like the gender distribution of domestic labour. I think we need to move away from an obsession with GDP as being the only thing that matters.

In terms of what we should measure, I will not answer that any more other than to say we do need to try to get ahead of the game a bit. I have spent my public health life trying to catch up with things that have already arrived: the tidal waves of obesity and alcohol-related disease. We do need to seriously invest in trying to get ahead of some of these problems as a society to try to stop them. So it is not just picking our problems now; we also need the foresight.

**Q72 Simon Danczuk:** Let me just briefly move on to the final question for Alan and Steve. How should local authorities be held accountable for poor outcomes?

**Councillor Alan Connett:** I would say primarily through the continuing vibrancy of Healthwatch and the scrutiny committees, and ultimately via the electorate.

**Councillor Steve Bedser:** I am reluctant to be held to account from day one because in some local authorities we inherit very stark inequalities that have been ingrained for many, many decades.

**Q73 Simon Danczuk:** But Alan says if you do not get it right, you should be voted out at the next election.

**Councillor Steve Bedser:** There is a danger that health and wellbeing boards will start behaving in a knee-jerk, short-term way, driven by the electoral society. That would be very retrograde, which is why that balance of the triple key of local authority officers, elected members and representatives from bodies like clinical commissioning groups is very important.

**Q74 Simon Danczuk:** You cannot have it both ways, Steve. As you were saying earlier, you set your own priorities; you want to concentrate on smoking. Government used to advocate a top-down approach, reducing this and affecting that, for example, teenage

pregnancies and so on, and working towards targets. You are saying you want to set it locally but not be held accountable.

**Councillor Steve Bedser:** There are clear accountability mechanisms in place; I am not saying we should not be held accountable. Things like health scrutiny and Healthwatch are going to be very important in keeping some local temperature in the relationships between health and wellbeing boards and the wider public. There will be the lens of the media. There are very strong levers that will hold us to account and so there should be.

**Q75 Simon Danczuk:** Quickly, I just want Peter to comment.

**Dr Carter:** I think you have touched on something very important: how do you measure the success? It has constantly been a problem for the health service. Every year there is a report published by an organisation called Dr Foster. We think there is a lot of very good stuff in it, but hospitals that come at the bottom of the ratings feel quite persecuted by it, when it is often a reflection of the population they are serving. These are often very good hospitals dealing with very unhealthy people.

In the first few years of these new arrangements, I think we need to be careful not to set unrealistic targets for local authorities, because this is about behavioural and lifestyle change. It will take a considerable amount of time before that supertanker begins to turn. You do not want people to be devising targets and outcomes that are measurable in a favourable way as opposed to coming to terms with the fact that, however much we do not like to accept it, the health of some parts of the nation is pretty desperate. We need to come to terms with that. The Chief Medical Officer, Sally Davies, pointed out last week that liver disease is increasing in England, unlike the rest of Western Europe, where it is decreasing. That is lifestyle related by and large, so if you are going to address that, you need to get a sensible understanding of how realistic it will be before you can start to turn that around.

**Q76 Bob Blackman:** We are moving on to financing and how that money should be spent and where it should be allocated. The money has been ring-fenced to ensure that it is spent for the purposes the Government intend. But local authorities have been very good at being creative in using that money. Penny or Gabriel, do you have any concerns about local authorities using existing services and saying, "Well, actually, that is health related, so we will take a portion of that money"? Should there be some safeguards put in place on this ring-fenced money?

**Dr Toff:** The money is ring-fenced, everyone understands that, and that seems to be very strongly supported both by the public health workforce and local authorities. I think the intention is that that money should be used to improve the population's health. One of the most important safeguards will be the key role of the director of public health and their input right across local government, and not only in the more obvious areas of public health spend. The

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chief officer will advise, with the support of the broader public health network and their own public health specialist staff within the local authority, around whether that is an appropriate use of the money. I would just like to support the comments that were made earlier by Professor Scally and others around the position of the director of public health. This is one illustration of why it is so important that the director of public health does have a place at the top table and that direct accountability, not only so their advice is taken seriously and they maintain their independence and credibility, but also so they can work right across the local authority and give that kind of advice on a sound basis.

**Q77 Bob Blackman:** To give you an example, a local authority comes along and says, "Improving our sports centres and increasing participation in competitive sport will improve the health quality of all the people who live in our area, so I am going to raid the budget for public health." Is that a concern?

**Dr Toff:** I do not think that is necessarily a concern.

**Bob Blackman:** Right, okay.

**Dr Toff:** Part of what we all support about public health coming into local authorities, and local authorities being responsible for the broad public health remit, is that we can work across all of those determinants of health. That may be an appropriate use of the money under some circumstances. The issue is whether it is in line with what has been identified as being the local priorities, and to approach things in a way that says, "Okay, we are going to spend our money on this. What impact will it have on other areas we need to fund?" So I do not think you can make any blanket statement about whether it would be right to spend this money on a swimming pool or a playing field.

**Q78 Bob Blackman:** So the safeguard you would have is the director of health being at the top table and able to say, "Oi, hang on, stop"?

**Dr Toff:** I think that is absolutely crucial.

**Q79 Bob Blackman:** Thank you. Gabriel?

**Professor Scally:** Directors of public health are used to dealing with avaricious heads of finance. They have been fending off rogues and villains in the NHS for decades. The analysis that was done about the levels of funding and the variation of levels of funding going into public health locally was really quite shocking. There is no excuse for that, and NHS management must bear a huge amount of responsibility for that.

Sir Liam Donaldson pointed out in one of his annual reports some years ago how budgets were being reduced in public health, so this sort of behaviour would not be new to directors of public health. If they are given sufficient status in the organisation, I hope they would be able to cope appropriately with it. My challenge back would be: "Well, show me your evidence." There is no evidence at all that investing more in leisure centres will improve physical activity across the board.

**Q80 Bob Blackman:** I do not have to produce the evidence. I just have a view of what local authorities finance directors may do.

**Professor Scally:** Yes, but some of the talk has been really quite fanciful. It is not as if there is a big bag of gold sitting around that is not being spent elsewhere at the moment. The final allocations have not been made, but the bulk of the money so far is for drug services and sexual health services.

**Q81 Bob Blackman:** We are going to talk about that in a minute. Is there any other protection that you would like to see on these ring-fenced budgets?

**Professor Scally:** No, I think the ring-fencing is entirely appropriate and should be maintained.

**Q82 Bob Blackman:** Okay. Alan?

**Councillor Alan Connett:** I take an entirely different view. I do not favour ring-fenced budgets. If councils and health and wellbeing boards have set very clear, strategic objectives with a common view about how best to achieve it, then that is an appropriate way to spend money. Ring-fencing may create barriers where they need not exist.

**Q83 Bob Blackman:** So, just to be clear, that means that of the money that is given to a local authority for all of its services, there should be no ring-fencing of the public health budget?

**Councillor Alan Connett:** I am very clear.

**Q84 Bob Blackman:** That is fine. Peter?

**Dr Carter:** We think ring-fencing is absolutely essential, but there is something else I want to bring to the Committee's attention. We have some concerns about how much money is being transferred across. In these difficult financial times, we are not convinced that the requisite funding is coming in the first place. Dr Stephen Watkins, who is a director of public health in Stockport, writing recently in the *Health Service Journal*, pointed out what with a study he had found 28 examples where significant sums of money are not being transferred across.

**Q85 Bob Blackman:** So just to be clear, that is money that is being spent at the moment on public health?

**Dr Carter:** Yes.

**Q86 Bob Blackman:** But not transferred to the local authorities.

**Dr Carter:** And not transferred across. So we do not want to set it up to fail before it starts. Then when it does come across, because obviously we would hope the right amount comes across, we do think ring-fencing is essential because over the years in the NHS—and we are great supporters of the NHS—it has been easy target to take money out of.

**Q87 Bob Blackman:** We have had evidence about the easy target. What safeguards, if any, would you want to make sure this ring-fenced money is not purloined for other purposes?

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**Dr Carter:** The director of public health being accountable to the chief executive, appearing before the council and being clear about what the money is that is being allocated, and throughout the year being clear that it is not being purloined for other, probably well meaning causes, but at the expense of public health.

**Q88 Bob Blackman:** Okay, thank you. Steve?

**Councillor Steve Bedser:** I have several comments, but I preface any comment about money with the observation that it is now the end of November, and we still have no idea of any notional budget that is going to transfer across to us in April, which makes it quite difficult for us. We are preparing our budget consultation in my own authority, and we are going to a proper consultation process with the public and having to make working assumptions about the public health money that will transfer across.

The position of the LGA is very clear. It is against ring-fencing because it constrains local decision making, and the purpose of local government is to make local decisions within the framework that has been allocated to us by Government. I am an evangelist for public health; it is probably one of the most important things that local government could and should be doing. From my point of view, the drawback of a ring-fenced approach is it defines the limit of public health spend.

**Q89 Bob Blackman:** I have been reading about the problems Birmingham City Council have in terms of their overall budget. Your leader would be turning round and saying, "We are very sorry, but we will have to reduce this budget."

**Councillor Steve Bedser:** If you want to take Birmingham as a case in point—

**Bob Blackman:** I am just taking your budget because we know.

**Councillor Steve Bedser:** At the end of the economic cycle, we reckon that about 48% of our controllable spend will have been cut.

**Q90 Bob Blackman:** So surely being an evangelist for public health, you want to keep that money safe, do you not?

**Councillor Steve Bedser:** But in terms of achieving all of the potential that exists with the transfer of public health from the NHS to local government, if it comes in a hermetically sealed bag labelled "public health", the danger is that it then does not properly integrate with all of the functions of local government across the spectrum of housing, education and environmental health, and bring alive all of the very real opportunities that exist with the transfer.

**Q91 Bob Blackman:** Leisure centres are a classic example. They will enable more people to do exercise.

**Councillor Steve Bedser:** I think leisure centres have the potential to become engines of public health outcome. I invite Professor Scally to come and look at Birmingham, because by offering free access to physical activity in leisure centres for deprived communities, there has been significant uptake and

improvement in people's actual measurable health status.

**Q92 Bob Blackman:** I turn to the formula then, because one of the issues about the money that is going to be spent is how the formula is determined. We have heard about the potential inequalities in health. What should the formula focus on? Penny, maybe you would want to start on this. Should it be sexual health, children's services, prevention of things, smoking cessation? How should that formula be structured? Getting that formula right will determine how much money each local authority area gets.

**Dr Toff:** Just to pick up on one of the points Steve made, I do not think all of this is about more money. A lot of it is about more intelligent and joined-up commissioning and integrated care. In terms of the formula, the allocation itself, I would just reiterate the concerns that have already been raised. The problem here is that this is based on existing spend. There are areas of historical low spend, and in those areas CCGs are going to struggle because the preventative agenda will not be being met.

The paper by Stephen Watkins that was referred to has been condensed into a letter. It has gone from the Chair of the BMA Council to the Minister of Public Health, outlining the reasons for the shortfall in the baseline allocation and making some suggestions about how that might be rectified. The issue of need has to come into the equation, and it is a very difficult one. In the immediate short term, we know that some local authorities will find themselves with a big shortfall, which has already caused them to make regrettable decisions about the transfer of public health into local authorities in some of the areas we have already mentioned in terms of the positioning and capacity of the workforce, which we can see being reduced already.

**Q93 Bob Blackman:** That is a general view, which I can accept, but should there be factors of particular elements of public health triggering how the formula works or should it be a global sum based on per head of population?

**Dr Toff:** I think the formula has to take into account the differing needs, but in the short term some action is required to bring up the amount of investment in public health because we know that there is going to be this serious shortfall, which will probably exacerbate the inequalities that are already there.

**Bob Blackman:** We cannot debate where that money would come from.

**Professor Scally:** I think the issue of the formula is extraordinarily difficult for the reasons I gave previously, in that substantial amounts of the money expected to come will be for extant services: substance misuse and sexual health services. I must point out that those services did not prosper in the NHS. For drug services the money had to be taken out of the NHS and put into a pooled treatment budget along with Home Office money. That is what enabled progress to be made on drug services, because it was not prospering in the NHS. In teenage pregnancy and

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sexual health services, we only made substantial progress in the last four or five years when there was significant additional money ring-fenced and earmarked for sexual health, because the NHS did not invest in it. So I am really worried about putting in a global sum that will then be preyed upon. I would favour a mixed pattern of budgets targeted towards the big service areas, and those are public health services that are delivered and need to be delivered in the future.

I would also argue that there should be a sum for the public health infrastructure. The success of public health under local government will not come around because of how these relatively small amounts of money are used; it will come through the influence of public health thinking pervading all of the actions and budgets under the control of the local authority. For that you need a director of public health, and adequate staff and resources to be able to produce that level of influence.

**Q94 Bob Blackman:** Steve, what about a formula for distribution of funds to local authorities? It is nothing new; we are all used to it.

**Councillor Steve Bedser:** One of the concerns we have is that the apparent allocation of money, which we do not yet know about, is going to be based on random and historic patterns of spend. The ideal of a rational way of apportioning the money would be instinctively appealing. There is one thing that public health is not short of, and that is data. So as an observation, it should not be too difficult to reach an agreement about what headline data we should be measuring to drive investment in public health in particular areas.

**Q95 Bob Blackman:** But are you happy that the formula is structured on particular sorts of needs?

**Councillor Steve Bedser:** My understanding is that the current deal on the table is historic spend. That is not attractive because that will not match actual need. So I, and I think the LGA, would very happily engage in a debate about matching the resource to need rather than history.

**Q96 Bob Blackman:** Okay, thank you. Alan, do you have a view on this?

**Councillor Alan Connett:** I very much share Steve's view.

**Q97 Bob Blackman:** Thank you. Peter?

**Dr Carter:** I agree with Steve. One of the very good things is that we have rich data. What you need is a sophisticated local needs assessment, and then you target the resources where you think the greatest need is. Although I agree with Gabriel, these are, relatively speaking, small sums of money. Sadly, despite the previous Government tripling investment in the NHS, a huge opportunity was lost to really get upstream in that good financial climate. That did not happen and we now know where we are.

**Q98 Bob Blackman:** Finally from me, in relation to the health premium, which will not come in for two-and-a-half to three years, do you have any concerns that this will either incentivise or reinforce poor performance? Will it actually reward the good performers or reward the bad performers?

**Councillor Alan Connett:** My view would be that, because at the moment it is unlikely to be shared with district councillors, and they are a key player, it may not act as the incentive that the system would like it to be. For that reason I think it is essential that the premium is shared appropriately with the sectors involved.

**Q99 Bob Blackman:** Okay. Steve?

**Councillor Steve Bedser:** My personal view is that, given the complexity and amount of change that we are dealing with at the moment, the health premiums still feel very, very abstract and difficult to conceive.

**Q100 Bob Blackman:** But after you have thrown open all these leisure centres in Birmingham to the people that have ill health, you will improve their health and you will get a big incentive to be paid.

**Councillor Steve Bedser:** That would be very attractive and rewarding. It does not always work out like that, but if the system rewards good behaviour and incentivises people to do more, then that would be a good thing. But it does feel very abstract talking about something that is not going to take hold in the system for two or three years.

**Professor Scally:** The nature of public health is that, with some exceptions, generally timescales are too long to make the health premium an attractive prospect. I do not think it is right. There does need to be a mechanism to reward local authorities that have put in effort and really bent their backs to this new task of improving health.

**Q101 Bob Blackman:** Should that be on the basis of the baseline data of performance when they take over, and then a year later, or two or three years later? If the outcomes are better, then they get a financial reward. Is that the way it should work?

**Professor Scally:** It may take some time for the outcomes to become apparent, but there are process measures that could be in place. I personally favour a system of accreditation of local authorities for public health, with judgments to be made around how well they are doing across a broad range of categories. I would put just one caveat, in that there should be no health premium to any local authority that maintains pension investment in the tobacco industry.

**Q102 Bob Blackman:** Okay, thank you. Peter or Penny, do you want to comment?

**Dr Carter:** I think it has been covered.

**Dr Toff:** I do not have too much to add. I would just agree with Professor Scally.

**Bob Blackman:** If you agree, that is fine.

**Dr Toff:** People have already mentioned the local agenda and making sure that the priorities are right at a local level. I think that needs to be constantly monitored. You would not want places to be penalised

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because they have realised midstream that perhaps actions they decided upon were not the correct ones. You would want them to be open to advice, particularly from public health specialists looking at the data in an ongoing way, that perhaps they needed to change their approach. That would then prolong the timescale again, and I do not think that you would want to dissuade people from that activity.

**Q103 Chair:** Professor Scally, who would do the accrediting?

**Professor Scally:** I think there should be an accreditation system set up by the LGA and by the Faculty of Public Health. A system has already been established within the NHS for pathology; it is long standing—20 years—and in the United States in September of last year they launched their accreditation system of local health departments in states and counties. I think we could very well follow their example.

**Q104 Mark Pawsey:** I just want to ask some questions about resilience and the commissioning of public health services under the new arrangements. On resilience, if there is an emergency outbreak, an epidemic, the Government is looking to Public Health England to bring people together to deal with that. Professor Scally, I think you are fairly critical of that proposal. Can you tell us why?

**Professor Scally:** I am, and I look forward to hearing Dr Toff's views on this. I listened to last week's session and the evidence from Duncan Selbie, and the assurances he gave, which I believe absolutely. I believe that Public Health England will continue to provide an excellent service, as it does in dealing with chemical spillages or infectious disease outbreaks. But I am not as convinced that the system as a whole will work, for a number of reasons. Reading the materials, it is not clear to me who would be in charge of an outbreak at the local level. Public Health England is part of the Department of Health; they are civil servants and they serve different masters. I am not convinced that if we have a problem across a substantial part or the whole of the country, Public Health England would be able to provide enough staff to lead in every local area. I believe it should be the local director of public health and the local authority that leads that function, but that is not clear to me at all.

I am also concerned about the structures and organisation of the NHS. Some of their structures are cutting across the local resilience fora, which, as you know, are charged with emergency planning. I am also concerned that the move of services, particularly community services, out of the NHS either to the private sector or to social enterprises will make it extraordinarily difficult to mobilise staff in the case of an emergency. There may well be clauses and contracts, and we could argue about that at the inquiry or in court afterwards. The good thing about the NHS system as it has operated in the past is it has been possible to mobilise staff very rapidly, and I fear the loss of that.

**Q105 Mark Pawsey:** We ought to ask the local authority representatives then. Do you feel able to step up to the mark or do you share Professor Scally's concerns?

**Councillor Steve Bedser:** In this period of managing the transition, I have been encouraging whole swathes of the NHS and local government not to obsess about structures and wiring diagrams, and to focus on relationship building and partnership.

**Mark Pawsey:** But people need to understand the structures, do they not?

**Councillor Steve Bedser:** But in this particular regard it is very clear to me that we need unambiguous wiring diagrams. Certainly in my own local authority we will be testing to make sure that there is very clear understanding of the role of Public Health England and the role of the local authority, and there will be tremendous goodwill in terms of stepping up to the plate and mobilising staff across the local authority and, indeed, still the Health Service in an emergency. But we need a very clear line of sight from top to bottom of who is in charge, who is calling the shots, who is accountable, and we need to be satisfied as a health and wellbeing board that we properly understand that in our local context.

As with several of the questions that have been asked today—we have talked about performance and accountability—there is a role for the Local Government Association. We have got 152 local authorities, and when we see that there are a small handful of authorities struggling with the new arrangements, that is where organisations like the Local Government Association can step in and give additional and intensive support. It is absolutely clear that when there is a public health emergency, we need to understand who is in charge so that we can get on and fix the problem.

**Q106 Mark Pawsey:** Dr Carter and Dr Toff, is the involvement of local authorities in an emergency such as this going to be helpful, or will it be another layer of consultation and bureaucracy getting in the way?

**Dr Carter:** I would say it is essential. This is one of the unintended consequences of these reforms, which I think some did not fully understand.

**Q107 Mark Pawsey:** This is an unintended consequence?

**Dr Carter:** Yes, there is real risk with this stuff. In this transition it is still not entirely clear who is going to be doing what, and that is not good. Having said that, one of the characteristics of the NHS and local government is in times of crisis they do tend to pull together really well, but we should not be relying on that. We are just a few months away now from the biggest change in the NHS, and with this transfer back there has been the huge distraction of the very things that Steve has talked about: jobs, structures and the rest of it. People are looking out for their own employment, quite understandably.

**Q108 Mark Pawsey:** Are you asking for a template then? Do you want Government to write a template to be applied to every local authority?

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**Dr Carter:** No, it should be clear, certainly by 1 April, what the contingency plans are. Who is responsible? When you press the hot button, who is the person on the spot that is going to be taking control? That is still not clear at this stage, and that is not good.

**Q109 Mark Pawsey:** Dr Toff?

**Dr Toff:** I agree with Peter and the others' comments. Ultimately local relationships will continue to be absolutely key in this. As others have articulated, it is an area of huge concern at the moment because it is spread across so many different organisations, it is very complex and there is very poor understanding of it. It is reliant on each of those organisations defining what their role is and making sure that they have the right structures, financing and staff in place to fulfil that role.

The other half of the equation is clearly placed firmly upon the director of public health, so it will be extremely important that they are given the resources and freedom to exercise that role in bringing the whole thing together locally, probably jointly with the local NHS Commissioning Board. The structures are very complex and not at all transparent to most people, and my main concern at the moment is what we are seeing as a result of that is huge variation. In some places people have worked very well together to set up health protection fora and so on to make sure that they do have the proper provision in place. In other local authorities, health protection has barely been mentioned or considered.

**Q110 Mark Pawsey:** Particularly in relation to emergencies, do you think there is a conflict between the 15 Public Health England centres that will be set up, and the 39 local resilience forums? How are those two bodies going to relate to one another?

**Dr Toff:** We really do welcome Duncan Selbie's assurances. I also have great confidence that, although they now only have four months to put everything in place, what they are going to provide is basically on the footprint of the Health Protection Agency's previous contribution. I do not see that as being a huge issue, but there is some realignment of relationships. There is now a responsibility that will be placed on the NHS Commissioning Board's local centres, which was not there before, to make sure that there is that capacity on the NHS side to respond to these emergencies. The only way we will really know about this is if there is a thorough scoping exercise carried out, and lots of training and rehearsing of scenarios. We will need to test this out to see whether it works.

**Q111 Mark Pawsey:** Right. Professor Scally, to whom do we look to provide this clarity that you suggest is currently lacking?

**Professor Scally:** I think the Department of Health and the Department for Communities and Local Government should be responsible, or perhaps the Cabinet Office in their overall contingencies role. I do not want to be sitting and talking about this in the aftermath of something that goes wrong.

**Q112 Mark Pawsey:** Is that your fear?

**Professor Scally:** That is my fear, yes. I have seen enough major incidents in my time to think that this is worrying. I know the lack of clarity worries directors of public health at a local level because some of the documents are internally contradictory about who is in charge.

**Q113 Mark Pawsey:** Right, if we move on to the commissioning of services, that will be carried out by Public Health England, local authorities and the local NHS Commissioning Board together. Is that going to give more clarity to the commissioning of public health services than the system we have been working with up to now?

**Dr Carter:** Yes, we are worried about this. We now have a lot of bodies and we are still not sure how it is all joined up. We are concerned about the fragmentation. You could get people falling through the cracks, and that might result in an increase in the postcode lottery. That will not be in anyone's interest, irrespective of where they are in this situation. So again, just to repeat myself, these reforms are still not without risk.

**Q114 Mark Pawsey:** Are these uncertainties so serious that you would suggest a delay in implementation?

**Dr Carter:** I do not think you can now. This thing is moving forward, there are people involved, people looking for jobs, job security and it needs to happen. We are only talking about 16 or 17 weeks away, so there has to be a real focus on how this is joined up otherwise you are really in danger of people unintentionally falling through the gaps and the postcode lottery increasing.

**Q115 Mark Pawsey:** Dr Toff, are you equally pessimistic?

**Dr Toff:** I do see that on the one hand most local authorities are going about this in a highly conscientious manner, and very much want to make sure that there is a very effective, safe transfer of commissioning contracts over into local authorities. I think there is predominantly a failure to understand the Public Health England role and their input into commissioning and that they will be a very key link between these different bodies, so that is an issue.

**Q116 Mark Pawsey:** Given a free hand, how would you get to where you would like to see us? What could be done?

**Dr Toff:** There are some excellent examples of good practice, where local authorities have ensured there would be specialist public health input directly in the CCGs, for example. That is something other places might want to consider.

**Q117 Mark Pawsey:** Do you feel that will not happen by 1 April?

**Professor Scally:** I think that is unlikely at the present time. Every time we go through one of these major reorganisations, we lose about 30% of our senior people in public health, so there are going to be some deficits in staffing. You asked about delay. No more



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delay, please. On Friday I will be in Birmingham, but maybe not in a leisure centre, it will be two years to the day since the White Paper on public health was published, and we still have not made the transition. There is a good case to be made that this could have been done far earlier, far faster and far more effectively, and the delay has been a substantial part of the problem.

I do think there is a real deficit. When you looked at the initial carve up of the public health budget, exactly the same amount was going to the NHS Commissioning Board as was going to the local authorities, yet there was a very clear but informal view that the NHS Commissioning Board did not want any public health people; they would do it themselves. They are dealing with important issues like screening and immunisation services that are absolutely core public health functions, so I find the whole way in which this has been pursued unsatisfactory in terms of its delay and its fragmentation.

**Q118 Chair:** We will come on now just to look at where we are up to. Clearly there are different things happening in different parts of the country. Probably not surprisingly, people are approaching things according to local circumstances. How much of a possibility is it that in some places all that will happen is the director of public health will move employees, get a new office and the major issues that people continue to argue about will still be adult social care and who pays for it, and which hospital will close or not close. Is there a real chance that there will be really good examples of public health starting to imbue the whole thinking of the services, and could it even affect the way the NHS thinks as well as local authorities think?

**Councillor Steve Bedser:** In Birmingham my cabinet responsibility, health and wellbeing, encompasses adult social care, public health and social aspects of housing, so I see the whole as a continuous spectrum. If we are going to solve the really challenging problems we have ahead of us in adult social care, the only rational way we can do it with the resources and system that we have is by prioritising the public-health-type interventions because they are the things that will broadly enable us to have people living longer, more independent lives in their own homes. That is the only way we will be able to make the money work in the long term. I am tremendously optimistic. I do not think any local authority is seeing this as a “lift and shift”. I think people are seeing this as a really important cultural change that is taking place across the health and social care economy. Look at some of the self-assessments that have been done with input from the likes of the Local Government Association and regional directors of public health. I am very glad that Penny Toff acknowledged that local authorities were being very conscientious. You will find people who are working very hard to make pragmatic sense. Two years after the announcements of the first notion of change, they are still grappling with uncertainty because there are really key things that are very important to us. How much money is

going to be in the budget at the point of transition is something that we need to know.

**Q119 Chair:** I am sure that there are some great examples around of constructive and original thinking, but are you not already starting to pick up one or two authorities that are probably not getting it right and not doing the right things? You were saying earlier that there are authorities that you would like to step in and help, but if you do not know who they are, or recognise they exist, how can you help them?

**Councillor Steve Bedser:** The LGA have been doing some very comprehensive self-assessment work. The good news is that 95% of local authorities are in an advanced state of readiness. In any kind of organisational change, to have 95% in a good state is a remarkable finding. That allows us to concentrate resource on the small number of local authorities that are struggling for one reason or another, and bring in peer support and expert support to turn those systems round. I challenge you to look at any other part of public sector delivery where you are having such a high compliance rate.

**Professor Scally:** There will be great examples of good practice, of course; there already are. A good DPH will not be changing office on 1 April; they will already have been there for maybe the last four or five years. I know in my own region, all but one of the local authorities properly jointly appointed DPHs for many years. My concern is exactly as you put it, however: that the spectrum will widen in terms of performance. I am concerned about the accountability issue. I am not clear how people who are not getting good public health services and function delivered, and whose local authority is not matching up to their future legal duty to improve health, will be dealt with. In relation to the DPHs, I think they will flourish in local authorities. They have nothing to fear from working with councillors; councillors care about their local populations. That was never an attribute that I saw universally displayed in the executive offices of the NHS. My advice to DPHs has been that they should love their councillors, and my advice to councillors has been that they should love their DPH. **Chair:** There is some nodding of heads going on at the other end of the table.

**Dr Carter:** I have said everything I need to say. This transitional period has a huge risk. Having said that, I still believe the direction of travel is right, and if this is allowed to bed in and mature, in a few years' time I genuinely think it will make a huge impact in the way that we all would wish.

**Councillor Alan Connett:** I thought Gabriel put it so eloquently; how could you follow on from that? From our point of view, districts have also seized the agenda. There is a lot to be very confident about in the future. The concerns that have been raised are right and justifiable at this stage, but I think we should step forward and say that local government and the NHS are embracing the agenda with confidence, and I think there is great scope for improvement.

**Dr Toff:** Your point is absolutely right. There will be considerable variation and it is very important that the examples of good practice are shared. Our concern at

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the moment is more that some of those directors of public health will not even make it as far as the office, and certainly their staff will not. That public health is everybody's business is a very clear message that has come out of this, and that has reached most people, particularly councillors and many officers as well. I think the message that it is not anybody's business—that there might be something very important here that specialist public health has to bring to the table and that has to make it all the way to the council and be retained as an adequate workforce—has not necessarily been heard quite as clearly.

**Q120 Chair:** One final point, probably for the two councillors most of all. There is talk about public health coming back to local government, but the reality is that in a council like yours, Councillor Bedser, you are chairing the health and wellbeing board. There is not another single councillor on there, as I understand it. Certainly many, in fact, will only have one councillor on there. You may have two or three; I do not know. The reality is that most councillors will not feel any personal commitment to a function that they are not responsible for making decisions about. They may know that there are some extra people who have come to be employed and that public health is something they generally do, but it is not going to be seen as one of the things they are accountable to the electorate for as individual elected councillors.

**Councillor Steve Bedser:** Just to factually correct you: we have three councillors, and very deliberately we have the cabinet member, me, who has a broad responsibility for adults. The vice-chair is the cabinet member with broad responsibility for children, and we also have an opposition member to ensure that it is

embedded on a cross-party basis. We took power in Birmingham in May. I saw public health transition come in a couple of years ago, and I actually made it my business to signal to our leader that this was the portfolio that I wanted. I wanted it on the basis that it was the portfolio that had public health responsibility, because I have got such vision for discharging that duty.

**Q121 Chair:** Has that translated through to the rest of your colleagues when they are looking at budgets and all the problems they have got?

**Councillor Steve Bedser:** There is nothing more socialist than caring about poor people dying 11 years younger than rich people. I have found it to be a compelling narrative with my colleagues. When I start talking about public health in terms of helping poor people live longer lives of greater quality, it is something that my colleagues understand very readily and get very passionate about.

**Councillor Alan Connett:** I think there is a very real job for the local government sector to do in terms of teaching councillors. Every year, the director of public health publishes a darn good report about the health inequalities in the area. I think the change will enable councillors, for once, to ask the pertinent questions of why this is happening in their area and what the health and wellbeing board is doing about it. I think local government, the District Councils' Network, all of us, need to seize that and empower local councillors, because this for once is opening the gate to them to be able to ask and hold to account.

**Chair:** Thank you all very much indeed for coming and giving such interesting evidence. Thank you very much.

### Examination of Witnesses

**Witnesses:** **Caroline Abrahams**, Director of External Affairs, Age UK, **Richard Blyth**, Head of Policy and Practice, Royal Town Planning Institute, **Andy Murdock**, External Relations and Policy Director, Celesio UK, and **Paul Woodward**, Chief Executive, Sue Ryder Care, gave evidence.

**Q122 Chair:** Good afternoon and welcome to you all. Thank you for coming to give evidence to us this afternoon. For the sake of our records, could you indicate who you are and the organisation that you represent?

**Andy Murdock:** I am Andy Murdock, External Relations and Policy Director for Celesio UK.

**Caroline Abrahams:** I am Caroline Abrahams. I am External Affairs Director at the charity Age UK.

**Richard Blyth:** Richard Blyth, Royal Town Planning Institute.

**Paul Woodward:** Paul Woodward, Chief Executive of Sue Ryder.

**Q123 Chair:** Right. There have been great arguments around the Health and Social Care Act 2012, not least in this place, where long hours have been spent debating it. Much of the argument was around what might be called the health side of commissioning of health services. Was social care an afterthought—

something that was tacked on or not really taken as seriously as it should have been? Or, when we see what happened with that Act, and then the draft Care and Support Bill coming along, could that actually be seen as the first step towards full integration of health and social care?

**Paul Woodward:** It obviously would have been better if the health and social care reforms had been carried out in tandem with the draft Care and Support Bill. There has obviously been quite a lot of focus on funding to date, and I think we need to widen that debate to the whole system. There is also the question of what social care is. I think there is a danger that social care is about older people and dementia, and yet from where Sue Ryder sits we are looking at a whole cohort of people with neurological conditions—over a million people who require care—and they live in the system for a very long time. They are often younger people, and with greater needs that span health, social care, housing, transport, welfare,

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and so on. Often their carers require that as well. So there are very different requirements, and a need for a very holistic approach.

**Caroline Abrahams:** I will have a bash, then, as well. Clearly, the two were not fully integrated in that piece of legislation, and they are not quite in parallel. The other thing I would say about that is that—depending on your time frames—it is not as if we are only now just starting to think about how better to join up across health and care. People have been at it for an awfully long time. A lot of people have been working hard on the ground to try to achieve this, before the Act came in. There is a bit of a longer term history, and the message from that is: if it was easy to do, it would have been happening already. There is quite a challenge for us.

Of course, I agree with my colleague Paul that social care is not just about older people. It is importantly about older people, but we are a member—and I think Paul probably is, too—of the Care and Support Alliance, which has over 70 organisations all working together. This encompasses both organisations working with adults of working age and with older people, all of whom think care is really, really important. In a way, the things that bind us together are a bit more important than the slight nuances of difference on the detail. We all agree that care is really, really important and needs to be joined up properly with health.

**Andy Murdock:** That one might be a university thesis question. Actually, does it really matter now? We are where we are, and we have just got to make it work. The social care aspect of it, with health, is a great opportunity for that if it is the first step on the road for that integration. I think that is massively important, irrespective of how we define that. Obviously, in the parochial pharmacy area from which I come, there are elements of care that we can give within the home, which is not the same type of care as other people give. I think it is a golden opportunity to take that care pathway and lock social care into it in its holistic form, and drive it forward. I think it is a massive opportunity.

**Q124 Chair:** Does it ultimately need someone to be responsible for it?

**Andy Murdock:** Yes, we do need somebody to be responsible for it, absolutely. That is going to be part of the challenge that we have got on the potential fragmentations of the system. Potentially, if you go from four levels of authority in the NHS pre-change to the numbers that we have got now, you think, “Well, how are these going to work together?” That clarity of how they are going to work together, and the communication between the organisations, is going to be absolutely key. I do not see that clarity at the moment. Perhaps it is still being worked through on the ground.

**Richard Blyth:** I am hopeful that, coming at the same time as the transition, the ability of the health and wellbeing boards to consider things like transport in relation to social care and housing together—rather than have different subjects being operated in isolation—will be a step forwards.

**Q125 Simon Danczuk:** Health and wellbeing boards are exceptionally important bodies, set up and determined locally. Is that going to make your engagement with them more or less effective? Is it going to make it easier or harder? Caroline, we will start with you. What do you think?

**Caroline Abrahams:** Engaging with health and wellbeing boards as a voluntary organisation? We have 170 local Age UKs, and, to be honest, they are finding it quite tricky to engage at the moment.

**Q126 Simon Danczuk:** Why is that, do you know?

**Caroline Abrahams:** All sorts of reasons. It is partly because, obviously, there is a lot of change going on locally across the NHS and in local authorities. A lot of all of this is based on relationships. Sometimes people are finding the people they knew have moved on to other things. Also, because health and wellbeing boards have a huge job to do, and lots of different interest groups are all badgering for attention, it is quite hard looking at it from the other end of the telescope. It is probably quite difficult for health and wellbeing boards to know how best to engage a very disparate sector. Some are doing it very well. Some are setting up subgroups. We are, frankly, just as interested in the health and wellbeing boards reaching out to older people directly as we are interested in them talking to us, for example. We can help facilitate that, but just as important are all those engagement mechanisms that they need to put in place. Some are doing a good job.

**Q127 Simon Danczuk:** Paul, do you have a view?

**Paul Woodward:** Yes. Like Caroline, I think we are finding it quite patchy. In some areas we are very heavily engaged, and in other areas we are not engaged at all. For instance, in Leeds we are talking with them at a strategic level about how to develop things. But I suppose, in a way, what we do not know is what we do not know. Where we are not being engaged, it is very difficult to figure out where that is coming from. We are finding that within local councils they are able to seek expertise on the boards, particularly where they do not have health representation. It is encouraging to see that the leaders of some councils are taking up the chair of these positions. Whether that is sustainable long term is difficult to say. We are trying to engage with the local Healthwatch organisations, and again, that experience is quite patchy. We are hopeful that over the course of the next year we will start to see some real change going on.

**Q128 Simon Danczuk:** Richard, your organisation’s submission said that planning and transport authorities’ officers needed training in how to effect and create dialogue with health and wellbeing boards. Is that right?

**Richard Blyth:** Yes. There has been a lot that has been going on on that score. A useful initiative came out recently from the Town and Country Planning Association about reuniting health and planning professionals. You have been hearing in the previous session about the question of tiers and whether district council services are going to be satisfactorily

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represented on the boards, so I will not go over that. I worry to a certain extent about how different health and wellbeing boards relate to each other. We are very concerned as a profession about how you deal with the larger than local considerations in local government as a whole.

If I give a theoretical example: if you have an area where chronic overcrowding is a problem and you have not got the land within your area to sort that out, and you are a unitary authority or a county, how do you then influence the health and wellbeing strategies of the neighbouring area and its board? That is possibly an issue over neighbourliness and over space, which may not have perhaps been the focus of other people's evidence before you. I think it is a very important question, and one where my members are going to feel that there is a need for some kind of mechanism for the cross-boundary health and wellbeing board issues to be considered.

**Q129 Simon Danczuk:** The NPPF will sort all of that, won't it, Richard?

**Richard Blyth:** Well, it will in relation to planning. I suppose the question is how that relates to how the health and wellbeing boards themselves work and the public health agenda, and also particularly the way in which the CCGs function.

**Q130 Simon Danczuk:** My second question is about the joint strategic needs assessment, which is pretty crucial. I think you were moving towards this, Caroline, in terms of how you consult, involve people and gather information. What do local authorities need to do to improve this aspect of their role—gathering all that information—do you think?

**Caroline Abrahams:** Lots, actually, to be quite honest. Firstly, getting beyond the jargon and being able to have transparent data available locally so that providers and others can use it as well, and presenting it in a way that is relatively jargon-free, would be a good step forward from the point of view of encouraging engagement. Secondly, getting beyond the numbers to understand attitudes and what drives local behaviour, for example, in our context, amongst older people, would also be very important. To give you an example, we have an initiative at the moment called the Cost of Cold, which is all about trying to reduce the numbers of excess winter deaths amongst older people. We know that there are a lot of older people who do not understand that the cold is a very real risk to their health and even their survival through the winter months, and they do need to take extra steps to wrap up warm. We have got all sorts of things going on to try to support that through volunteers and so forth, but there is also a big issue there for health and wellbeing boards and local authorities more generally.

Ensuring that local authorities and their colleagues are able to understand that, and find ways to engage with it and communicate properly with groups in the community, would be quite a good place to start. Clarity of communication, good use of transparent data, and making sure that it is kept up to date—because, of course, things change quite quickly in lots of areas—would all be a good start with the JSNA.

**Q131 Simon Danczuk:** Paul?

**Paul Woodward:** We are often seeing a focus on what they do know, rather than what they do not know. We published a report, *The Forgotten Millions*, a couple of weeks ago. As part of that, using the Freedom of Information Act, we asked local councils what provision they were making for people with neurological conditions. Only 10% of those councils have an agreed local commissioning strategy for people with neurological conditions. Only 5% knew exactly how many individuals with any neurological condition they care for, and only 6% categorise and collect data on people they care for with specific neurological conditions. Now, that is pretty poor. If we are talking about people who are in the system for many, many years, it is not just about planning for the needs of today. It is about planning for the needs in five years' time and in 10 years' time. Without good data, you are not going to get a good strategy, and without that strategy you are just going to get a fairly scattergun approach. For us, data collection is a real concern, particularly for people with neurological conditions. Obviously, the joint strategic needs assessment is the vehicle by which that data can be collected.

Where you do see best practice, the local authorities are collecting data from health; they are collecting data from social care; they are collecting data from charities; and they are pooling that information together. That is what we should expect to see across the whole country. Neurological conditions are very, very complex in nature. Broadly speaking, you can characterise them as relating to either a cognitive or a motor capability, so somebody, for instance with multiple sclerosis will go down a trajectory of motor capability as that disease progresses. Somebody with dementia will be very mobile, but will have cognitive issues. Then we also have the added complexity of people who have both cognitive and motor impairment: people with Huntingdon's disease, acquired brain injury, and so on. There cannot be a "one size fits all" in terms of developing that strategy. It has got to take into account individual needs.

**Q132 Simon Danczuk:** Andy, I read that your organisation had raised concerns about pharmaceutical needs assessments. Are they now being included in health and wellbeing boards' joint assessments?

**Andy Murdock:** They should be, but the challenge is not only their inclusion; I would argue for their mandatory inclusion, which should form a data set for the JSNA to be founded on. The challenge is also the quality of those PNAs. They first started to be formed back in 2009 or 2010, and the first tranche of those that came out were of variable quality. There is the essence of that, because one of the aspects at which PNAs should be looking is the improvement of access to health and wellbeing, and pharmacy's ability to do that. It is absolutely crucial to make sure those PNAs are in the JSNAs, have good quality, and—as somebody has already said—are updated in a timely manner.

One of the challenges that pharmacy will have in that respect will be that health and wellbeing boards do not really know pharmacy as a channel access for the

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distribution of public health in the way it should be. Pharmacy, historically, has never really needed to engage with the local authorities. It has always been with the PCTs in that respect. That is a fantastic opportunity, because there are some good delivery mechanisms there.

**Q133 Simon Danczuk:** Yes. Richard?

**Richard Blyth:** There is some good news on JSNAs. You mentioned the NPPF: for some time before that came out, my profession was encouraging its members to get thoroughly involved in the process, although it was originally seen as a health thing. The health and planning interface is a lot healthier than the education and planning interface, where there is not the same commitment to a joint evidence base. There are things to celebrate about the JSNA process.

**Q134 Simon Danczuk:** One final quick question: do you think there is going to be an issue around information sharing or concerns about data protection—you know, sharing information that enables different agencies and bodies to work together to solve the person's health and wellbeing issue? Any issues around that?

**Paul Woodward:** I am not aware of any data protection issues around that, because I am not an expert in that area. Obviously, it is really important to collect this data and data from diagnosis. Health data really needs to be plugged in, because you cannot do any serious planning if you do not know what is coming down the track. At that diagnosis phase, it would be really useful.

**Andy Murdock:** This is not from a data protection perspective, but actual access to a comprehensive record is absolutely key. If we have various healthcare professionals working across various levels and channels, we need to know what that continuity of record looks like. At the moment, that is pretty hard to get hold of, so that would be my plea if anything else.

**Caroline Abrahams:** I think much of the data they will need will be population level data, which will be anonymised, so there should not be a problem with that. With more niche areas, it might become more problematic. Although in principle, as I understand it, there is no reason why data protection gets in the way of that, we know there are still lots of myths around between different professional groups—particularly on the front line—about what can be shared and what cannot be. We would be wise not to assume that it is all done and dusted. There may still be some more clarity and really clear messages needing to go out about that.

**Q135 Mark Pawsey:** Chairman, in our previous session we spent some time talking about setting objectives and identifying outcomes. I am just wondering if you could tell us your views about constitutes success at this, and in particular, Mr Murdock and Mr Blyth, how your bodies can contribute to improvements, particularly in the areas of public health.

**Richard Blyth:** I am conscious of the contents of the domains of the public health outcomes framework. We note that, although they are described as the wider

determinants for health, there is not a reference to overcrowding and housing as a measure. If we were to have another one when the current framework expires, there might be a question there, because there has been this concept of returning public health and local authorities to their 19th-century roots. In both the public health profession and my profession, there has been a longstanding understanding of the relationship between housing conditions and health, which are currently quite poor in some places. It is interesting that, although it is an outcomes framework, the first domain is about the things that cause ill health rather than the outcomes. There is a question there about possibly measuring the housing aspect of it, and also, maybe, the worklessness aspect that currently only comes under the NEET area. It is young people's worklessness, rather than overall. From my evidence, also, there is the whole question of the health of places: so if you really are living in a place that has got no town centre to speak of at all, will there not therefore be some kind of connection to public health outcomes as well?

**Q136 Mark Pawsey:** In your representation, you argued very strongly for returning healthcare services into town centres. Why is that so important?

**Richard Blyth:** There are two clear reasons. One is that it is important to give people access to healthcare. If it is in locations you can get to only if you have your own car, that either requires having to ask people to take you, or complex taxi or bus arrangements. So there is an "access to the care" aspect. There is an issue in terms of take-up. I have this vision of a drop-in wellness centre in the middle of the high street, next to the sandwich shop and the place where you go and get your salad at lunchtime, to encourage take-up of the kind of public health preventative services that are so important to get, particularly among busy working people. If you could do that in a town centre rather than having to make a complicated trip somewhere, even if you have access to good transport, and you have got the opportunity to do a dual function—you can deal with your health and also your sandwich—then that makes it quicker.

**Q137 Mark Pawsey:** If we accept that that would be a good thing, how would you go about measuring that? Is it not completely peripheral and on the edge? It would be a nice thing to happen, but how are we going to say there are health benefits from doing it? I may ask you: how are we going to implement it? How are we going to achieve it?

**Richard Blyth:** A number of PCTs in the past have tried to maintain standards about the travel time to GP surgeries, for example. My slight worry about the transition and the new arrangements is who is going to be responsible for maintaining, say, a high standard of accessibility? It is quite possible to measure that—you can say how many people are within 10 minutes' walk or 800 metres of their GP surgery—but who is going to be responsible for continuing to ensure that that is maintained? That will hopefully be something that will come to the local authorities along with the health and wellbeing boards.

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**Q138 Mark Pawsey:** Mr Murdock, what input can pharmacy have?

**Andy Murdock:** I can solve the access point. That is not an issue.

**Q139 Mark Pawsey:** How?

**Andy Murdock:** There are 11,300 pharmacies in England, and you will see that the distribution of those will go from local communities right through to town centres and retail parks. Therefore, the community pharmacies have a fantastic opportunity to spearhead some degree of public health and wellness-type activity. If you take the access data in that respect—DH figures, I appreciate—they reckon that 99% of people have access to a pharmacy within 20 minutes by car, and it is 96% if you go by public transport. That access is there to a point. To come back to your question of how we look at it and what is on offer, rather than go through it now, I can send in some data if the Committee wants. There is stuff around how pharmacy has contributed to sexual health and has had—from our perspective—better chlamydia detection rates than the national programme. There is stuff around diabetes, blood pressure, NHS health checks, and a great study from the Isle of Wight on flu vaccination programmes. Pharmacy has delivered on that.

The interesting concept is possibly a concept called Healthy Living Pharmacy, of which some of you may or may not be aware, which started out of Portsmouth. It took about 17 pharmacies and trained the staff up as healthy living champions, so they promulgated healthy living and wellness. There were some leadership skills put in that, and then they ran a number of services, including smoking cessation, I think some sexual health ones, and minor ailment services. They did 23% of the quit rates of Portsmouth. Now, that Portsmouth model has been taken and it has been distributed across the UK. There are about another 100 pharmacies across the UK that are now being evaluated to see if the Portsmouth study can be uplifted and put across the rest of England. We are waiting for that data to come out now. I am not expecting that to be adverse, and I think that would be a good mechanism.

**Q140 Mark Pawsey:** How would you engage with health and wellbeing boards, then, to bring forward those health improvements?

**Andy Murdock:** It is around us being able to get into the health and wellbeing boards. If the health and wellbeing board wants to commission, they set up services, be it smoking cessation or sexual health.

**Q141 Mark Pawsey:** Do you have enough access to those bodies now?

**Andy Murdock:** No.

**Q142 Mark Pawsey:** You would like to be closer to them?

**Andy Murdock:** We would love to be a lot closer to them. At the moment, as somebody mentioned, there is a lot of focus—which you also see with commissioning support units and other parts of the restructure—on a lot of internal stuff being sorted out,

and just getting the things up and running and operative before we actually go out and talk to some of the other bodies. Yes, I would love to be talking more with the health and wellbeing boards.

**Q143 Mark Pawsey:** Do our other two witnesses have views on how we should be going about measuring some of these very difficult concepts, so that we can actually establish that we are going in the right direction?

**Caroline Abrahams:** Sure. With any group, it is quite useful to start by thinking about what they think good would look like. When we asked older people “What does wellbeing mean to you?” they mentioned five things: positive frame of mind, a balanced diet, keeping active, mental stimulation, and social contact. If you translate that into a public health context, that suggests it would be important, for example, to measure levels of participation and contact by older people, and not to look just at, for instance, by how much we have managed to bring down the number of smokers over the last period.

**Q144 Mark Pawsey:** How would you manage that content? Who would do it? How would you do it?

**Caroline Abrahams:** I think you could do that by surveys, to be honest. You could certainly do it by working with and through voluntary sector organisations. While the direction of travel of many of these reforms is very welcome, given that they are happening at a time when resources have never been tighter, one of the messages back to health and wellbeing boards and local authorities is that they have got to sweat every local asset that they possibly can in order to make these reforms work as well as possible.

**Q145 Mark Pawsey:** On that point, would you argue that the tightness of the Government’s spending framework means that, if someone comes forward with an idea that is perhaps radical or rather different, local authorities are less likely to implement it? They will stick with what is safe and what is sound,

**Caroline Abrahams:** It could work either way, to be honest. Some people would say that, when things are really tight, it forces you to think much more creatively. There is a kind of happy medium around all of that. One fears that in other areas—and we have seen, of course, a degree of salami-slicing, which we may be talking about a bit later—just at a time when you would want lots of those cheap, lowlevel support services to be operational as one of the mainstays of any kind of local health and wellbeing strategy, they are coming under real pressure. That is because councils and others are feeling that they just cannot prioritise them. Some are, but very many are not.

**Q146 Mark Pawsey:** Mr Woodward, would you agree with Caroline?

**Paul Woodward:** Yes, I do, indeed. Obviously, our service users are somewhat different. We have a younger age group: in fact, last year we published a report through Demos called *Tailor Made* which looked very specifically at these outcomes issues. Our service users do not tend to see their lives in silos.

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They see things as just wanting to achieve broad outcomes: so maintaining their independence, being able to spend time with family and friends, and also being engaged with the community.

**Q147 Mark Pawsey:** Are you happy that there are measures of those kinds of things, and that surveys will bring the answers forward that will tell us whether or not a set of policies are taking things in the right direction?

**Paul Woodward:** You could certainly look at that through surveys, yes.

**Q148 Mark Pawsey:** Is that the only way? Are there other ways?

**Paul Woodward:** No, because it is about the quality of life that our service users with neurological conditions are actually enjoying. What is a good outcome? It will be those things: maintaining their independence, engaging in their local communities, spending time with family and friends. These are just broad things, which I cannot see any way of measuring other than asking people whether they are actually getting it or not.

**Q149 Bob Blackman:** Just moving on to some financial issues, if I may, the King's Fund, in their evidence to us, suggested that there is an imbalance between social care funding and NHS spending that is coming in. That, potentially, could skew where money goes and how it is spent. Do you think there is an opportunity here for better integration of social care funding and health funding? Paul, in your evidence, you have given a very strong view that this could be a huge opportunity.

**Paul Woodward:** Absolutely. There is no doubt that if you join health and social care together, then you should be able to get funding reductions. We see all sorts of instances, for instance, where people are kept unnecessarily in hospitals because they cannot be discharged into their communities.

**Q150 Bob Blackman:** Because there is nowhere for them to go?

**Paul Woodward:** There is nowhere for them to go. We had an incident, in fact, last Christmas, where somebody was admitted to one of our hospices. Their continuing care funding was cancelled as a result of their being admitted. Our interventions took place, and this gentleman was able to go back into the community, but that could not be done because his continuing care had been taken out. That sort of thing happens as well when people are admitted to hospital, so if you do join the things up, you can take money out of the system.

**Q151 Bob Blackman:** Okay, thank you. Richard?

**Richard Blyth:** We cite an example of a social enterprise in Bromsgrove. I think I have got seven bullet points of the different under-contract activities they are undertaking, such as mental illness reablement; intensive breaks for the carers of very disabled children; stopping smoking; healthy lifestyles; and youth work. The fact that one social enterprise is able to perform all of those functions

does lead to some internal economies of scale for them. Also, it is not just town centres; this is located in a formerly abandoned shopping parade in a largely affordable housing estate, so that is reinvigorating what was previously a dying district centre. Because one organisation is undertaking a number of parallel contracts, there are these spin-off benefits, which it is good to have in addition to the ones that you are formally measuring in order to make sure that you have delivered your service.

**Q152 Bob Blackman:** Okay, good. Caroline?

**Caroline Abrahams:** Yes. I think that we are all going to agree here.

**Q153 Bob Blackman:** But I have got a sting in the tail for you.

**Caroline Abrahams:** Okay. Just to give you an example, in Cornwall we are trialling an integrated care pathway, as they call it in the health jargon. That is a joint approach among Age UK, local GPs, the local authority and all the local health bodies, and is trying to work out what you can do in terms of prevention and early intervention with older people at risk of sudden admission to hospital because they are frail and they are not otherwise getting the support they need at home, and then helping them to make a good recovery afterwards. The whole point of that scheme is that we are going to trial it using a social impact bond. The theory behind the social impact bond is that you can extract cashable savings through that kind of approach, because you are essentially saving the cost of keeping older people in hospital, which I think is £250 a day. That adds up pretty rapidly, as you can imagine. Therefore, that cashable saving goes back to your original social investors. Now, who knows whether we will pull that off, but it will give us a very good example.

**Q154 Bob Blackman:** One of the clear concerns for your organisation surely has to be that a lot of the emphasis is on sexual health, children's services, etc, which tend to be aimed at younger people. How are older people going to get a fair deal out of this, particularly when local authorities may start stretching the envelope, and saying "Well, a bit more investment in leisure centres," and goodness knows what else. It is all good for the health of the locality, but how do older people get a fair share?

**Caroline Abrahams:** You are right to point to the concern. Obviously, there are lots of different groups, and health and wellbeing boards are being asked to do an awful lot of different things all at once. I go to lots of meetings where people say, "That is okay; the health and wellbeing boards are going to do that." After a while, you begin to think, "Hang on a minute; if that is always the answer, that is telling you something about the expectations on these groups." Ageing well is one of the strands of activity that the health and wellbeing boards are required to look at, so from that point of view we are pleased to have a hook.

I think the truth is that, as Paul was saying in his opening remarks, the backdrop for many local authorities—and, indeed, for local NHS bodies—is



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the knowledge that we have an ageing population and that that is a big call on health and care services, and the realisation that we have to work differently to meet those costs and sustain good quality services. The context is there, and the knowledge that these things now are high priority is there, but how you do that alongside everything else is a really tough question. Traditionally, older people have not been a central focus of public health activity. We need to get those messages across that it is never too early for prevention, but it is also never too late.

**Q155 Bob Blackman:** Some of the evidence we have heard—for example, earlier this afternoon—suggests that not enough money is being spent on public health and not enough money is going into local authorities. So, given all of these other competing priorities, how are you going to make sure that older people do get their fair share?

**Caroline Abrahams:** Organisations like ours will be jumping up and down locally and nationally, as you can imagine, because that is our job.

**Q156 Bob Blackman:** I am sure you will, yes.

**Caroline Abrahams:** But, of course, so will our colleagues representing other groups. I think you are right. It is such a shame that the right thing is happening at a time when the trend in the resources is going in the opposite direction. With the best will in the world, it is going to be hard for health and wellbeing boards, but, as all our answers have explained, there are also potential ways of working differently to make more of the resources that are around.

**Q157 Bob Blackman:** Andy?

**Andy Murdock:** I concur. There is a question—almost a rhetorical question—that I have not yet come across the answer to. Again, from earlier in the afternoon, there is a £2.2 billion budget that is historical transfer, and you have intimated “Well, is that right?”

**Q158 Bob Blackman:** I do not think anybody knows.

**Andy Murdock:** Has anybody done that analysis? What concerns me is, if the view is that we should be moving to more public health and preventative type care, I do not necessarily see that tide moving massively. We talk about it, but I do not see the tide moving massively, and therefore the cash that goes alongside it. Has anybody done that analysis? I suppose it is a bit like a Wanless-type review for public health. I know Marmot did it, but have we got a cash analysis that sits there and says £2.2 billion is the right figure or not?

**Q159 Bob Blackman:** The BMA suggest, for example, that all public health funding should be signed off by the director of public health in the area. Do you think that is the right level, or should we devolve down further?

**Andy Murdock:** It depends how you classify what public health is at that point.

**Q160 Bob Blackman:** For example, if it is the whole budget that is dedicated to public health in the area,

should it be signed off at the director level or should it be devolved to particular areas within that bigger area?

**Andy Murdock:** Ultimately the activity within those subareas—if I can use that terminology—will be determined by the JSNA and the joint health and wellbeing strategy. Once that is signed off, and the director of public health buys in to that strategy, then, to me, it is a devolvement down to that particular level.

**Q161 Bob Blackman:** Richard, do you have any concerns that people representing housing and housing bodies do not have an automatic right to be on these health and wellbeing boards?

**Richard Blyth:** I concur, to a certain extent, with the views expressed by the District Councils’ Network, in the sense that services provided by district councils are very important in the social determinants of health. I also recognise that, if you have got a county with 14 districts, you are not going to have 14 districts around the table. I understand that, in evidence put to you, there have been examples of the ways in which districts have clubbed together to make a single voice in twotier areas. It is not necessarily just a housing question: it is a question of the whole function of district councils. In some large areas where, for example, the council has become unitary, one of the bases on which unitary county councils were set up was partly a compact saying, “If we have a unitary county council, we will do a lot more devolvement of decision making.” Arguably, that same model could be used in relation to the question you posed, as it has already been used by some of those large unitary county councils already.

**Q162 Bob Blackman:** An argument could be put that people suffering multiple deprivation frequently are in social housing, and yet the landlords of that social housing—be they housing associations or authorities—do not have an automatic person on the health and wellbeing boards. These are the very people that have the severest inequality in terms of expectancy. Should they not have an automatic right to be there?

**Richard Blyth:** It is difficult to say, because of this whole question of the size of the board and the area they are covering. I do not have a view about whether I would definitely say that housing should have an automatic seat.

**Q163 Bob Blackman:** Any other views? Paul, you were nodding.

**Paul Woodward:** I think they should. Certainly, people living with neurological conditions will have some housing need at some point, and therefore the sooner that is plugged in, the better. I can give you an example of somebody we care for with multiple sclerosis who waited for four years to get appropriate housing. Of course, because she has a degenerative condition, she now cannot use the house that she is in, so she cannot use the stairlift and get upstairs. She has now converted her dining room into a bedroom, and the only sanitation is an outside toilet, and she has to have her clothes removed in the house before

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going out to this thing. All the while, the local council and the housing association are arguing as to who should pay for any sort of conversion. After many months of arguing, it has been decided that she is going to have to be moved anyway.

**Q164 Bob Blackman:** The only drawback of that—and I have every sympathy with that specific case—is that it is a specific case, and the health and wellbeing boards are going to be looking at the generality of spending and not necessarily specifically.

**Paul Woodward:** But it is symptomatic of not plugging housing in when you are looking at the overall needs of somebody with a very complex condition, and so the earlier that is put into the equation and the greater understanding that the health and wellbeing boards have about very complex conditions, the sooner they can start planning.

**Richard Blyth:** There certainly might be a case for saying that, although housing is not in the national outcomes framework, it may be that local areas might wish—in terms of the strength of feelings expressed tonight—to include it in local outcomes.

**Q165 Bob Blackman:** Caroline, any concern for the elderly?

**Caroline Abrahams:** We said that we thought housing should have an automatic seat at the table, but representation on these boards is not everything. I think it is also open to boards to set up other arrangements for ensuring that really important issues get the airtime that they need. We certainly know of one or two that have set up specific subgroups of people to look at the importance of housing, and that is another way in. What matters is the priority they accord to it. We totally agree that it is a very important issue.

**Q166 Bob Blackman:** Andy?

**Andy Murdock:** No. Nothing further to add on that.

**Bob Blackman:** Fine. Thank you.

**Chair:** Thank you very much for coming to give evidence to us this afternoon.

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## Monday 3 December 2012

Members present:

Mr Clive Betts (Chair)

Bob Blackman  
Simon Danczuk  
Bill Esterson  
Stephen Gilbert  
David Heyes

James Morris  
Mark Pawsey  
Andy Sawford  
John Stevenson  
Heather Wheeler

### Examination of Witnesses

*Witnesses:* **Councillor Mary Lea**, Cabinet Member for Health, Care and Independent Living, Sheffield City Council, **Councillor Anthony Devenish**, Cabinet Member for Public Health and Premises, Westminster City Council, **Councillor Nick Forbes**, Leader, Newcastle-upon-Tyne City Council, and **Liam Hughes**, Independent Chair, Oldham shadow Health and Wellbeing Board, gave evidence.

**Chair:** May I welcome you all to our third evidence session of the Inquiry into the role of local authorities in health issues? Just before I come on to our first witnesses, we have a new member of the Committee, Andy Sawford, and at the beginning we ask new members to make a declaration of interests for our records. So, Andy, over to you.

**Andy Sawford:** Thank you, Chair. I am in the process of resigning from a number of posts, including my trusteeship of the Centre for Public Scrutiny and a number of posts related to my previous employment as the chief executive of the LGiU.

**Q167 Chair:** Thank you very much indeed for that. That is on our records and noted. Thank you all for coming this afternoon to give evidence to us. You are most welcome. For the sake of our records, please say who you are and the organisation you are representing. Thank you.

**Councillor Anthony Devenish:** Anthony Devenish, Cabinet Member, Westminster City Council.

**Councillor Nick Forbes:** Councillor Nick Forbes, Leader of Newcastle City Council and also a member of the Local Government Association's Children and Young People Board.

**Liam Hughes:** I am Liam Hughes. I am the independently appointed Chair of the Oldham Health and Wellbeing Board and retired from the LGA at Christmas.

**Councillor Mary Lea:** I am Mary Lea. I am a Cabinet Member in Sheffield City Council.

**Q168 Chair:** You are all welcome this afternoon. Clearly, you have a range of different backgrounds, experiences and ways in which you are doing things; however, if there are things that one of the witnesses says that you get asked about and totally agree with, you do not have to repeat your agreement. Just say you agree, and then we can get on to make sure we cover all the issues in front of us this afternoon. We begin with something that we picked up from the evidence from Sheffield City Council. They talked about local government's history of place-shaping and that general role, and how bringing public health within local government and working together could help combine more effectively the expertise that local authorities and the NHS have. We have a lot of

evidence of partnership between local government and the NHS in recent years. Why do you think the proposals we have now for local authorities to work at, with their place-shaping role, might be more successful in the future than we have been in the past at these various partnership arrangements?

**Councillor Mary Lea:** I think in Sheffield we have had some joint posts with public health and the Council for a couple of years. Our director of public health and the public health consultant in children's services has been a joint appointment, and another one was appointed a couple of years ago, the public health consultant, as a joint post. Lots of people say that public health's place is with local government rather than with the Health Service anyway, and many, many years ago, before my time, obviously, that is where it sat—in local government. In terms of Sheffield, and I am sure other local authorities as well, we are a public health council, and everything that we do, you could say, will benefit the public health of the citizens of Sheffield, whether it is in terms of the work we do on employment, the work we do in our communities, or the work we do in our environmental services. It is all to do with public health, and I think public health from the PCT coming into Sheffield will bring their particular expertise in terms of how they can gather information, analyse evidence and so on and so forth, and give that to the Council. The way we have organised the public health staff in the Council is to have the director of public health sitting in a hub—I am not sure if that is what we are going to call it now—and the consultants then sitting in each of the directorates with the staff that they manage underneath them contributing their expertise to that particular directorate within the Council. But I think Sheffield City Council has always been, as I said before, a public health council, whether it is at a very local level in terms of regenerating parks in local areas with friends' groups and so on, to the big new City Deal that we have just gained from Government.

**Liam Hughes:** I would just say that we are in a slightly different world. We are in hard times, and the partnership for a health and wellbeing board is much tighter than anything we have seen before. I think there is ample evidence of partnerships being loosely formed and failing to achieve very significant changes in outcomes for people, and this time, I have to say,

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it feels different. There is more focus and there is more of a sense of commonality, say, between CCG members and councillors in the health and wellbeing boards that I see, not just in Oldham but in the perhaps 18 or 19 others I am working in as well. So I am optimistic despite the evidence of history.

**Councillor Nick Forbes:** Health, be it good or bad, does not exist in a vacuum. It does not exist in isolation of the wider social, environmental and economic context that operates in society, and so, if we think about improving health, we have to also think about the wider determinants of health. I think that is why the new system is different, because local authorities are able to operate in the social realm, in the economic realm, in the environmental realm and in the realm of public policy, whereas I think many of the partnerships that we had before were often about the integration of health and social care service delivery. So this feels to me to be qualitatively different, having public health as part of the local authority function, because it gives us the opportunity to think more broadly about what Derek Wanless called the art and science of changing society. I think it is the art, science and politics of changing society for the better.

**Councillor Anthony Devenish:** I would agree with most of what has been said. I think we have been well prepared. We started 18 months ago in terms of our health and wellbeing board, and I think the cross-cutting nature of some of the issues that have already been touched on is very important, and the preventive side particularly. To give you one example, we have made sure that my portfolio does not just cover public health; it covers licensing as well, and clearly there are cross-cutting issues there. For example, on shisha pipe smoking, which is a big issue in central London, we want to make sure that we work with the community to ensure that we do alleviate those issues, because obviously smoking shisha is a lot worse than smoking normal cigarettes. There are a number of issues we are looking at and working on; there may be pilots on specific issues and attacking those. And we are more local, I think, than the NHS, with the greatest respect to them.

**Q169 Chair:** You have given us practical examples, I think, in your evidence of things you intend to do in your new role on unemployment, dentistry and adult social care. Do you just want to say a little bit more about those and just highlight maybe what the public of Westminster can see in a couple of years' time being different from the way things have been in the past?

**Councillor Anthony Devenish:** We are still working on all the details about each of those, but, for example, we are making sure that we will be focusing particularly on dentistry in the schools where there are issues of deprivation. But there are a number of things we are working on in terms of the evidence.

**Q170 Chair:** Would the rest of you give one practical example of things that you might be looking at where people could see a significant change?

**Councillor Nick Forbes:** We are having a very different approach to alcohol policy. The licensing

legislation has been to all intents and purposes market-led, and yet what we have seen in the health statistics is an extraordinarily alarming rise in liver disease and liver cirrhosis, and a ticking time bomb, I think, for future generations of liver problems related to alcohol. That is why instead of simply looking at alcohol treatment services, which is dealing with the problem too late, we are looking at the environment in which people think about and consume alcohol. That includes looking at the availability of it through not just pubs and clubs but also off-licences. It is about looking at the affordability of it in terms of the price—and we are campaigning as a council for a minimum unit price of alcohol—and also the desirability. This I think is one of the new areas for public health to get into, but we are faced every day in our lives with social norm change behaviour, which is called advertising, and yet nobody is countering that. I think there is a role for public health in terms of changing social norms around the way that we think about alcohol, in much the same way as social norm changes come about through the work done in tobacco control. That is just one example where local authorities will be able to take a much more holistic approach, bringing together their range of regulatory services and other functions in a way that the Health Service, when it provided public health functions, just was not able to do.

**Liam Hughes:** I have two very quick examples. The first is the focus on the emotional wellbeing of very young children and also on early speech and language. Over a period of a few years we should be able to see those children more ready for school at age four and a half or five.

The second example I will give is recognising that the support for the carers of people with dementia is critical to making the whole system hold together. That has been a particular major focus, and whilst we have put the first building blocks in, we are in the middle of a very interesting debate about which is the most effective way of providing support to those carers, supported by the Alzheimer's Society and others.

**Councillor Mary Lea:** Over the course of this last year, we have had a task and finish group of local members looking at what the public health service does that is coming over to the Council. We have looked at that in terms of just the work that they do and also what priorities we might have as members in changing some of that work. We would like to see rather less work done on getting people to change their lifestyle, and more work done on looking at the root causes of ill health—some of the barriers that people have in changing their lifestyle. We could say we have two parts to Sheffield: we have the southwest of the city, where people have taken on the lifestyle messages and are living longer and healthier lives. They have taken on all the health messages and are doing what we exhort them to do—take responsibility for their health. But in other parts of the city, for some reason—because of, I am sure, the barriers that lie there—it has proved very difficult for people to take on those lifestyle messages. So we want to get to the root causes of some of the barriers that are preventing people from making those changes that will have

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long-term benefits for them. That would be one of our priorities.

Another one is to do with what we can do as a council to lobby Government in terms of some of the big health issues that we face: for example, obesity, how food is produced, how food is manufactured, how food is advertised and sold. I think there are some changes there that only Government can make. We also want to look at some of our by-laws to see what we can do in terms of where food outlets are placed: are they near schools? Do we want some food outlets, takeaways and so on, in certain places? We want to look at what we can do about those sorts of issues.

We think it is really important to focus on early life, nought to three, that age group; that is obviously vital.

**Chair:** That is one or two examples, which is fine. We will probably come on to some of those issues in a minute.

**Q171 John Stevenson:** The health and wellbeing boards are central to the changes, but under the legislation there is limited statutory prescription as to membership. What I would be interested to hear from each of you is who is going to chair in your particular area, what is your membership over and above the statutory requirement and how will you have future appointments?

**Councillor Anthony Devenish:** Our Leader chairs our Board, and I think that is a good example; it is not me as just a cabinet member but the Leader of Westminster City Council, Councillor Philippa Roe, who chairs it.

In terms of the membership, we are still considering exactly how wide that is, but we already have a number of both voluntary sector and NHS individuals involved. We are tri-borough in Westminster, so we are also involved in the Royal Borough of Kensington and Chelsea, and Hammersmith and Fulham, so, again, they are all involved in the process.

I would not want to preclude the future. We have an open mind on it at the moment. We are 18 months into our Board running shadow-wise, but as to how we get members, I personally have an open mind; if somebody adds value, we would certainly consider that organisation for the Board.

**Q172 John Stevenson:** Will the additional membership in your case always be with the Council rather than the Board itself? Once the Board is formally constituted, would it choose successor members or would it always be the Council that decides what the membership is?

**Councillor Anthony Devenish:** I think I would probably have to reflect on that.

**Q173 John Stevenson:** Are you going to have a limit on the number as well or be open-minded?

**Councillor Anthony Devenish:** I think we are open-minded about that.

**Councillor Nick Forbes:** In Newcastle, I chair the Wellbeing for Life Board, as we call it. As Leader, I also chair the Council's Cabinet. It was a very explicit decision to do both, because I think the Cabinet is the internal decision-making arrangement within the Council, and I have constituted the Wellbeing for Life

Board as the major partnership within the city, so I am one of the pivotal points between inwardly looking to the Council and externally looking to partnerships within the city.

The way that we have structured the Board is around what we are calling a Newcastle Future Needs Assessment, which is a successor to the JSNA—joint strategic needs assessment. The JSNA process defines particular areas of need in either health or social care. The Newcastle Future Needs Assessment process that we are adopting looks at the whole lifespan in the city of the population, so from cradle to grave. The idea is that, if we can use our partnership arrangement through the Wellbeing for Life Board to determine at which points in people's lifecycles they are held back—

**Q174 John Stevenson:** I just want to concentrate on the membership rather than what it is going to do.

**Councillor Nick Forbes:** Yes, but the reason I am explaining this is because it explains the rationale for the membership. We therefore know the points in people's lifecycles where they perhaps are held back from achieving their potential, which means that we can target resources, which means that over time, using shared analysis between public sector agencies, we can start aligning resources around that. That starts to inform the wellbeing strategy that we are developing, and the wellbeing strategy itself will determine the future membership of the Board, depending on the areas that it needs to focus on.

**Q175 John Stevenson:** So what you are saying is that you think your Board will continuously change.

**Councillor Nick Forbes:** Yes.

**Q176 John Stevenson:** And who will determine that change? Will it be the Council or will it be the Board itself?

**Councillor Nick Forbes:** Ultimately, it will be a committee of the Council, under the governance arrangement, so it will have to be ratified by Council, but as a partnership I would not expect to make changes without reference to the wider city.

**Q177 John Stevenson:** And would you put a limit on the number of members of the Board?

**Councillor Nick Forbes:** I do not think big boards work. We are currently thinking about whether some kind of broad-based board membership but with a smaller executive structure would work in terms of making sure that we cover day-to-day business. The other thing we are looking at is, to avoid confusion, thinking about a public sector agencies board that would look at issues around service delivery so that the Health and Wellbeing Board can focus on the strategic picture.

**Q178 John Stevenson:** So you would envisage trying to keep the Board as small as possible.

**Councillor Nick Forbes:** I would try to keep it as small as possible. It is that paradox of people feeling included and involved but not necessarily having a seat at the table.

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**Q179 John Stevenson:** Mr Hughes, you have rather a different set-up, because you are an independent chair.

**Liam Hughes:** Yes, I am independent simply because the Leader was new and there were lots of changes on the NHS side and the local government side simultaneously. My job is to steer the Board in shadow form into existence, and at that point the Council will reflect on how it wants the Board to be chaired.

One thing we did was have a look at the skills, knowledge and experience of the people on the Board against what we thought were the emerging themes from the JSNA and from consultations, and we were really short of people who understood regeneration and housing in depth. We have co-opted from the social landlords an able member to the Board not as a representative—and that is very clear—but as a full Board member, because of that background and skill that we felt we were missing.

**Q180 John Stevenson:** Is it the Board doing that rather than the Council?

**Liam Hughes:** The Board identified the gap. I then had a conversation with the Council Leader and Chief Exec about filling the gap. The decision is the Council's, so that is how it has worked in our context.

**Councillor Mary Lea:** In Sheffield we have one CCG, which is very helpful, and we decided early on that four GPs, the Chair of the CCG and three others would sit on the Board—and four Council members.

**Q181 John Stevenson:** How many Council members?

**Councillor Mary Lea:** Four elected members. The Leader of the Council and the Chair of the CCG are co-chairs of the Health and Wellbeing Board. I sit on it, obviously, because my portfolio is health, the Cabinet Member for Children's Services and the Cabinet Member for Housing. The reason we chose housing is because we think it is so fundamental to health that we need a direct link in to the Cabinet Member and the housing services that his portfolio provides. That is how we have made up the Board.

We made a decision that at the moment we will not have providers sitting on the Board. We have had lots of people beating on the door saying, "Please give us a place on the Board," but we have decided that there may be conflicts of interest with providers, and we want to take a very strategic view from the Council and the CCG perspectives of health and wellbeing across the city. I think the plan will be in time to have sub-groups, where we will call on the expertise of other people in the city, whether it is housing, social landlords or the trusts or whatever, to do specific pieces of work or to advise us.

**Q182 John Stevenson:** Out of curiosity, none of you have decided on an absolute number, so in the future it would obviously be at the discretion, I think, from what you have all said, of the Leader of the Council of the day or the Council to appoint additional members. Effectively, what you are saying, I am concluding, is that the Council would have a very, very strong influence on the direction of this board and should

there be a difference of opinion on the board and there was a vote, quite clearly it would be, to a very large extent, the ability of the Council to determine the final decision. Would that be correct?

**Councillor Anthony Devenish:** I would not quite put it like that, but I guess, effectively, governance-wise that is probably the case.

**Liam Hughes:** I wonder if I can just say two quick things. One is: if it comes to a vote too often, we have probably missed the plot. We are probably in the wrong place.

The second thing is it feels to me very different in large counties and in unitary metropolitan authorities, and I have seen some large counties set up a very large board but then pay very little attention to the executive and working groups that hang underneath it. That is because of the sense that the district councils are very important players in this, and we have seen a number of different systems, from a federated system of one or two representatives from the districts through to all district councils having a seat on the board, and the numbers can vary between about 20 and up to 30-odd.

**Q183 John Stevenson:** Do you envisage a difference between the unitaries and the two-tier authorities in terms of the success of this?

**Liam Hughes:** I do not see why there should be a difference in the success if the design is functionally sorted out in terms of those two layers. I cannot say that I think that large county boards are heading towards being unsuccessful, because that is not my experience of them up to this stage.

**Councillor Nick Forbes:** I would just raise a potential inconsistency in Government guidance here, because I think what we are reflecting on is the importance of local democratic leadership in the process, and yet the Government has specifically barred councillors from being members in CCG boards. It just feels to be an inconsistency that needs not be the case.

**Q184 Andy Sawford:** Would it be your view that councillors should sit on clinical commissioning group boards? What would be the advantages of that?

**Councillor Nick Forbes:** Certainly our experience in Newcastle is it has been invaluable in terms of simply being a channel of communication between the Council and the CCG. So, in my case, I have two deputy cabinet members who sit on our two CCG boards. They are able to relate the priorities of the Council to the CCG Board and relate the priorities of the CCG Board back to the Council. Severing that link for no apparent, obvious purpose is a mistake.

**Q185 Chair:** On that point, we went to Kent to look at what they were doing there. What came out very clearly was that the overall strategy was very much being driven by the County Council along with the districts on sub-groups, but the commissioning groups were, in the end, meant to be implementing their commissioning according to the overall strategy. Is that what is happening in your areas as well?

**Councillor Nick Forbes:** I think we have a way to go on that. My experience of the CCGs is that, firstly, a lot of the time that they have spent over the last six

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months has been on the authorisation process, and therefore they have just not had the capacity to get involved in the wider discussions in the city about the future vision and direction. Secondly, I think CCGs are working within a very nationally prescribed framework, and therefore have very strong clinical delivery targets that they have to meet, and I think that limits their ability to operate within a partnership environment, particularly in terms of deployment of resources. There is a fundamental issue here about the balance of power between CCGs and providers within the NHS. The gravitational pull of the big foundation trusts is such that, if you look at the allocation of resources between prevention and treatment, you see it is almost all skewed towards treatment within the NHS. I would question whether many of the public health resources that we are thinking about inheriting in the future are fit for purpose.

**Q186 Chair:** We will come on to that point in a second. Anything else?

**Councillor Mary Lea:** Obviously, we have our joint health and wellbeing strategy, and we will look at our commissioning plans based on that and challenge each other when necessary, but that is the fundamental basis of how we will go forward. As part of the work of the Health and Wellbeing Board, we have five other strands of work that are ongoing with GPs and members taking a lead: health, unemployment, care closer to home, emotional resilience and mental wellbeing, children's services—looking at early years—and food and activity as well. Those five work strands are ongoing at the moment, and they will feed into the strategy as we go along and into the commissioning plans.

**Chair:** So they may influence commissioning plans as well. Okay, that is fine.

**Liam Hughes:** Every one of our strands of work has a GP attached, and they are enthusiastic. The real success for me was shown in Fair Fuel with the building up of the co-operative arrangements, which the GPs supported and put cash on the table for. That was a sign that things were changing.

**Chair:** Getting GPs to put in cash is certainly a step forward.

**Councillor Anthony Devenish:** We have not found any particular issues, because we have a programme board that is chaired by a chief executive and we have the same kind of work streams as the others. The others I am sure have contract and commissioning, finance and procurement, communications, HR, information governance and IT, and estate and facilities. We have a robust risk register and we have been going for quite a while now, so I think we are fairly confident.

**Q187 Bob Blackman:** Turning to the vexed issue of funding, obviously the Advisory Committee on Resource Allocation have come out with a draft interim funding formula under which, uniquely, all four of you lose, so I assume you are not very happy about that. As I understand it, it is based on the under-75 standardised mortality ratio. Presumably there are other factors that you would like to see included in the formula.

**Councillor Anthony Devenish:** Absolutely.

**Q188 Bob Blackman:** At Westminster you lose most of all, so there must be some things that you would like to see included.

**Councillor Anthony Devenish:** The two biggest examples are that about 35% of our spend is demand-led on open access sexual health services and around 39% is demand-led drug and alcohol services. To put it in layman's terms, obviously Westminster has about 200,000 residents, but we have three-quarters of a million people coming into the city every day and it is those younger people who are coming in to enjoy our city who also, dare I say it, do other things. I would not say they are a drain on resource—that would be the wrong word—but we have to allocate resource for those individuals.

**Q189 Bob Blackman:** Westminster is a unique case because of the transient nature of visitors, but should those visitors not be looked after by the local authorities where they live rather than by you?

**Councillor Anthony Devenish:** Well, no, because the reality is most of those people who come out and socialise often work here, and therefore they are going to be here during the day getting the medical resources they need. Wherever they come from, they may only sleep there. They spend as much or more time in Westminster as they do in their own communities, so that would be more feasible for them and for their businesses and for the wider national interest.

**Q190 Bob Blackman:** Apart from parking, how else do you charge them for the services you provide?

**Councillor Anthony Devenish:** Hopefully, through the DH agreeing to the suggestions that we have written to them about and asked for.

**Councillor Nick Forbes:** We suffer from a not dissimilar phenomenon, which is that the number of people who turn up and use Newcastle's services is far higher than the number of Newcastle-based residents. Similarly, in the use of sexual health services, use of drug and alcohol services, homelessness support, we tend to find we have higher levels of need than our base population simply because of our position as a city that people gravitate towards.

**Q191 Bob Blackman:** So what factors should be taken into account for this funding formula?

**Councillor Nick Forbes:** My understanding is that the funding formula has been shifted towards age, whereas I think that is a separate argument. Indeed, the Public Health Outcomes Framework clearly says it is about increasing the length of life and tackling health inequalities, and yet the funding that is there to tackle all of the areas of deprivation that prevent people from living a long and healthy life is most at risk and is being cut back. I think there is a separate argument about provision of services for an ageing population from one of providing public health services that enable people to enjoy a long and happy life, and yet they have become confused within the argument about the funding formula.

**Liam Hughes:** I would just say one very simple thing. If we are listening to Sir Michael Marmot, we are



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looking at the 100-year scenario. That suggests that we invest early on and, if we are doing that, the formula is not fit for that purpose.

**Q192 Bob Blackman:** So what would you like to see included in that formula?

**Liam Hughes:** This is a very small thing in the total picture, but I would want to look at how well children are doing in terms of their speech and language development as well as their emotional development. These are tricky to count, and I know that the technicians will say, "It is very hard to get to readiness for school," but I am looking for that. That is what I would really want: to make sure that the Oldham children went into school with a fair chance.

**Councillor Mary Lea:** I would agree with everything that has been said, but I would just like to point out as well that we are facing significant budget cuts in Sheffield, as other councils are, particularly in our Early Years Service. Much of the work that the Council does, as I pointed out before, is public health work, and the resources are now being cut for some of the services that provide that kind of work. Although public health will bring some resources with it, it will fill a gap.

The welfare reforms that will kick in next year are going to cause significant problems and difficulties for already very vulnerable and deprived areas. There is £180 million that will probably go out of Sheffield's economy and out of people's pockets, out of families and out of communities, so that is going to be very difficult. We have some significant communities in Sheffield that are deprived and also we have lots of migration into the city, particularly from Eastern Europe. These are people who have come from extremely deprived circumstances in their own country and have very great difficulty adapting to the communities they are going to live in, which causes some difficulty. So we have all of these cuts, we have the welfare reforms, and although we will have the resource of public health and the expertise, we are not starting from where we were a year ago and building on that, so it is going to prove extremely difficult.

**Q193 Bob Blackman:** Where do you stand on ring-fencing and the money for public health being ring-fenced: for or against?

**Councillor Anthony Devenish:** I think it has been a very simple way of doing it in the past, and I do not particularly feel you need to ring-fence it. At local level we can spend the money we get whatever the figure is.

**Q194 Bob Blackman:** But suppose in Westminster you are going to take a potential cut of 57%, according to the figures we have. So, your Leader is going to say, "You are not getting any more, so you have to do public health with the money you have and, funnily enough, I need some of that money for other purposes."

**Councillor Anthony Devenish:** To some extent, but we would like to work out our overall budgets. It is the overall pot you have, and obviously we want to put our begging bowl out, to put it bluntly, but we do not really need to ring-fence it. In the old days,

wherever it was ring-fenced, you had lots and lots of people having to administer exactly what you spent everything on in various budgets; that is not a way we want to go back to.

**Q195 Bob Blackman:** Okay. Nick, where do you stand on ring-fencing?

**Councillor Nick Forbes:** Instinctively, I do not think ring-fencing is a good idea. I would like to see simply the resources of the Council being considered as public health resources.

**Q196 Bob Blackman:** As I understand it, there would be nothing wrong with you deciding to take some resource from other purposes and putting it into the budget.

**Councillor Nick Forbes:** Except the experience that we have had over the last few years of the Government de-ring-fencing budgets at the same time as cutting them means that I do not think it would be a sensible thing to do at the moment, because public health colleagues need some certainty that public health will continue to be seen as a national priority. One of my concerns is that, if it is de-ring-fenced entirely immediately, it will simply disappear into local government in the context of the massive cuts we are facing.

**Q197 Bob Blackman:** Would you prefer a place-based budgeting system rather than ring-fencing?

**Councillor Nick Forbes:** Absolutely, yes.

**Bob Blackman:** Presumably, Anthony, you are the same.

**Councillor Anthony Devenish:** At the end of the day, it is the money you get.

**Bob Blackman:** And how you use it.

**Councillor Anthony Devenish:** Yes, not the ring-fencing versus non-ring-fencing.

**Councillor Nick Forbes:** There are far too many turf wars between adult social care, children's social care and health service delivery. I agree entirely; what we need is a total-place budget approach that looks at the whole system from a population and people perspective rather than an organisational perspective.

**Q198 Bob Blackman:** Can I get Liam and Mary's view?

**Liam Hughes:** What I would add to this is that I think ring-fencing will serve a purpose for a period of time, and that purpose will be to give confidence to those staff who are transferring into local government.

**Q199 Bob Blackman:** So, if it is interim, how long should it last?

**Liam Hughes:** I think it should last for five years, but that is a personal view.

I think there is a slightly different set of questions around substitution. Substitution is where the local authority is running some public health service and is being hit in the way Nick has described, and it chooses to take that into the ring-fence because it is part of the function that has been transferred. I think there are subtly different arguments about each of those.

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**Councillor Mary Lea:** I agree. I think there will be some pressure in terms of what the council delivers in terms of public health activity and what the public health service already delivers, which is very similar, so there will be pressures there. But we would like to see maybe more powers devoted to local government so that we can tackle more of the social determinants of poor health and inequalities. In particular, maybe we are looking at the Work Programme. That may be something that we would like to see devolved down to local authorities, because we think we can maybe make a better job of that than is currently happening. We know our local people and our local communities; we know how to get in there and address those issues. Also, in terms of any welfare savings that are achieved by getting people back into employment, maybe some of that money should be then brought back to the local authority so that we can again use that to tackle some of the social determinants of ill health.

**Bob Blackman:** You can recycle it. Thank you.

**Q200 Andy Sawford:** I sense a difference of view. Anthony, your perspective is that community budgets are the right thing but, Nick, you were arguing for both. It seems to me that if this Committee were to make a recommendation that ring-fences should remain for a period, then—you were juggling with it in your answer—that does somewhat argue against the case for total-place community budgets. So I would just put it to you that they are contradictory positions. To your point about the turf wars, if you want central government to be the grown-up to resolve the turf wars, then it will be. But if you want to make the argument to have total-place community budgets, then you must do so very strongly with the down side of the ring-fence. We will need to take a position on this.

**Councillor Nick Forbes:** There is an idealistic solution, which is about simply looking at the resources available in an area and deploying them according to the need of the local area. That is my vision for how things would work. That is how we are structuring our Wellbeing for Life Board. That is how we are putting in place the Newcastle Future Needs Assessment. We are trying to get to that point. There is a series of tactics, though, to go through first, which recognise that we do not live in an ideal world yet and there are politics at play. I do not mean big “P” politics; I mean small “p” politics, between different organisations. There are certainly politics around the funding formula, and there are issues around needing to instil confidence in people who are transferring from the NHS to local authorities that public health is treated seriously across the board and not just by those local authorities that are saying that they are treating it seriously. So, for me, there is a kind of “this is where we want to get to” argument, but there is a “this is how we are going to have to deal with it in the short term in the real world” argument as well. That is why I think Liam’s point around protecting the ring-fence for a particular period of time is probably the most pragmatic position in the circumstances.

**Q201 Heather Wheeler:** I would like to take us towards the practicalities of merging all of this

together. How have you found bringing National Health employees into local government and becoming local government employees? I am just wondering if, very briefly, you could give us a quick rundown on how you got on and what issues that brought to bear.

**Councillor Anthony Devenish:** It is like any major transition: it is how early you start, the fact that you plan it properly and you have two-way communication. We have had a very good reputation and history of the NHS locally anyway in Westminster, and we are just continuing that process. We are TUPE-ing over potentially up to 38 people. We have our DH here today, and she is working closely with the individuals. By early action you can avoid losing good people, because otherwise they do get concerned about their job security, obviously. As I say, we have been doing this for well over a year, so it is prior preparation—the old cliché.

**Councillor Nick Forbes:** One of the things we have found quite difficult to get to the bottom of is exactly what is being commissioned by the NHS in public health terms. A lot of the contracts that we have been presented with as public health legacy contracts look to me as though they are more like service delivery contracts that should be mainstream commissioned services rather than public health activity. So I think what it has revealed is a difference of opinion on what public health activity is between the PCT in the old world and local authorities in the new world. I think part of the role that we are having to go through now is to navigate those differences of opinion in a relatively short period of time to come up with conclusions that will match our priorities as a council.

**Liam Hughes:** I just wanted to talk about culture and the change of culture that comes with entering local government. The LGA with the Department of Health ran a series of workshops for staff working in public health well before the transfer. At first, they did not know that much about how councils operated and they were very pleased to hear from leaders of councils, chief execs and others about that. There was a light-bulb moment when some of them realised that, even under these difficult times in local government, there are far more career opportunities in the local authority than there would be in a small public health department inside a PCT. I think that began to open up different sorts of discussions with those staff, because they bring a skill set that is about public health in the way Nick described it—in the very widest sense.

**Councillor Mary Lea:** We have had a transition board up and running for quite some time now. I think it started towards the end of 2010, beginning of 2011, and that has been working with the local authority, the PCT and the trade unions to cover the transition process from the PCT into the local authority. That has worked well. We have held a number of induction workshops for staff and we have done an equalities impact assessment—that is ongoing—and staff are moving in. I think some of them were moving into our premises last week. They all started to move in and find computers and desks and you name it. But I think one of the things that has been highlighted for many staff is a big cultural shift, and we should not

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underestimate how difficult that can be. Intellectually, they might have thought this might be a good move for them, but I think their hearts are with the Health Service, because that is where most of them have been for most of their working life, so they have to make that shift. I think also we need to help them to look and discover the opportunities that are there within the local authority that you certainly would not have within the Health Service. As we have said before, the Council is a place-maker, if you like. We can gather people together. We can get all the organisations within the city. We can ask people to come together to discuss any problem we would like them to discuss and come up with solutions, and public health will have access to all that resource, which I do not think they have had in the Health Service. We have to help people understand those opportunities as well as help them through this difficult time.

**Q202 Heather Wheeler:** My second question, which sounds like it is going to have unbelievably brief answers—which is good because I have a third question—is that I was wondering whether you were envisaging having problems filling vacancies and if you needed any extra budget to do that. But it does not sound like you are going to have any problems, which is very good news. What do you reckon?

**Councillor Anthony Devenish:** I think I would rather go back to the demand budget point than this point. I cannot foresee every circumstance, but the demand issue of potentially London Councils saying, “We are losing 57% of our money,” is our number one concern at the moment.

**Liam Hughes:** I think there is a problem. I think we will discover that a significant number of senior public health leaders will take this opportunity to retire, and I am not sure that we are doing enough to prepare the next generation for working in the new context that they will be in.

**Q203 Heather Wheeler:** That is great. I will do my third and last one, if that is okay. Now that the staff are moving into the local authority world, with much more access to political members and councillors, which they would not have had in the public health service, do you think the priorities that they are going to work to are going to be swayed by public issues rather than time-served knowledge about what they ought to be doing, whether it is addressing smoking, obesity or whatever it is? There is going to be a public issue that the councillors are going to demand they spend their time on.

**Councillor Nick Forbes:** I think at the heart of that question is the fundamental issue about what the role of public health staff is and who public health professionals are. I consider myself, as Leader of the Council, to be a public health professional because, to me, public health is about improving the quality of life for everybody. I think the role of public health specialists who are transferring is to enable a wider discussion about the things that local authorities can do that will make a bigger difference. That is a crucial point about the integration of public health into local authorities: it is not about a stand-alone department that will come and sit alongside everything else; it is

about something that has to permeate. To use an analogy, it is a bit like putting squash in a glass of water. We need it to dilute right the way throughout rather than remain concentrated at the bottom, and occasionally it might need a bit of a stir to do that.

**Q204 Heather Wheeler:** Good luck with that. Mary, do you have some views on that?

**Councillor Mary Lea:** I think the most valuable thing that we feel is coming across to the Council is the expertise of the people that are going to come and join us. It is not so much the activity. The activity can be shaped and changed and will change over time. I do work already with public health consultants in the ward I represent. I work with the local public health staff and have worked with them closely over a number of years, including the consultants, so there is that contact already. I think there is a bit of a change in culture, because elected members have an opinion and they will give it. They will say, “These are our priorities,” and maybe sometimes it will conflict with what they feel they have always done as health professionals. Obviously, we will prepare them for that, but we do listen to advice, do we not? We do not ignore it, and we can be very helpful to them as well, as local members—extremely helpful to them.

**Liam Hughes:** I ran a PCT and I just want to say that there were debates and sometimes conflicts about evidence and particular themes that commissioners were wanting to pursue, and that was happening even within the PCT. I think that is healthy, because I think we need to look at the best evidence we can get but also check it out against our intentions and our values and that grey area, where things are not very well evidenced, which is an awful lot of daily life in cities.

**Councillor Anthony Devenish:** I would say that Westminster has a number of amazing councillors who do specialise in particular areas of local government. There are one or two that specialise in the health area and I think their views are very valid. We are a very diverse council in terms of everywhere from my ward, Knightsbridge and Belgravia, to Harrow Road, which is a very deprived ward, and I think it is right that the clinical experts, who are excellent, interface with the councillors and come up with locally based solutions.

**Q205 Simon Danczuk:** Concerns have been raised about immunisation and screening services and that began to get me worried about them as well. Then, to add insult to injury, the Chief Executive designate for Public Health England told this Committee, and I am quoting him here, “There is an issue about screening and immunisation. I agree that we would not have invented this system,” which caused me even more anxiety. If we start with you, Anthony, have you received assurances from Public Health England that immunisation and screening services will be maintained and local diversity will be considered?

**Councillor Anthony Devenish:** Well, I think we are having a dialogue on this issue. Because of the churn of the population, particularly in places like Westminster—and some of our wards have a 30% or 40% churn a year—there is clearly the issue that a woman could be on one list in our area and just miss

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it and then move off somewhere else where they have already done the list for breast cancer, for example. So it is certainly something that we need to give some thought to.

**Q206 Simon Danczuk:** You guys have been good at it from what I have read previously. You say you are “having a dialogue”. We are running out of time; are you a bit concerned like I am?

**Councillor Anthony Devenish:** I think there is always concern, absolutely, but I always like to look at solutions rather than just saying the word “concern”. We need practical solutions at a local level and, yes, we would obviously like them to particularly take account of local factors in places like ours.

**Q207 Simon Danczuk:** Are you comfortable and confident that everything will be in place and it will be seamless?

**Councillor Anthony Devenish:** “Seamless” is a great word, is it not? I think we need to keep the dialogue going.

**Q208 Simon Danczuk:** Okay, fair enough. Nick?

**Councillor Nick Forbes:** The concern that I have around immunisations and screening is that any period of transition means there is an increased risk that people will slip through the net, and what I have not yet seen is sufficient contingency planning to ensure that that does not happen. I think there are opportunities with local government, particularly through things like Sure Start. The reach that local government has to communities in very different ways from the Health Service gives a great way of reaching parents who otherwise would not be part of the system and people who are most likely to slip through the traditional Health Service net—the people who might get one of the MMR vaccines, but not all three, for example, or follow up on the course. But it does seem odd, and I agree with Mr Selbie’s evidence: having it as a responsibility of the Commissioning Board rather than the new local authority arrangements I think misses the local flavour of what is needed in order to ensure that it is consistent across the board.

**Liam Hughes:** My experience is that nurses are fundamental in this, and the question is: can you deploy them? When you need to, can you take them off other work that they are doing and make sure they are directed to the response? I think an area that came round very well in a practical example, but after a really worrying time, was on Merseyside in relation to the measles. That shows just how serious this is and why we need to take it very seriously. I do not think I am reassured. Although I know people are working as well as they can locally, personally I am not yet reassured.

**Councillor Mary Lea:** I think there is an issue about the relationship between councils and Public Health England. I think that needs to be worked through and sorted out.

**Q209 Simon Danczuk:** What is wrong with it, Mary, just briefly?

**Councillor Mary Lea:** If we look at health protection, we only found out on Friday that community infection

control is coming to the Council. This is very late. It all happens in a few months, and we have only just found this out.

**Simon Danczuk:** Sure, and we have Christmas in between.

**Councillor Mary Lea:** Yes, and Christmas is in between, so that takes a couple of weeks out. So we just found out last Friday that comes to the Council. There are also things like TB: whereas the PCT had control of the treatment and management of that, it is now divided between the CCG and Public Health England. It is very difficult to see how that is going to join up. At the same time, directors of public health have to ensure the safety of the community and the safety of the people within Sheffield. When other people have the authority and resources for commissioning these services, it will prove very difficult. So I think those issues do need sorting through, and very quickly.

**Q210 Simon Danczuk:** You are not assured either, are you, Mary?

**Councillor Mary Lea:** No, I am not.

**Q211 Simon Danczuk:** Just staying with you briefly, Sheffield said in its submission “there is still no clarity about how the on-call, out-of-hours cover for health protection will operate”. Are you still unclear about that? Do you still have concerns?

**Councillor Mary Lea:** Yes, we are still unclear about how that will operate and we do have concerns, so we do need some clarity on that. That is urgent, I think, as well.

**Q212 Simon Danczuk:** My final quick question: the BMA, an important organisation, have raised some concerns. They said, “Current proposals do not address the need to establish an effective health protection workforce at the front line.” They also raised concerns that organisations that have a national role will have difficulty tailoring their responses to local plans. How do you respond to that, starting with you, Anthony, just briefly? What do you say to the BMA?

**Councillor Anthony Devenish:** They are a respected organisation and they have their point of view. What I would like to do is push the whole localism agenda generally and let Westminster decide for Westminster.

**Councillor Nick Forbes:** The fundamental point I make is we do not know whom to talk to, because Public Health England does not exist yet, apart from in shadow form. So it is not just what conversation do we have, but who do we have it with? I do not know.

**Simon Danczuk:** Is that proving a real problem?

**Councillor Nick Forbes:** Yes.

**Liam Hughes:** Yes, and directors of public health historically have been absolutely instrumental in making this work. I think they need to have that role reinforced, and it is local. The issue is it is local but it spreads over several authorities, so that will be a test of working co-operatively, say, in Greater Manchester or Merseyside or up in the North East.

**Councillor Mary Lea:** In terms of our Director of Public Health, he should know to whom to go to get some of the answers that we need to clarify these

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issues, but I think it is proving very difficult for him to get the answers that he needs in order to advise us as a council.

**Q213 Mark Pawsey:** I would like some views on what success will look like. What measurement criteria would each of you place on the new regime? How do we know whether it is working or not, and are you happy as individual authorities to be called to account for the activity you have done and the results that have been achieved?

**Councillor Anthony Devenish:** Well, it will be the preventive measures that we decide on in our plan in terms of going forward effectively. We have two overarching main priorities: one, the lifelong health and wellbeing of people in their first five years and then the issue of older preventive work for senior citizens going forward effectively. We are working on various KPIs at the moment. They are under development at the moment.

**Councillor Nick Forbes:** Nobody has held the NHS to account for the fact that health inequalities have widened over the last two decades, and I think that partly reflects that health inequalities are multi-faceted, complicated, and driven by a wide range of factors.

**Q214 Mark Pawsey:** Alright, I accept that. How are you going to identify the activity that your council does in narrowing that gap?

**Councillor Nick Forbes:** We are presented with whole options around dashboards and all sorts of indicators. The three that I am going to be watching out for are smoking rates, because half of the health inequality rates are due to smoking, particularly in routine and manual workers, so I will be looking very closely at smoking rates. I will be looking at literacy rates, because leaving school able to read and write is probably the biggest single factor of being able to cope in a modern, complex world. And I will be looking at employment rates and unemployment rates, because being in a job is the best single factor in terms of people's mental wellbeing and health. So, in amongst the whole cornucopia of options that we have, those are the three that I am going to be looking at.

**Liam Hughes:** I would add housing and housing conditions to that. I am aware of how complex it is to get this right in terms of attribution—to understand where the effort comes from and where the results are to be found. Looking at it in a very simple-minded way, it is a proxy. I would just like to track that more money is being spent on evidence-based prevention.

**Councillor Mary Lea:** I think if we wanted to measure the outcomes of public health coming over to the councils, skills, employment and attainment are the best measures of public health outcomes. If you get that right, then people will take responsibility, as we know, for their own health and their own wellbeing. We have to use the resource and the expertise of the public health service to help us get those right. I think you can measure specific interventions and say, "This is an intervention we have used and it has this outcome and it has been good," but that is very small scale. It can sometimes take

many, many years for the outcomes that you want to show themselves, and the current climate, whether it is welfare reform or the recession and so on, is going to militate against some of the outcomes that we would like to see.

**Q215 Mark Pawsey:** We have had a broad range of answers, and, Nick, in an earlier answer you spoke about treatment for alcoholism and the propensity for that. Now, these are all things that Government takes very, very seriously as well, and Government is doing such things. Let us say the Government introduces a minimum price for alcohol, which you are going to be lobbying for. How would you identify what you have achieved and what Government has achieved and, if there is an improvement, are both local government and national government not going to be claiming credit for the same thing? How are we going to isolate what has happened at a local level?

**Councillor Nick Forbes:** Well, if we have improved health, does it matter?

**Q216 Mark Pawsey:** Maybe not, but how are we going to measure what you have done? If the result would have been achieved anyway, what has been the input of health and wellbeing boards?

**Liam Hughes:** I cannot answer that question. I think it might come in in the later session that you are looking at, in terms of what that dashboard might look like from that point of view. These are complex adaptive systems, so if we think we can measure them easily, we are probably misguided.

**Councillor Nick Forbes:** Absolutely.

**Q217 Mark Pawsey:** Mr Hughes, you particularly spoke about the amount of money that goes into preventive work rather than treatment. How would you measure that?

**Liam Hughes:** Well, it is tricky, because the further upstream you go, the cloudier it becomes, because you are really talking about the conditions of life rather than some preventive intervention. But I would look at, for example, whether we are really putting enough money into smoking—whether we are dealing with some of the known conditions that we can make a difference on. You can measure those things, but when you get further upstream it becomes much more difficult to work out.

**Q218 Mark Pawsey:** Mr Hughes, you also spoke about the specific target to reduce the number of men dying prematurely by 2015 that followed some work from Professor Chris Bentley. How will that local targeted approach work?

**Liam Hughes:** Sorry, I am not following that. I am not with you.

**Q219 Mark Pawsey:** You have done some work with Oldham on specific targets to reduce the number of men dying prematurely. How will you set a target on that?

**Liam Hughes:** Oh yes, that is right. Well, we know what the figure is at the moment. We know what some of the interventions might be able to do—smoking cessation and alcohol-related and the work of the

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GPs—and I think there is an element of using best evidence and trying it.

**Q220 Mark Pawsey:** Going back to your campaigning work, Mr Forbes—and, Mary, you spoke about your council role within public health being to lobby Government—would your electors not just say your job is to get on with delivering good services, not lobbying Government?

**Councillor Nick Forbes:** Can I give you a specific example on this? Newcastle PCT spends £77 per head on cancer treatment. Currently, it spends less than 50 pence per head on tobacco control and smoking cessation services, and yet all of the evidence is there that comprehensive tobacco control measures make a big difference in terms of rates of cancer. So I think it is entirely legitimate that we would not just look at what we are doing on the ground around tobacco control but lobby for legislative change as well, because we can see the wider benefits that would have in terms of shifting the balance of resources from treatment to prevention.

**Q221 Mark Pawsey:** Right. Tony, are you going to be spending your scarce resources in public health on lobbying the Government?

**Councillor Anthony Devenish:** Well, I think you have to communicate. I would not call it lobbying. I would not say it is a contradiction in terms in the way perhaps you may be implying, sir. At the end of the day, you have to get your message across, and the value for money point, which we have just touched on, is that if we can prevent things through reducing binge drinking, that is going to help the NHS overall. I think we all agree with that.

**Q222 Chair:** One last question: you have all talked about the wider roles and responsibilities that local government have and what they can do with a variety of different mechanisms. You are all responsible, either singly or collectively, for pension funds. Just very briefly, do you all have a policy with regard to public health and your pension funds—say, not investing in tobacco companies?

**Councillor Nick Forbes:** I know exactly how much money the Tyne and Wear Pension Fund invests in tobacco companies. I think it is completely inconsistent with the policy that we will have around improving health. The fact that £1.6 billion nationally

is invested in tobacco companies is a shame on local government, at a time when we are supposed to be improving health.

**Q223 Chair:** So the answer is you are getting round to it, in due course.

**Councillor Nick Forbes:** I am very clear that it cannot continue.

**Councillor Anthony Devenish:** Shall I answer the question next? I was on the Superannuation Committee at Westminster before I became a cabinet member, and we did look into this. You should remember superannuation committees in local government are independent and they would not want cabinet members or, indeed, the leader of the council telling them what to do. They are there to represent the interests of the pensioners.

**Councillor Nick Forbes:** Except that is where I disagree, because I think we have a moral responsibility to think globally but act locally. When we look at the amount of damage that is done around the world by tobacco, in the 21st century more than a billion people will die from tobacco-related causes. We have that responsibility, because otherwise the investment that we make in tobacco control at a local level will be far outweighed by the damage that is done internationally.

**Councillor Mary Lea:** We have the South Yorkshire Pensions Authority of the four leading authorities in South Yorkshire. I do not specifically know what they invest that money in, but I will go back and find out. If we go back many, many years, maybe you could tell us the answer to that one, Clive. I do not know.

**Q224 Chair:** Thank you. I was chair at one point; thank you for reminding me of that. Perhaps you could let us have a note on that; that would be helpful.

**Councillor Mary Lea:** Yes.

**Liam Hughes:** I do not know the answer. I am going to go and find it out when I get back. What I would say is that, within the prime purpose of the pension fund, it would be very legitimate to look much more widely than just at that investment, and to look at how the fund can do some local good. Quite a lot of local authorities have been looking at this through their funds.

**Chair:** Thank you all very much for coming and giving evidence this afternoon.

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### Examination of Witnesses

*Witnesses:* **Kim Carey**, Corporate Director, Adult Care and Support, Cornwall Council, **Councillor Roger Gough**, Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council, **Dr Mike Grady**, Principal Adviser, University College London, Institute of Health Equity, and **Councillor Ernie White**, Cabinet Lead Member for Health, Leicestershire County Council, gave evidence.

**Q225 Chair:** Good afternoon. Thank you all very much for coming to our second evidence session this afternoon. For the sake of our records, could you just go along and say who you are and the organisation you represent?

**Councillor Ernie White:** My name is Ernie White. I am a county councillor. I am the Lead Member in the Leicestershire Cabinet for health and sport. I also lead one of the Leicestershire districts.

**Dr Grady:** My name is Mike Brady. I am the Principal Adviser at the Institute for Health Equity at University College London, which was formerly the Marmot Review Team.

**Councillor Roger Gough:** I am Roger Gough. I am a Member of the Cabinet at Kent County Council and I chair the Kent Health and Wellbeing Board.

**Kim Carey:** Good afternoon. I am Kim Carey. I am the Corporate Director for Adult Care and Support with Cornwall Council.

**Councillor Ernie White:** I forgot to say I also chair the Health and Wellbeing Board, Chairman, sorry.

**Q226 Chair:** Okay, and quite an important thing for this occasion. Just before we begin with questions, I will just thank Roger Gough very much indeed for all the help he gave us with our visit to Kent last week. It was a really excellent visit. Pass on our thanks to your colleagues as well.

**Councillor Roger Gough:** I will do so, Chairman, thank you.

**Q227 Chair:** You probably heard some of the discussion with the last witnesses about how there may be some tensions between trying to get some short-term wins—individual measures that can show the new arrangements have been successful—and the longer term interventions. The latter were referred to as “very upstream” actions; it might take a long time for them to come through or to prove that they are the measures that are having the effect. Do you see that tension and do you see the possibility of resolving it, or will it always remain?

**Councillor Ernie White:** There is a tension, Chairman, obviously, but I think the trick is to do both, surely. I know from my perspective in Leicestershire we have had some early wins to demonstrate that the partnership working developed by the Health and Wellbeing Board has made it easier to protect the Healthy Schools Programme. It has made it easier to change the focus of the County Sports Partnership to encourage not just sport but physical activity for its own sake across the age range and in family groups. We also managed to lever £1 million of NHS money into district councils for Disabled Facilities Grant work in people’s homes where they have lost mobility, because the NHS saw that as very early intervention and prevention, which is a key priority for the Health and Wellbeing Board.

**Councillor Roger Gough:** It is important to keep a perspective on short, medium and long term. I heard

that Chris Bentley was referred to earlier on and, as some members of the Committee will know, we had him come and speak at our Health and Wellbeing Board in Kent about 10 days ago, and he had a very, very profound effect. One of the things he always emphasises, as many people will know, is that you can look at the very long-term determinants of health and move, if you like, way upstream. You can also come various ways closer to the more immediate term, and, in particular, you can look at provision, for example, and how that serves the people who are, in many ways, in most need. Is there adequate cover for the people who are most deprived and, in many ways, at the biggest risk in terms of health? Those are areas in which you can have an effect in one, two or three years, not five, 10 or 20 years. It is important that you keep an eye on all of those things. Of course there is a trade-off in doing those things. There naturally is, but I think that is part of the normal business of making difficult decisions in local government and in health.

**Dr Grady:** I would agree with that point. It was not by chance that we called the first report of the global Commission on Social Determinants of Health *Closing the Gap in a Generation*. Some of this will take us a generation, but equally you also know from the work that we did on *Fair Society Healthy Lives* that, if we used an indicator of readiness for school at five, we would know within a relatively short period of time whether we were having an impact. If we used the NEET figure, then again we would know within a short period of time whether we had had an impact. So it is about pulling all of those strands together and using proxies where we cannot define evidence immediately.

**Kim Carey:** I would echo what all of my colleagues have said, but of course be mindful of the fact that we work to political terms as well, and clearly within local government there is an imperative to make sure that we can evidence where our investments are making a very real difference to the people living in our communities. So it is about having that mix of shorter, medium- and long-term effects.

**Q228 Chair:** In the way you have constituted your Boards, have you reflected on the need to have both the immediate wins, if you like, and the longer term overall strategy, and have you managed to integrate that with the public-health-type work that local authorities have always done?

**Kim Carey:** I think we have done that very successfully in Cornwall. The work that we have been doing to set up our health and wellbeing strategy has been co-produced with people who are supported within Cornwall. They are very clear that they are going to hold us to account and want to see a very real difference, so we are being driven not only by national targets that we are aware we have to achieve but also by what is important to the people living in Cornwall.



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**Councillor Roger Gough:** If you look at us in Kent, it is true that the Director of Public Health, who is of course a statutory member of the Health and Wellbeing Board, is the only person on our Health and Wellbeing Board with “public health” specifically attached to their name. That said, the public health consultants have played an extremely active role in the agenda of the Board and in developing it over the last year to 18 months. So in that sense—this is something that I suspect we may come to later—as you, Chair, and some others will be aware, in Kent we are moving to more local health and wellbeing boards as well. In those areas, the public health support for it will be significant.

**Dr Grady:** Locally, I do not have a health and wellbeing board, but I do advise health and wellbeing boards across England on their constitution and arrangements. I say to them that if they are going to address the social determinants of health—the things that really matter are education, transport, housing, and social cohesion within communities—then they are going to have to co-design and co-produce their strategies with local communities and, as importantly, they need to orchestrate the collaborative partnership. Orchestras do not need everybody playing at the same time, but they do need the right players in the room to address the right issue, and it is that dynamic, I think, that needs to be built into the system if it is going to be a bit more than the talking shop that local strategic partnerships became.

**Q229 Chair:** And are you seeing that happening or do you have concerns it is not happening in some areas?

**Dr Grady:** It varies quite considerably, as indeed the linkage between strategies and projects to deliver those strategies varies local authority to local authority; practice is very mixed across the country.

**Councillor Ernie White:** We have been meeting in shadow form now for nearly two years, and I guess recently, in the middle of this year, I, as Chairman, began to feel that the Board was working as a Board and not as a collection of various agencies. That was quite a profound change in the psyche of the Board, and I think it is beginning to show the value of having that kind of organisation, where, as far as we are concerned, the major commissioners sit round the same table at the same time with a common agenda, having had lots of work done in preparation in terms of building up papers for the Board. We have a fairly sound sub-structure, and I think local people know that they do not have to be on the Board to influence the work of the Board. We have managed to keep the membership tight as well.

**Q230 Bob Blackman:** Last week we saw at Kent the rather complex arrangements that you have had to make because of the position in relation to the county and the number of CCGs, with the Health and Wellbeing Board having a series of sub-committees co-terminus with the CCGs to sign off the strategy and then try to remove any hassle and grief that might result. I am not sure what the position is in Cornwall and Leicestershire in relation to the number of CCGs and the arrangements that you have made. If there

are a number of CCGs in your two counties, what arrangements are you making to ensure that you do not get duplication or conflict with the strategies adopted by the wellbeing boards and the CCGs?

**Kim Carey:** We have a single CCG in Cornwall, which makes it very easy.

**Councillor Ernie White:** In Leicestershire we have two, neatly sliced east and west, both led by GPs who are extremely good in public, and that helps an awful lot. They are very good in committee. In fact, you would often take them for council officers sometimes—they are that good—and you do not always get that mix with clinicians of being able to work in public at that level, so we are quite fortunate.

**Q231 Bob Blackman:** Roger, have you given advice to other areas where there is possibly an equally complicated strategy or structure as in Kent?

**Councillor Roger Gough:** We have not given advice to anyone in particular on it, because we have not been asked for it, as such, but if asked we would give it. As far as I know, Staffordshire is the only other one that has moved somewhat down that route. But we are in a different position from some of the other colleagues around the table because we have seven, and only one of them is completely co-terminus with a district.

**Q232 Bob Blackman:** Just to make it even more complicated, as we saw last week. Dr Grady, you have hinted at the orchestra being conducted in terms of the various different strategies to be adopted. Can you give us any examples of good practice?

**Dr Grady:** Yes. The example of good practice that stands out to me in terms of orchestrating immediate activity is that of Birmingham City Council. If you look at the figures for Birmingham City Council in relation to readiness for school, what you will find is within three years they shifted that figure from 38% to 55% by having a coherent strategy, agreed joint priorities, integration of services and an absolute focus on what the health outcome was that they wanted to achieve. There are significant other examples up and down the country that leave me feeling optimistic that local government is grabbing hold of this agenda, driving forward with partners in relation to addressing the social determinants of health, and avoiding being dragged back, as has been the history, into lifestyle initiatives, which we know do not work and certainly do not work in the bottom 50% of the social gradient of health. Therefore, I feel very optimistic in terms of collaborative partnership working in the future.

**Q233 Bob Blackman:** Clearly the agenda moving forward is for adult social care and health coming together, and obviously there is the role of the private, voluntary and community sectors in that. How do you see those coming together to deliver for people in your areas?

**Councillor Roger Gough:** We have a patchwork of arrangements at the moment across Kent, and I think one of the roles of the Board—and I think this will be for the Kent-wide Board to do—is in many ways to help spread that best practice. So we have examples in some parts of the county where you have teams

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around the practice—very much, if you like, on the provision side—and that has been developing extremely well. Again, you heard a little bit about that from some of my colleagues last week. What we are doing in other parts of the county is focusing quite a lot on the commissioning side, where you have in effect a virtual commissioning team. So what I would see us doing in many ways is building on those initiatives, spreading them bit by bit across the county and ensuring that each of those CCG areas delivers on it, because there is clearly a very strong shared interest for us in that.

**Kim Carey:** Locally there has been quite a lot of political noise and noise from the public about the role of the private providers, particularly around providing health. Through our scrutiny function we have already pointed out that quite a lot of health is provided by private providers already, who have been trying to provide reassurance. We have a very large private and voluntary sector within Cornwall that offers some very good support to people and we want to build on that, so we are trying to steer that through in a way that does not cause unrest and concern for people.

**Q234 Bob Blackman:** Are you bringing them into the Health and Wellbeing Board or the CCG?

**Kim Carey:** We have a stakeholder group that supports the Health and Wellbeing Board. The main membership of the Health and Wellbeing Board are commissioners, but we have a very large stakeholder group. It is one of the very few meetings that I attend that people want to join, but the stakeholder group is informing us and just challenging us and keeping us in check.

**Councillor Ernie White:** My experience is very similar. In a former life I worked for a local charity, a very large county-wide charity, of which there are a number in Leicestershire, and the issue with membership of the Board was where you stopped. In Rutland, for instance, which is fairly small and tight as a county, they have a well established, well respected county voluntary sector body, and the leader of that is accepted as representing the whole of the voluntary sector in Rutland. We do not have that kind of organisation in Leicestershire. So, to repeat, the work of the voluntary sector is very much respected and very much encouraged, and, through the sub-structures, they do make an enormous contribution. I know we are having a stakeholder event this week on our health and wellbeing strategy. They will all be there and they will all tell us what we are getting wrong and occasionally what we are getting right. But they are very vociferous and extremely welcome in the whole agenda-setting arrangements for both the JSNA and the strategy.

**Q235 Bob Blackman:** Mike, what do you see nationally?

**Dr Grady:** I certainly want to see a level of coherence around the approaches taken that move us beyond just provisioning commissioning, because this is, yes indeed, a commissioning and provisioning debate, but it is also a debate about local democracy and it is a debate about how we develop and empower individuals and communities and create greater levels

of social cohesion within those communities. We know from the evidence that, in those societies where social cohesion is much tighter and much more powerful, it builds health, wellbeing and resilience in communities and people do better. They flourish more and they thrive more, and we should not lose sight of the fact that the primary driver needs to be the empowerment of individuals and communities, and then a range of support services and commissioned services support that activity.

**Q236 Chair:** Just picking up on that point and what we saw in Kent last week, it seemed very clear there that Kent County Council, as the democratically elected body in the area, was very much seeing itself as taking the lead independent from the strategy. It was certainly working with partners, but it was creating a framework and a lead not merely for public health but for the commissioning groups as well. Did I get it right that you see yourselves in that role—as a key to pulling these things together?

**Councillor Roger Gough:** I think particularly at this stage, to some extent, yes. I would not over-emphasise the point vis-à-vis the commissioning groups, because in many areas it is very much their area of expertise and areas that they will develop in partnership with us, because of the health and wellbeing strategy and so on, but nonetheless it is very much, if you like, their area to lead. What I think is the case—and, funnily enough, this was mentioned at a meeting I was at before I came here, looking at developments across the country—is that because local authorities are mature organisations and have many of the structures in place to do this kind of thing, it is quite natural that many aspects of development and leadership will fall to them particularly at this point. In many ways, I think it is down to them to pick up that particular ball and run with it.

Now, I think you have to be very careful, because everything that we are talking about in this should be about shared leadership, and there is a very easy temptation, perhaps particularly for bodies like ours, to be a bit directive. I think we have to guard against that extremely carefully. But it is natural, I think, just given the shaping of the organisations, because if you look at who is round the table on a Health and Wellbeing Board, CCGs have come into being over the last year or two and are, in the case of Kent, still going through their authorisation process. Healthwatch is still in the process of coming into being, etc, etc. So in many ways I think it is natural that the local authority will take quite an active role in all this. Over time, as some of the other organisations mature, that may well be shared a bit more.

**Q237 Simon Danczuk:** I wanted to ask about funding. I notice that Leicestershire County Council, Ernie, said a significant issue of concern is the budget. The final allocation for 2013–14 is due to be announced on 19 December. A budget pressure in excess of £1 million is anticipated. Cornwall Council explained it has been challenging to manage preparedness without knowing the full extent and impact on resources. Not knowing the budget then yet

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and whether it will be £1 million or not, how much of a problem is this creating, Ernie?

**Councillor Ernie White:** It is a problem not just for the public health budget; it is a problem for all the partner organisations. We had a session last week about joint commissioning, asking partners where they were with planning their commissioning around the JSNA priorities. They were all saying, “We do not know our budget. Of course, we will commission together, but until we know where we are with our budget, we really cannot get into a positive mood about sharing.” So the sooner we get our allocation, the better. If it is £1 million, as we expect it to be, we will have to manage that through 2013, because there is a reputational issue. If, on vesting day, as it were, there were huge cuts in public health budgets when one of our priorities is prevention, it would look silly. So we have made plans to cover ourselves over certainly the 2013–14 budget and, hopefully, we can manage some of the costs down through better procurement and commissioning. We may be able to find some reserves, although when you talk about reserves in local government these days, people give you a strange look. But there are always little pockets that you can work at, and we have to be very swift on our feet to make sure we do not have any embarrassments from next April.

**Q238 Simon Danczuk:** Mike, do you have a view on the lateness with which budgets are being set?

**Dr Grady:** I certainly do, and I have a view about the 4%. 4% as a proportion of the budget spent on public health is one of the lowest proportions within the OECD. A clear recommendation in our review was that that figure should increase significantly as time moves forward. The lateness of it does not help either. Most of that 4% is linked into public health service delivery, and therefore creates anxieties both for staff involved and for the organisations involved. There is an interesting debate to be had about the 4%, but what really interests me is how we are going to spend the rest of the money on addressing the social determinants of health in relation to early years education, our young people who are unemployed and not in training, our people who need support in terms of communities, and our older people. It is that kind of spend that needs to shift into a public health agenda rather than provision.

**Simon Danczuk:** We are going to come on to that.

**Councillor Roger Gough:** I think there are two or three elements. Firstly, as was mentioned earlier on, there is uncertainty about public health budgets and there is uncertainty about total budgets. We confront both of those, and that should be clarified sometime between now and Christmas, but it is extremely late in the day.

**Q239 Simon Danczuk:** What impact does that lateness have for you as a local authority?

**Councillor Roger Gough:** It naturally means that you have to think long and hard about the priorities that you have set. When you have engaged, as we have, in public consultation and debate around “this is how we see things going”, and then, thinking here about the wider budget, you see the prospect of further

reductions in Government grants at the last minute, it makes that difficult.

As far as public health is concerned, I think there is a short-term and a long-term issue. The short-term issue for us is much the same as has been discussed already. In our case, we look at what we believe has been spent on the equivalent services this year, and that is just over £43 million. The minimum guaranteed, from what has been said so far, is £36 million, and we are not quite sure where between those two it is going to end up.

Leaving that to one side—and that is obviously a major issue this close to the whole system change in spring next year—there is the longer term question, which is: what happens to public health over time in terms of the allocation of funds across the country? Obviously, what has happened so far is very much built around existing patterns of spend by PCTs, and in some parts of the county there was a historic pattern of under-spending, and of those areas being the victim, if you like, of the last minute dash to balance the budget. The end result of that is that, if we look at what we get on a historic basis compared with what we think a needs-based analysis would be, the latter would work in our favour. The question of how quickly one might move towards that, given that the Government understandably does not want any area to lose out and we know what the overall constraints on spending are, is a long-term challenge for us, because it means we suspect we will not get what we would otherwise expect to get and think would be good for delivering what we need to.

**Q240 Simon Danczuk:** Kim, you have to organise these services and make them work, and you are going to know how much you have to spend at the last minute. What is the impact?

**Kim Carey:** We are flagging the budget transfer high on our risk programme, and it is becoming more of a risk the closer we get to the transfer of the service. I think the biggest risk is to those people who have been providing services through contracts with the PCT. We are unable to issue those new contracts or have any reasonable debate with those providers because we do not know whether we will have the resource to enter into new contracts with them. Whilst it is a risk to the Council, the larger risk is to those people who have been delivering services in the past.

**Q241 Simon Danczuk:** Do you mean local voluntary organisations that are dependent on funding and things like that?

**Kim Carey:** Yes, and some of the other health trusts that deliver services.

**Q242 Bill Esterson:** On this point, Ernie, you made the point about vesting day, and, having been through local government reorganisation many years ago, it has a profound effect on the management of services if not necessarily on the delivery. That disruption to management can then have a disruption to service delivery. Kim, you were touching on that in your risk assessment. To what extent is that planning going on regardless of the issue about uncertainty over budgets?

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**Councillor Ernie White:** The planning is going on, but we are kind of holding our breath. As I said earlier, if we are a million short, we intend to manage that through to next April or May and through next year, and we will get down to the hard yards, if you like, about managing within the allocation throughout next year. It is bound to mean some change and it is trite to say we can get more for the same, but we have been doing it in local government now in a heavy way for the past two or three years, and we are learning the tricks of getting more out of the same pounds spent. No doubt when we apply that kind of expertise to the public health budget, we will make some more savings.

**Q243 Simon Danczuk:** Mike, I particularly wanted to come to you. In the long term, is a transition from ring-fenced public health funding to place-based funding desirable, logical and inevitable?

**Dr Grady:** I would have thought so, absolutely, and the evidence supports it. If you go back to the total-place pilots that we looked at, they were very good examples of greater efficiencies, savings, engagement of communities, and co-production of services with people and communities. It is the place to go. In the meantime, I do believe that in the shorter term, whilst the transition takes place, we do need a ring-fence to protect the public health spend and make sure that we can maintain particularly the preventive services within public health. That is a really important issue, but place-based budgets are the way to go in the longer term.

**Simon Danczuk:** Any other quick comments on that before I move on to the final question?

**Councillor Roger Gough:** I absolutely agree with that distinction between short term and long term. I think that is absolutely right.

**Q244 Simon Danczuk:** My final question: drug misuse and sexual health services account for 50% of public health funding. Do you envisage any political problems with this, Ernie, Roger? It is quite up front, is it not? The public are probably not aware of that, are they? You guys are politicians. Are you going to be out there shouting about where you are spending half of your cash?

**Councillor Roger Gough:** Well, I do not think we are going to seek to obfuscate about it, but so far that has not been an issue, I would say. There has been no evidence of that as an issue at all for us. What has been the case is that we have been going through a process of discussing, certainly in very public forums and in our own Health Overview and Scrutiny Committee and other such things, what the public health budget embraces. Sometimes you get some interesting reflections about which demographic it is looking after: how much of this service is focused on younger people and whether there should be more focus on older people—that kind of thing. But I do not think there has been any evidence so far of difficulty on the specific area that you describe. If it comes, we will have to deal with it as it arises, but there is no evidence so far.

**Councillor Ernie White:** Didn't someone use the phrase the "oxygen of publicity" regarding certain

issues? I think the more we share with the public what it is costing to deal with some of these lifestyle issues, the more they are prepared to accept change in the way of a minimum price for alcohol. That kind of national change might be better accepted once the public know the full cost of trying to deal with the consequences.

**Simon Danczuk:** That is a good point. Are there any points from Kim or Mark on that? No? Thank you.

**Q245 Andy Sawford:** Given the time, I hope you will not mind if I ask some direct questions. In the first instance, can I ask Roger and Ernie for a simple yes/no? On your main Health and Wellbeing Boards, so I am not talking about sub-structures and so on, are district councils represented?

**Councillor Ernie White:** Yes.

**Councillor Roger Gough:** Yes.

**Q246 Andy Sawford:** In what form? How many representatives are there and how are they elected to represent the districts?

**Councillor Ernie White:** In Leicestershire, we have a district leaders' forum, where the district leaders meet every so often, and we use that forum for nominations for membership of the Health and Wellbeing Board. So there is a two-way dialogue between district leaders and their Board representatives. One is a district leader and, in fact, because I am a district leader as well, on our Board there are three district councillors.

**Q247 Andy Sawford:** Roger, come in on the point about the composition, but how important do you consider that district council representation?

**Councillor Roger Gough:** It is absolutely essential. We have 12 districts in Kent. We went for three district council representatives on the Board. As I mentioned earlier, the sub-structure plays an important role in the district contribution as well, but, in terms of the main Board, there are three, chosen by a mechanism very similar to what Ernie described. As it has worked out, it represents west, east and middle, which is perhaps as much luck as judgment. It has been down to the district leaders themselves to choose.

**Q248 Andy Sawford:** Given the clinical commissioning groups have a statutory role, and given the importance, you believe, of district councils participating, looking at the evidence the Committee has had from the District Councils' Network, who note that discrepancy and also say, "The lack of statutory recognition for districts has contributed to some unnecessary local confusion over the role of district authorities," and that that has "in some cases affected the adequacy of local preparations", would you support a statutory role for district councils on health and wellbeing boards?

**Councillor Ernie White:** It should not be necessary, I do not think. One essence of the change is that these things will be decided locally. Why tell them what to do? Let them sort out these issues, these conflicts, locally. What we have done in Leicestershire appears to work. We have enthused the district council as well,

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because these two representatives also link with what we call a local health forum within each district. Each district has its own health champion. They have their own very localised programmes for public health issues, and the public health staff visit on a regular basis to sit inside the district council buildings and work with district council officers. I do not think we needed to be told to do that as far as Leicestershire is concerned. That has happened naturally.

**Q249 Andy Sawford:** That sounds like an arrangement that is working, and Roger might comment on whether he thinks a statutory duty is needed, but the experience of county areas is obviously different, because the District Councils' Network say, "In some county areas, there continues to be reluctance to have sufficient representation on boards (including voting rights) or to effectively communicate HWBs developments and the role of district councils locally." So whilst you may have effective arrangements, they are making an argument for statutory recognition. I am going to ask Mike in a moment, but what is your view on the statutory point, Roger?

**Councillor Roger Gough:** I would be reluctant to see further prescription, though I say from a Kent point of view we would not have any objection because we do it already, but I suppose I instinctively lean a little bit against yet a further bit of statutory prescription.

**Q250 Andy Sawford:** Mike, do you see differences around the country?

**Dr Grady:** I do see differences, but if there are a set of relationships that mean that you cannot sit round the table and take concerted joint action, then I do not believe a statutory requirement is going to change that. It seems to me the partnerships that work most effectively are those where there is a network of relationships that allow people to trust each other and do, not sit there because they have a statutory requirement to do so.

**Q251 Andy Sawford:** The Committee is interested in the role that housing has in your assessment of strategies. I wonder if you would, given the hour, say something briefly, and if you have any further evidence, perhaps you might send it to us; I am sure it would be welcome as well. Kim, what role does housing have in your strategies in Cornwall?

**Kim Carey:** It is absolutely fundamental. What we recognise is that health and wellbeing is not just about people's health and their social care. It is about where they live; it is about the relationships they have; it is about how they live within their communities and the value that they both give to and get from that community. Housing is an absolutely vital strand within our strategy.

**Q252 Andy Sawford:** Have you anticipated changes in the coming months due to the effect of the Housing Benefit reduction, the Council Tax Benefit reduction, the Universal Credit, and the likely increase in homelessness that some organisations are predicting? Have you put in place strategies through the Health and Wellbeing Board?

**Kim Carey:** Yes, we have. We have had a number of presentations. In fact, we had one just last week updating us, and it is of great concern to the Health and Wellbeing Board. We are making sure that every opportunity is taken to look at the likely impact and minimise the impact of the welfare changes on the population. We know it is going to hit those who are most in need.

**Councillor Roger Gough:** If I could just add something that fits in with what Mike mentioned about relationships, I think a key element of how we approach housing is that we already have a thing called the Kent Housing Group. It has a whole series of offshoots, which brings the districts, the county and, indeed, Medway, our neighbouring unitary authority, together, along with a whole number of other players in the housing sector, to try to look at housing from a strategic point of view. A number of their streams of work link in to what is in the health and wellbeing strategy and what is already in the Health Inequalities Action Plan that we have. So, for us, housing is very, very important, and that is one of the key things that the districts bring to the table.

**Councillor Ernie White:** I agree with that.

**Dr Grady:** It makes me very excited to see urban planning and the planning of our cities' housing come to the centre of this agenda, because they have needed to for a long time. It is okay talking about smoking and alcohol and what have you, but what we know is the places where people live are critically important to their health and wellbeing. If you are happy with the area in which you live, you are 200 times less likely to have a mental health problem. They are really important issues, and they need to come to the fore in terms of encouraging greater levels of activity, greater levels of social cohesion within communities, and greater levels of support networks, because it is those support networks that help people to flourish.

**Q253 John Stevenson:** Just very quickly, Ernie and Roger, you have three district councillors on your Board; how many county councillors do you have on your Boards?

**Councillor Roger Gough:** Four.

**Councillor Ernie White:** Three.

**Q254 Mark Pawsey:** I would like to ask about how scrutiny is going to work under the new arrangements post-April 2013. Within the councils themselves, councils now have responsibility for delivering health services. How is that going to affect the scrutiny? That is probably particularly a question for Ernie and Roger, who are from county councils.

**Councillor Ernie White:** I sense, in Leicestershire anyway, that scrutiny has been re-energised by this agenda.

**Q255 Mark Pawsey:** Because councils can do something about it now.

**Councillor Ernie White:** Well, yes, but the Health and Wellbeing Board is not a balanced political arena. Because it will be a sub-committee of the Cabinet come next April, there are no Opposition members on it, so the Opposition argument, debate, discussion goes into scrutiny. They have done some really, really

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good work this year, and they know they have my commitment and support, and I go when I am invited; I am not allowed to go unless I am invited, because, apparently I scare them. I do not know why, but they are shrinking violets, I am told; anyway that is an aside. The work of scrutiny, I think, will be enhanced by this new agenda.

**Q256 Mark Pawsey:** Roger, have you found the same thing in Kent?

**Councillor Roger Gough:** Yes. When the White Paper first came out, you will recall that the suggestion was that somehow the scrutiny role could be collapsed into the Health and Wellbeing Board, and we, like many others, made representations to the Government to say this was a very bad idea. The end result, as you know, in the Act is that there will still be a scrutiny committee arrangement of some kind for the local authority. Our view, I think, is if it looks like a HOSC and it quacks like a HOSC, then it is a HOSC, and so it will continue. Now, what it will do, I think, is two things. Firstly, it already does a great deal in terms of looking at providers—and remember the reform widens that function, in that anything funded by an NHS pound, if you like, can come within the HOSC's frames of reference.

**Q257 Mark Pawsey:** Sorry, could you just explain "HOSC"?

**Councillor Roger Gough:** Health Overview and Scrutiny Committee. I do apologise.

The second thing is that we have already been bringing forward a number of the major initiatives, and it sounds as though Ernie is doing something very similar. As we have been bringing forward our work on Healthwatch, as we have been bringing forward our health and wellbeing strategy—a whole number of the staging posts towards the implementation of the reform—we have been taking that to the HOSC. I think that we see them, over time, holding us, the Board, to account for the outcomes that we seek to achieve. So a major function that they will have, quite apart from what they see vis-à-vis the providers, is to look at the Health and Wellbeing Board and whether it is doing its job in terms of delivering those outcomes that it set itself.

**Q258 Mark Pawsey:** And Mike and Kim, how do you see scrutiny working out?

**Kim Carey:** There is a healthy debate going on between our Health and Wellbeing Board and the scrutiny function at the moment. I think there are still some issues to be resolved as we move forward.

**Dr Grady:** I think it is a triangle of the Health and Wellbeing Board, Healthwatch and the Overview and Scrutiny Panel, and I think the development of those relationships will be critical. There is a change in focus away from providers and the NHS and acute beds into the social determinants of health, and there is some good evidence that the work the Centre for Public Scrutiny has done over the past couple of years with overview and scrutiny panels has allowed that to happen. I was reading only yesterday a report from Leeds Overview and Scrutiny Panel that was looking at how to generate employment within Leeds. That is

the kind of activity that we need to see coming forward, but we also need to hold the health and wellbeing board to account for what is in its JSNA and that what is in its JSNA is driving the priority for the health and wellbeing board.

**Q259 Mark Pawsey:** But we are not very far away from the reforms and there is still some uncertainty about the role of Healthwatch. I think, Kim, in your Council's submission you said, "It is unknown how the role and relationship with local Healthwatch will unfold." I do not know when that was written, but are you any clearer now?

**Kim Carey:** I think we have moved significantly closer to getting an outcome. We are hoping to complete the process for setting up a new Healthwatch very soon, so we have gathered pace.

**Q260 Mark Pawsey:** But it is not yet in existence. We have had shadows on councils for two years, but Healthwatch is due to take over the scrutiny role in just a few months' time. Nothing is in place in Cornwall.

**Kim Carey:** No.

**Q261 Mark Pawsey:** What is the situation, Mike, across the rest of the country?

**Dr Grady:** It is very variable. Personally, I feel very sympathetic towards Healthwatch. We have been through CHCs, LINKs, Public and Patient Forum, Public and Patient Involvement and now LINKs transforms itself into Healthwatch. I think there is a great deal of uncertainty, a great deal of confusion and, frankly, disillusionment about the seriousness of putting patients and the public at the centre of these reforms.

**Q262 Mark Pawsey:** Mike, you have given a lot of advice to councils on LINKs. Do LINKs simply morph into Healthwatch? What happens?

**Dr Grady:** No, it is not as simple as that. It will be quite variable. In some cases they will do that; in other cases there will be a tendering process and a commissioning process, and it is quite a variable position across the country. This again builds into the uncertainty, because a legacy of LINKs need to transfer over if we are going to maintain good public involvement in relation to the health reforms.

**Q263 Mark Pawsey:** Will Healthwatch cover all services and all groups, and what is going to happen if there is a gap?

**Kim Carey:** We anticipate that it will cover all services and all age groups.

**Q264 Mark Pawsey:** Alright. What if you have a vulnerable group who have a complaint? How will they get that through to somebody like Healthwatch? Who is going to be their advocate?

**Kim Carey:** Our tendering process ensures that Healthwatch will respond to anybody who needs their support. So we are trying to move away from client group-specific or condition group-specific needs and look at the needs and demands of people who use health or social care services.

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**Q265 Mark Pawsey:** What is Healthwatch looking like in the areas of the two county councillors here?

**Councillor Ernie White:** We are out to tender for the new Healthwatch. We worked with the LINKs representatives on the tender document. We intend to have the new Healthwatch in place for 1 April.

**Q266 Mark Pawsey:** Do you expect to achieve that?

**Councillor Ernie White:** We will, yes. Yes, that will happen. We have some work to do on writing up some protocols about who does what and who is responsible for what, because there is a degree of overlap, but Healthwatch is independent. It is patient-centred rather than a generality of service for the public. LINKs are frequent visitors to the Overview and Scrutiny Committee. They work together to get us. They do work together, and as long as we can get the protocols right, I think there is a powerful duality there in the overview and scrutiny position, both of the Health and Wellbeing Board and of the system in general.

**Q267 Mark Pawsey:** Roger, we are more aware of what goes on in Kent as a consequence of our visit, but I am not sure we spoke about Healthwatch when we were there.

**Councillor Roger Gough:** We did a little, I think, but perhaps I can go into a little bit more detail. We too are out to tender. We hope and expect to award very early in the New Year—in January. I think, and I suspect this is true across the country from all I hear, there is a distinction between having the body there and established formally, and it being, if you like, all-singing, all-dancing, delivering all that it is expected to. Therefore, my view is that if you have, say, a three-year contract, which we will be managing with our successful provider, I think that will turn into very much a game of two halves. For the first year to 18 months, our relationship with that body will be one as much of nurturing, support and development as it will be hard-nosed contract management, which I think we will move more towards in the second half of that three-year period.

First of all, we took stock of where we were vis-à-vis the LINK, Healthwatch and so on. Relatively early on, about 18 months ago, we had a process working with the Centre for Public Scrutiny, a so-called “readiness review”: what we were doing well in Kent, what we were doing not so well, how we could develop, etc. Earlier this year, we had a couple of sessions with the voluntary and community sector, and that was designed to do two things. One was to draw on their thinking about the kind of models that might evolve

for Healthwatch, and that has helped shaped the tender document that we have put out. The second was obviously to drum up potential interest in that as well. Obviously, who bids is ultimately down to them, but we certainly sought to engage with as much of that sector as possible to see who else might well be bringing forward some interest in helping shape Healthwatch.

**Q268 Mark Pawsey:** Are you satisfied that all services and all user groups will be covered? Is there going to be some little service in a corner that might be overlooked or neglected?

**Councillor Roger Gough:** Certainly, we have set our tender in terms that would seek to preclude that. A key thing that we have is an outcomes framework by which we will judge the successful bidder over time, and that would certainly embrace both relationships with the whole network of the voluntary and community sector and also the key acid test: do the people of Kent know it is there?

**Q269 Chair:** Just turning to the question I asked at the end to the other witnesses, does your public health strategy for your area include the investment strategy of your pension fund, and have you, for example, decided not to invest in or withdraw investment from tobacco companies? Could I have a short answer from each of you as to how you are thinking on this?

**Councillor Ernie White:** A very short answer, Chair: pass. I will write to you, but I do not think so.

**Councillor Roger Gough:** We have debated on it and we have not withdrawn that at present. I fully heard what was said about this earlier on in the discussion and take the point entirely. I think there has been a genuinely difficult trade-off between that and the value of the fund and the pressures on the finances in that connection. That has been the dilemma we have had to face.

**Kim Carey:** We have had the same debate and have time and again come back to the fact that it is an independent body that makes those decisions on behalf of the pension fund, so it is a knotty issue.

**Q270 Chair:** Mike, you probably do not have a position to report, but you might have a view.

**Dr Grady:** I certainly have a view, and it would be an ethical view in relation to addressing the social determinants of health and what is our priority. We cannot, on the one hand, say we are investing in our pension funds but on the other allow them to invest in services that will undermine the public's health.

**Chair:** Thank you all very much indeed for coming and giving evidence today.



## Monday 7 January 2013

Members present:

Mr Clive Betts (Chair)

Simon Danczuk  
Bill Esterson  
James Morris  
Mark Pawsey

Andy Sawford  
John Stevenson  
Heather Wheeler

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### Examination of Witness

*Witness:* **Professor Chris Bentley**, Independent Population Health Consultant, gave evidence.

**Q271 Chair:** Welcome to our fourth evidence session on the inquiry into the role of local authorities in health issues. Professor Bentley, thank you very much for coming this afternoon. For the sake of our records, could you indicate the capacity in which you are here this afternoon? That would be helpful.

**Professor Bentley:** I am an independent consultant, these days, and I was invited to give evidence to the Committee based on some work I have been doing with local authorities around the country.

**Q272 Chair:** Thank you very much for sparing the time to come and discuss these issues with us. Professor Bentley, there is obviously quite a lot of controversy over the Government's legislation that brought in the Health and Wellbeing Boards, for matters not connected with them, but that was probably one of the proposals for which there was general support. Certainly the evidence we have had so far seems to be indicating quite a lot of hope and expectation that some really serious and beneficial improvements were going to come out of this. Your evidence is slightly less optimistic—slightly more cautious, at the very least—about what may be going to happen and whether things really are going to change and improve with these measures. Would you like to expand on that for us?

**Professor Bentley:** Yes. I go with the hope and less with the expectation at this stage. My take on the whole issue came through when I was heading up the Health Inequalities National Support Team under the last administration, and in that guise I was looking to work with the 20% of most deprived areas in the country. The very testing homework question that was set for that piece of work was, "How do you reduce the gap between those 20% and the national average by 10% in mortality terms?"

That is a very testing question. How do you make a percentage difference at population level? That target was added to by saying that we had to do it in a short timescale; we had to do it in just three or four years. How you manage to achieve a measurable change at the population level was a question that we explored quite extensively for five or six years as part of that initiative. It made you realise how difficult it was and what needed to be in place to achieve that. Armed with the knowledge and understanding that we gained from that, looking at the way the new arrangements are coming into place, I am a little bit worried that they do not have the firmness and stiffness of spine

that will be necessary to drive forward measurable change at population level for our local authorities.

That is my concern. I am not saying it is not happening in places. It is happening, I would say, in a number of places where I have been working, but I would not say it is universal. There are some areas where I would say arrangements are a bit what I call "pink and fluffy", and will not necessarily enable people to drive forward those percentage changes.

**Q273 Chair:** We will probably come onto the precise ways in which you think some of those strategies and developments are not really satisfactory. What you are seeing, then, is a very patchy framework across the country, is it, with some areas doing quite well in terms of preparation, and others probably not really getting it at all?

**Professor Bentley:** Yes, I think that is right. Nowhere I have seen has got it perfect yet. As I put forward in my written evidence, there are 10 steps, and you would say that some have three or four of those going well, and others have a different three, and so on. It would be nice to find somewhere that has the whole set steaming away.

**Q274 Chair:** Are there some areas you think are at least doing better than most? It is always good to have one or two areas that seem to be making a real go of it, so that other areas can be pointed in their direction as to how it might be done better as far as they are concerned.

**Professor Bentley:** Yes. As I say, it is different for the different parts of the different steps, but the critical one at this stage—because it is early days—is to try to get the governance structures right. The thing that worries me is that a lot of places have Health and Wellbeing Boards that, when they are formalised and come out of shadow, are aiming to have four meetings a year, for example. If you are only going to have four meetings a year, you need to have some pretty durable structures that will do things between meetings. What are the governance structures that sit below the Health and Wellbeing Board and allow it to motor and produce stuff between the potential talking-shops of meetings?

I would say a couple of places have done that quite well. Recently I came across the example of Haringey, who have done a lot of work on trying to get their work right. They have concentrated on getting a set of substructures underneath the Health and Wellbeing Board. They have pared the Health and Wellbeing

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Board down to 12 good people and true, and they see it as a joint commissioning body. They then have an operational partnership group that sits below that, which really processes the work and drives it on. There are two or three committees that report through that operational group; they have a separate provider group, and a separate group for communities and patient input. That seems to be quite robust. Each of them will have its own terms of reference and membership and the governance set out. And then they have an annual meeting set to open it up to a wide reference group, to help to guide at the right points in the commissioning cycle. That is a good, tight delivery mechanism, I would say, which allows you to have confidence that things could be processed in a way that is very businesslike and effective.

**Q275 Chair:** You seem to be implying that in other cases the structure is not being created to imbue the whole public health approach into the workings of the authority and service delivery. Indeed, to some extent it has been used as an opportunity to settle turf wars between the council and the Health Service about who pays what for elderly care.

**Professor Bentley:** That is certainly one of the agendas that will come up on those. There will never be any harm in getting both sides—the health service side and the local authority side—to come together in a forum. That will be beneficial. There is no problem with that. In quite a lot of places, they have arrangements to drive on some of the main priority areas already, derived through partnership. The question is how it will really add value—this whole business that is laid out in statute about having a joint strategic needs assessment leading on to a joint health and wellbeing strategy and so on.

The question I have to keep asking is: “If such-and-such a place has chosen dementia as an important priority in its health and wellbeing strategy, how will anybody, including the public, see a difference in this particular borough in dementia, in three or four years? What will enable them to see a measurable difference?” That will not just happen by itself. It has to be organised and structured to happen. They are the things I am looking for, to try to see how we drive that better.

**Q276 John Stevenson:** You touched upon governance, which I take as a very important point. In many parts of the country there are two-tier arrangements. Do you envisage problems there? There is quite clearly a division of responsibility between the different authorities, county and district. How do you envisage overcoming those difficulties, and what difficulties do you see?

**Professor Bentley:** I have seen a couple of different versions of this. It has always been difficult. I have seen it under the last jurisdiction, and there were problems there as well. I am doing work at the moment with Kent County Council, and it is a big county with a lot of difference across the geography. There is no doubt that the different parts of the patch—what is the district local authority and what is now the CCG—know each other much better than the county does. Therefore, where there are already

relationships and understandings and histories between the two, it makes good sense to use that as the building block, to build upwards.

The question then comes as to what the added value of the county-level organisation is, but I can see the value of it in Kent; it seems to be working on a good basis. I was exploring my test question with them the last time we met. Kent County Council—it is quite a well-to-do county—has acknowledged the fact that there is a huge gap between the worst 20% of people in Kent and the second-worst 20% in terms of mortality, and then obviously other things as well. Kent County Council are saying, “Right, this has to be a priority for us. It has come out of our JSNA; we are taking it into our health and wellbeing strategy to say that we need to narrow that down.”

The question then is, “How do we attribute the action that needs to be taken for Kent to narrow that down to each of the different district or CCG areas that they are using there—Ashford, Dover, Thanet and so on—and say what we expect from them and how their actions will add up to make a difference to Kent as a whole.” That is the idea; that is what they are intending to work on, and I can see that that could work.

**Q277 John Stevenson:** But that demands a high level of cooperation between district and county. If that is not forthcoming, what do you think can be done?

**Professor Bentley:** The issue about the whole health and wellbeing strategy that we have all been talking about in the last week or so is: “What levers does it bring with it?” There are not that many. What you are doing is setting up a structure that then relies on the people within that structure to make it work. It does not bring powers. What it does potentially bring is relationships. That is what you are relying on: you are relying on the fact that those relationships, bringing people into the same place, giving them the same information and having the discussion, allows them to agree things together, which they can then take out to their separate places, either districts or organisations, and say, “Yes, we are all agreed on this. This is what we need to do in our particular place or organisation.” That is okay, but of course it depends on the quality of leadership and relationship, which brings more patchiness into the system. When it works well, it works; but when it is not there, you’re stuffed.

**Q278 Heather Wheeler:** You have almost touched on where I want to go with this; it is a little bit about central direction from Government, but versus localism. How do you think that will marry up at all, if it can?

**Professor Bentley:** The first thing is that there is a difference between diktat and guidance, of course. The move to localism certainly has its pros. It does have some cons with it as well, of course. You can look at different slices of action coming into the Health and Wellbeing Board. I still think the NHS Commissioning Board will be giving quite a lot of top-down direction, and that will still play in. It is not Government; it is slightly separate from Government, but I know a little bit about the players in the NHS Commissioning Board, and they have quite a

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top-down feel to the way they run things. There will still be some of that coming in.

**Q279 Heather Wheeler:** So more than NICE?

**Professor Bentley:** With NICE, I think, it is always guidance. We have backed off slightly from saying, "You have to follow NICE." Now, it is, "Here's the evidence, and if you want to disregard it, you can, but you have to say why." The difference in this setting is how good NICE will be in working with local authority evidence. They have a good track record with health, and we can see that. It has had some of its rough edges knocked off now, and it is functioning okay. However, to move into an area where we are moving less into randomised controlled trials and all that sort of thing into a different kind of evidence that local authorities are used to using, how good will it be at that? How will it bridge across between those different types of evidence and still come up with the type of product that people will be able to follow well? The same will apply for Public Health England. A lot of the resources in Public Health England are coming from the health service, and I think the question is how much local authority-based evidence do they understand and will how they take it on board to be able to be the advisors on it?

**Q280 Heather Wheeler:** All of that is very interesting, and thank you for that. If the Health and Wellbeing Boards have somebody from the National Health Commissioning Board on the board, how do you think the relationship will play? The Health and Wellbeing Board will feel that they represent their people, and that they know their people even better than the National Health Commissioning Board does. How do you think the relationship between the 11 and one who makes the twelfth will work? The National Health Commissioning guy will be the one with all the historical power and information, but the Health and Wellbeing Board will be made up of people who think they know their area very well. How do you think that will work? Who will listen to whom?

**Professor Bentley:** There are a lot of different angles on that one. As I said before, the Health and Wellbeing Board is not really about powers; it is about influences. We had an interesting discussion in one of the places I was working with where we had reached the point where we had decided some priorities, and then the CCG said, "So are you saying that the Health and Wellbeing Board is going to tell us what to do? We have been deciding what our plans are going to be. Are you saying that the Health and Wellbeing Board is going to tell us what to do?" I said, "The Health and Wellbeing Board 'R' Us." You are the Health and Wellbeing Board. You are a core part of it. It is not telling you what to do. You should be, as a group of people, making joint decisions and then taking away the findings to implement them. It is not a question of one person telling another what to do. One of the members of the Health and Wellbeing Board will be someone from the LAT, the Local Area Team, of the NHS Commissioning Board. The question is how they then play it—whether they see themselves as an inspector sitting there watching what is going on and being judgmental, or whether they will pitch in there,

bringing their resources to the table, and then helping to make decisions that will fit all the systems. That will be an interesting question.

The second answer to it really depends on how much the whole system is driven by outcomes, because there is a lot of pfafting around that can be done, but at the end of the day it is about how we change the health and wellbeing of our local population in measurable ways. That is in the interests of the NHS Commissioning Board, which will have its outcome targets through the NHS Outcomes Framework, etc, and in the interests of the Health and Wellbeing Board working perhaps more with Public Health Outcomes Frameworks. They should both be looking at outcomes, and if they are not being achieved, then they both need to work on why that is and how they can change things to make it better.

**Q281 James Morris:** Professor Bentley, you are quite disparaging about the capacity of the Health and Wellbeing Boards to produce a good joint strategic needs assessment. I think you said in your evidence that "the transfer of public health professionals and practitioners into local authorities has been very variable, and some do not have the critical mass to do other than minimalist churning out of an annual JSNA report." I am wondering how you think that situation might be improved. How can Health and Wellbeing Boards produce a genuinely strategic assessment?

**Professor Bentley:** I have some genuine concerns about this. Information and data is the stuff of my profession, and I have to state a concern that quite a lot of analytical capacity is being moved into something called Commissioning Support Units. These are there to support CCGs in their commissioning, and the intention is that by 2015 they will become independent and will become some kind of social enterprise, being slightly outside the system, and will therefore enable CCGs to have a marketplace to choose where they will get their support from. In the meantime, that means that some of the analytical support we have currently in the public sector is going off into that sector, which means we are concerned about whether local authority-based public health will get sufficient access to that resource.

Other than that, there is a lot of patchiness about how much analytical support there was and therefore will be. The history of JSNAs shows that in quite a number of places they commissioned a JSNA from outside the sector. They asked consultancy organisations to do them a JSNA, which was most unsatisfactory, because they were dead documents. Nobody knew the origins of the information and how to take it forward and on. They did not have the data. They were not living, working documents that helped the local organisations, and the danger is that you have more of that kind of, "Do me a JSNA."

**Q282 James Morris:** Do you think there is a capacity gap, then, in terms of fully understanding how you create a fully comprehensive strategic needs assessment in local authorities?

**Professor Bentley:** I think it is a quality issue, rather than a quantity issue. It is not so difficult to produce a nice big JSNA with lots of data in it. I have seen

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quite a number of those. The proper JSNA is supposed to take it on beyond that and say, "So what? This is what our finding is, and what does that mean in terms of what people might need to do about it?" One of the ones I have seen recently had 10 pages of findings and recommendations—10 pages of them tightly printed in the executive summary.

The question then is, "How do we turn that into a health and wellbeing strategy?" You end up—and did end up, in that health and wellbeing strategy—with three priorities. If the Health and Wellbeing Board is the beating heart of health and wellbeing improvement in a particular area, it must be more than that, I would say.

**Q283 James Morris:** The other area you identified in your evidence was that in order to create this beating-heart strategy, we need to drive activities by sharing data across different Departments—the NHS, local authorities, maybe DWP, other relevant functions. That is a big barrier to getting the strategic assessments in place. What could be done in order to make data-sharing better? We have had submissions from Sheffield City Council and Kent County Council already, saying that one of the things that is hampering them is a lack of ability to share data with other agencies.

**Professor Bentley:** I think someone was suggesting: "Is this is an area where we could get guidance from Public Health England?" I think that would be a good idea. This has gone on for years and years, and my original contact with it was through a thing called Health Action Zones—I don't know whether people remember those. They were quite a few years ago now—2000. What happened in the Health Action Zone programme was that when you were signed up to the health action zone you were allowed to appeal to the centre where there were difficult bits of legislation and regulation getting in the way, creating barriers to you moving on. You were allowed to appeal and say, "Could you hold these back for us to make progress?"

It was very interesting; I cannot remember the statistic, but the large bulk of what was asked for in terms of leniency, as it were, was something that could be done already. Quite a lot of the barriers are perceived barriers, as opposed to real. I am not saying that there are not real barriers, but, for example, if all the organisations you are working with have Caldicott Guardian status, you are allowed to transfer quite a lot, with the confidence that it will be handled safely and securely. That gets over some of the barriers. It is a question of saying, "What is left, when you pull that all away, that would be a barrier?" I think you can share quite a lot.

I have seen examples: somewhere like Islington, a couple of years ago, had reached the stage where they had moved on further than most on the Single Assessment Process, which was allowing social care and healthcare to share information about their clients and patients. Other people were claiming that there were big barriers to that happening.

**Q284 James Morris:** Could I just ask one final quick question? You also talk about the importance of the

public in all of this, in terms of the public easily understanding what it is that the public health strategy is for their particular area. "How will it affect me? What does it mean?" In your evidence, you talk about, "the presentation of the resulting information has not been converted into user-friendly formats, to inform and tell the story to a range of audiences." Could you just elaborate a little more on what you mean by that, and how the public could be more engaged with the information that is at the heart of some of these strategies?

**Professor Bentley:** The first part comes back to your earlier question about the resources to do the JSNA. Quite a lot of the resources for the JSNA do the analysis. You come across some very clever analysts who do very clever things that an epidemiology person like myself will appreciate the skill of, but then it is left there. A lot of people will not understand what the story that is emerging from the information is.

I am not just talking about the public; it starts earlier than that, with a lot of the frontline staff who do not get it, because it is not being presented to them in ways they can follow and understand. That is true in the health service, with health service information. You have to try to get that information into, for example, local elected members, some of whom will not have a technical background. You cannot expect them to pick up on some of that. It needs to be laid out in different ways for different people.

Just as an example of that, which I push a lot, is moving away from rates. "We want to reduce the mortality rate from heart disease from this to that." I don't know what that means. I do not feel it.

Change it to people. How many fewer men will die in 2015 if we hit this target? How many fewer women? People can then get into that discussion. They can say, "How many in my practice? How many in my constituency? How many of those would be South Asian?" You can begin to have a conversation with people who are not technical in nature about what this really means. It takes a little extra resource, and a different type of—almost marketing—skill to take the initial analysis and turn it into something that will affect decisions. That, again, is somewhere we often fall short.

**Q285 Simon Danczuk:** In your submission, you have made the point about inequality targets not being achieved, you say, "by a series of small but eye-catching projects." You also outline the example in Oldham, however, which is a relatively small, defined pilot project. I was wondering how you square the two there.

**Professor Bentley:** What we are saying there is that a lot of people including in Oldham, were doing work, but had not calculated what was necessary to produce the percentage change. It is a question of getting the dimension of the change right. A population health approach to alcohol-related heart conditions, for example: "We are going to have 56 extra places". You say, "What difference will that make at a population level? How could we measure that? Could we?" The answer is, "Probably not". The question is, "How do we get the right dimension of change into the system

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to know that we will make a difference?" The Oldham example was showing how you can do that. You can work it all through and work out exactly how much of what you need to achieve that level of change. It was an example—it was probably one of the "lower-hanging fruit", one would have to say—but it is showing the mechanism that would be necessary to get a handle on these things for population work.

**Q286 Simon Danczuk:** On that, from what little I know about the Oldham example, it appears that language is important. In the Oldham example, you talk about people dying; that is the reality. A lot of this stuff, particularly around health, seems to be steeped in terminology that ordinary people just do not relate to, and that is part of it.

**Professor Bentley:** That is exactly true, and that comes to an important issue for Health and Wellbeing Boards. It is a question of demystifying the whole thing. When I was trekking my way round the 70 most deprived areas, in a large majority of those you would go in there and you knew that the chief executives and directors and whoever thought that if you were to change the inequalities agenda thing, it would be through some kind of white magic that public health would achieve it, with partners somewhere off there somewhere, whereas when you had finished, and you had dissected it out and shown what actually needed to be done, what people were dying of, what the causes were, what would make an impact on that and how much of it you would need, you could boil it down, and chief executives would then say, "But we can do that," and you would say, "Yes, that is absolutely right."

The question is, how we translate that over to Health and Wellbeing Boards, so it is not some vague mystery "Oh yes, we are very committed to reducing this or that, or making that better", but saying, "Yes, but how do we pin it down? How do we demystify it as an issue, and therefore how do we take it on as a programme to make a measurable difference?"

**Q287 Simon Danczuk:** The BMJ published a report relatively recently that showed that unemployment is directly related to life expectancy. Should all authorities include employment initiatives in their public health work, do you think?

**Professor Bentley:** I would not say 'all', because we are not being top-down; we are doing localism. However, a good guide is the Marmot Review, which most people will know about. This basically picked out six sets of objectives that cover the life course. It started with Early Start, and employment and employment issues were there about number three or four, but we are talking about moving across the life course. I think that all local Health and Wellbeing Boards should appraise their own system against that checklist and say, "Where is our weakest link? Where should we be working?"

For me, the key one is about Early Start, because if you miss children in the first five years of life, when their cognitive abilities are developing, it means they are playing catch-up for the rest of their lives. It is not just then a question of giving them equal opportunity, because they will not have the skills to be able to

capitalise on those opportunities. It is really a question of saying, "We must put some emphasis on early start". Yet Health and Wellbeing Boards seem to be neglecting that, on the whole.

**Q288 Simon Danczuk:** That is interesting.

**Professor Bentley:** I am not saying they necessarily need to be doing it, but you need to have the driver coming from this 'beating heart' of health and wellbeing, saying, "We need to have stuff on early start, or employment", and then making sure that part of the system is dealing with it, so that we can keep taking stock through you, and saying, "Yes, we are the guardians of this, and we will make sure it is being done appropriately."

**Q289 Simon Danczuk:** A quick question about funding: you said in your submission, "systematically scaled-up public health intelligence-driven, evidence-based programmes". That sounds expensive to me. How will this be funded? What about the cuts? Do you think they will have a big impact?

**Professor Bentley:** No, it is not. I think that that is given as an excuse. A lot of the stuff that we saw that needed to be done at population level was a question of working on quality, for example—quality of provision. You have very patchy quality within primary care. I have graphs—I put some in the evidence base there—about how variable it can be simply managing blood pressure for someone with heart disease. That is not rocket science, and yet they are all over the place in some of those places. Getting to the point where that evens out is not something that is grossly expensive, and yet it has a real impact, so we are making sure that we know, "This stuff works, and we'll apply it to as many people as possible who can benefit from that, and we will get the results from it."

There is a lot to be gained from that way, and there is a lot to be gained from the working-together component, with which the Health and Wellbeing Boards should really help. That is one of the real pros of Health and Wellbeing Boards. Things like integrated care services and things like single infrastructures working into communities, where at the moment we have a whole plethora of them, all separately funded and adding up to chaos rather than a smooth interaction with communities. There are also things like community budgets, and working with troubled families. They are all things where there are huge inefficiencies and overlaps and difficulties for the user, and we can smooth that out by working on it together. That will make the whole thing much more efficient and therefore more cost-effective. It is those sorts of things, in this austerity environment, that we need to be working on first. We need to get that sorted out: "What can we do when we go in in the morning?" and then we can start saying, "If we had a bit more money, how would we invest it to make even further change?"

**Q290 Simon Danczuk:** My final quick question: Westminster Council cannot be accused of being "pink and fluffy" or, as you said earlier, "faffing around". They have come out and said, in my

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interpretation, “Fat people will not get benefits if they do not get in shape”. That is the general idea of what they said in terms of benefits and being incentivised to get healthy. What is your take on what they have said?

**Professor Bentley:** I think it depends on how much support they will give people to make the change. It does not mean, “We are not going to intervene. We wash our hands of you until you sort yourself out.” That would be a dire thing to be doing. However, if they are saying, “We have a range of other things we can do to support you to get yourself in a position where you can benefit from these interventions”, I think that is perfectly sensible.

**Q291 Mark Pawsey:** You have talked a lot about the challenges faced by Health and Wellbeing Boards. To sum up, are you confident that Health and Wellbeing Boards will make a significant difference in the area of public health, and how much time would you give them? How long do you think it will take to get to where we might want to be?

**Professor Bentley:** I think Health and Wellbeing Boards, in some places, will make a difference quite quickly. I have seen some evidence that gives me confidence that that is true.

**Q292 Mark Pawsey:** What timeframe is “quite quickly”?

**Professor Bentley:** It has to be within an electoral cycle, has it not? You have to make a change. In reality, you have to do that. Aiming to make a difference by 2015, I think, is what they should do. There should be some outcomes they could achieve by then, and some indicators of change they could have achieved by then, to show that they are making a difference. I would hope that they would do that. That will be the point at which we can say how patchy the delivery is.

**Q293 Mark Pawsey:** Are you of the view that in some places they will not make any difference at all, but will end up being elaborate talking shops, unable to deliver; or do you think that, in time, those that

are struggling to get their act together will be able to do that?

**Professor Bentley:** I would imagine that it will always be a bit patchy, because that is the way systems are unless you regulate them, and this is not a system that will be regulated very hard.

**Q294 Chair:** Finally, Professor Bentley, will you be doing a review in due course of how things have progressed? Is that something you intend to do, to keep your eye on the situation? I think that exactly what you have just said now is likely to happen; some areas will do it better than others, and it would be very good for someone to be looking at it and saying, “There is some really good practice out there that ought to be shared and disseminated.”

**Professor Bentley:** It is not me, because I am an independent person. I will do it if someone employs me to do so, but I would like to be. I think that where we need to be looking for this initially is Public Health England. It is the new player on the block. When Public Health England was set up I heard the Secretary of State talking about it, and he said he was looking for a world-class public health system, delivering world-class outcomes. I have been trekking around the country, and I have seen some world-class public health, but it was the patchiness of it that meant it was not nationally world-class. The idea was that the system—this would be the Public Health England system—should enable us to get rid of some of that patchiness, and have a better and more consistent use of the evidence base, better drivers on quality, and so on and so on. That is where I would think the expectation is. We do not know yet, because they still have not got their knees under the desk. They will do in the next month or so. That is where the hope will be: that Public Health England will provide a spine on which quality and outcomes can be driven.

**Chair:** Thank you very much indeed for coming this afternoon. It has been very interesting to have evidence from you.

**Professor Bentley:** Thank you very much.

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**Monday 21 January 2013**

Members present:

Mr Clive Betts (Chair)

Bob Blackman  
Simon Danczuk  
Bill Esterson  
James Morris

Mark Pawsey  
Andy Sawford  
John Stevenson  
Heather Wheeler

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**Examination of Witnesses**

*Witnesses:* **Anna Soubry MP**, Parliamentary Under-Secretary of State, Department of Health, **Tim Baxter**, Deputy Director, Public Health Development Unit, Department of Health, and **Baroness Hanham CBE**, Parliamentary Under-Secretary of State, Department for Communities and Local Government, gave evidence.

**Q295 Chair:** Welcome, everyone, to the final evidence session of our inquiry into the role of local authorities in health issues. You are all most welcome this afternoon. Could you say who you are, please? That would be helpful to put into the record.

**Tim Baxter:** I am Tim Baxter, deputy director and head of the public health policy and strategy unit, Department of Health.

**Anna Soubry:** I am Anna Soubry, Member of Parliament for Broxtowe and also the Minister for Public Health.

**Baroness Hanham:** I am Joan Hanham, Parliamentary Under-Secretary of State in the Department for Communities and Local Government.

**Q296 Chair:** You are all most welcome this afternoon. Joan, you have been with us on a number of occasions; for Anna I think it is the first time. Thank you very much, all of you, for coming along. We have taken evidence already, and no doubt you will have seen some of the evidence sessions that we have had. The Committee at one of the sessions was slightly disturbed by what was said to us by the chief executive designate of Public Health England with regard to screening and immunisation services: "There is an issue about screening and immunisation. I agree that we would not have invented this." I would have thought it is not the best start to a new system for the chief executive to question whether the whole structure with regard to screening and immunisation is fit for purpose. Have you got similar concerns, Ministers?

**Anna Soubry:** Not particularly. The movement of public health back into local authorities, which has been largely uncontroversial, should genuinely be welcomed by everybody. The feedback I am getting is that by and large, with a few exceptions, local authorities are excited at the prospect, and, as I say, it is to be welcomed. I welcome the idea that for immunisation in particular it should be the responsibility of the commissioning board to put it out at the level they intend to. I do not share Duncan's concerns about it particularly. As you would expect me to say, I am more than willing to listen to anybody, and when it is him who is saying it I particularly hear what he says. I do not know what Tim says about it.

**Tim Baxter:** I know exactly what Duncan is saying. We did not redesign the whole health system with screening and immunisation in mind. The benefit of

the new system is that you will have a single national commissioner for screening and immunisation programmes. There will be an NHS commissioning board. They will be commissioning with evidence-based specifications. There will also be Public Health England staff seconded to the commissioning board, running the screening and immunisation programmes, so you will have a greater critical mass of public health expertise in charge of these programmes. It will be an improvement on the current arrangements.

**Q297 Chair:** What about at local level?

**Tim Baxter:** At local level it will be run through the 27 area teams of the commissioning board, so it will be sufficiently local to be locally sensitive, but I should also say that, subject to Parliament, local authorities will have a duty to advise on health protection arrangements. They will be able to scrutinise what is happening on screening and immunisation and, if necessary, raise any concerns, and that includes through the health and wellbeing boards.

**Q298 Chair:** You have already mentioned four organisations: the local authorities; the health and wellbeing boards; the commissioning board; and Public Health England. Once you get four organisations involved in doing something, isn't there a worry that they all try to do it, or they do different things, or nobody does it because they think somebody else is going to do it?

**Tim Baxter:** The important point to make is about accountability. There will be an agreement between the Department of Health—the Secretary of State—and the commissioning board to commission these programmes, so it will be for the commissioning board to make sure they get things right. I know that this is being treated very seriously. There are senior people in the commissioning board and Public Health England who are very much focused on ensuring that we have the people in place to transfer the responsibility for these programmes from next April.

**Anna Soubry:** One of the really good things about this system is that health and wellbeing boards, which are part and parcel of the local authority, are exactly the places where local people, whether they are elected representatives or their CCGs—in other words, local GPs—may well say they have a problem.



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To take TB as an example, they may say, “In our particular area we have a big problem with TB in certain parts of our communities.” They can make their representations to the local NHS commissioning board far more powerfully, because it is far more local, and say, “Can we beef up on this? What can we do to improve this? How can we go about it, maybe with some screening as well as immunisation?” They can do that in a much better way because it is far more locally focused. That is a good idea of where the delivery of public health at local level could be hugely beneficial, drilling right down to communities and sometimes within wards.

**Q299 Chair:** So you have no concerns, and the chief executive of Public Health England is a bit over-cautious, is he?

**Anna Soubry:** There is nothing wrong with being over-cautious. Duncan Selbie, being the man that he is, is quite rightly looking at every single aspect of what is a new brief. I would not say he is being overly cautious. I do not have a problem with people being cautious as we move into a new delivery of a system; so you should be.

**Q300 Simon Danczuk:** A number of witnesses have told the Committee of their concerns about the preparedness of Public Health England and the NHS locally in the event of a national emergency. The head of Public Health England told us, “I will do everything I possibly can to make sure that people know whom to talk to from day 1.” After that, Newcastle City Council said, “We do not know whom to talk to”; and Sheffield City Council went on to say that it was proving very difficult to get the answers they needed in order to advise them as a council. Are you comfortable with the preparedness in terms of a possible national emergency?

**Baroness Hanham:** I am going to leave that for the Department of Health, if I may, and then I will come in on local government.

**Anna Soubry:** I am going to hand over to Tim on that, because it is very important that we get the absolute detail and also know exactly where we are now.

**Tim Baxter:** As Duncan made very clear in his evidence, the people who are currently providing health protection services in the HPA just move across to PHE. They are staffing up the 15 PHE centres. It is very important that people know who will be the relevant people within the area teams and commissioning board, and that is being dealt with. I should also say that as part of the recent self-assessment process that local government has led, one of the areas they focused on was emergency preparedness, resilience and response. The general message was that people felt they were moving forward and they understood the new arrangements. There will be local health resilience partnerships on local resilience fora footprints. Not all of the leads for those have been appointed, but that process is going on.

You raise a very important point but it is very much one that has been gripped. Four regional exercises are being planned. I am not sure whether any of them have taken place yet, but they are planned to take

place before the whole system goes live, to make sure people understand who they talk to and how responses will be made in an emergency. I think people are clear about the general architecture. The point is more about nailing down exactly all the people in the local resilience architecture, but the critical point is that local authorities do not change. They have their Civil Contingencies Act responsibilities, and health protection agency resources all move across to PHE.

**Anna Soubry:** There is also the role of the NHS. They are absolutely at the front and obviously they bear a large part of the responsibility. We should also not forget the director of public health in every local authority. As a Department, we have always recognised, as now are local authorities—I was going to say those out in the real world—and many others, the real role of the director of public health and the way he or she will sit within local authorities. Without being controversial, I hope and I genuinely believe that as politicians when we go back to our constituencies and political parties we are beholden to say to our colleagues that this is a real opportunity that exists. It is for the politicians to lead at a local level in their local authorities to make sure that their directors of public health, as I am sure they have done where they have been appointed—there are only a few vacancies left—are of the highest quality, and that they have the power, respect and status in the local authority that they should have given the job we want them to do.

**Q301 Simon Danczuk:** Just for clarity’s sake, which Department has lead responsibility for ensuring that contingency structures are clear and transparent?

**Tim Baxter:** If the question is, “Who leads in a health-related emergency?” that is the Department of Health.

**Q302 Simon Danczuk:** Which Department has lead responsibility for ensuring that contingency structures are clear and transparent?

**Tim Baxter:** The Secretary of State for Health has a duty to protect the health of the population, so in terms of the overall policy framework it is his responsibility to make sure that the legislation and guidance are clear. Then individual parts of the system all have their own responsibilities. For example, the NHS Commissioning Board has a duty to ensure that the NHS prepares for, plans for and responds effectively to emergencies and major incidents, which would be critical.

**Q303 Simon Danczuk:** We are about 70 days away, Ministers. Can you give us an assurance that if there is a health emergency on 2 April, the new arrangements will be as effective as those that operated on 2 April last year?

**Baroness Hanham:** From the point of view of local government, as long as the directors of public health are in place—I think they will be because there are very few vacancies left—and the arrangements are co-ordinated, it is now in a good place to deal with any emergency. In reality, the number of national emergencies can probably be counted on one hand. These will be things that are happening locally; you will get a big norovirus outbreak, an outbreak of TB

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or something. It is terribly important that the local authority, local government and the public health director are together.

**Q304 Simon Danczuk:** That is a “yes”. You agree that things will be as good this year as last year?

**Baroness Hanham:** Yes.

**Anna Soubry:** I agree. One of the things that gave me great comfort—I was not a Minister at the time, but I learnt about it very swiftly after my appointment—was the real feeling within the Department that, because of the processes, structures and so on that had been set up for the Olympics, almost as a nation we had learnt a great deal about how to cope with the sorts of situations that might arise, so I am okay.

**Q305 Andy Sawford:** The Committee is interested to know how much central guidance local authorities can draw on and who will be responsible for its production. We heard from David Buck of the King’s Fund. He talked to us about the impact of work being carried out on smoking. He went on to say that he thought Public Health England was in a very good position to make recommendations, advise and support local authorities in taking forward evidence. Similarly, we heard from Duncan Selbie of Public Health England who expressed a willingness to take on the role. He said, “We will be seeking to share the evidence about what works, not telling people what to do but opening up possibilities.” What exactly are Public Health England, or any other agencies of your Department, going to do to make high-level policy and advice meaningful for local decision-makers?

**Anna Soubry:** Smoking is a really good example of how this system could work. At the moment the Department of Health can do national campaigns. We can suggest that or say that this looks like a good idea; we can do what we have just done, which is to launch another campaign against smoking with an advert showing a cigarette turning into a tumour and so on, and with some success. When we did Stoptober we were very pleased with the take-up of the kits and so on. Smoking is an example where even better work can be done at local level. Under the guidance of PHE, who can provide statistics, advice and so on, because this will now sit with local authorities it means that in your area, and everybody else’s, the local authority can drill right down to ward level. You can identify an estate or development where you know the demography and you will have a very good indication from your GPs, linked with the health and wellbeing board, as to the incidence of smoking. You will have the power, political will and drive, which is a local decision, to target smoking in such and such a ward; to apply an order to make children’s playgrounds no smoking areas; to work with the local school and, at the same time, run a campaign there; and to make sure that all the pharmacies have got the right gear, that the GPs are stuck in on it and so on. Instead of taking a more blanket approach, although we target our anti-smoking work on particular demographics, you can do it so much better in a local area. It is under the guidance of PHE, often working in conjunction with the Department of Health, that the actual delivery will be even better, because it will be at such a

drilled-down local level. Politicians, of whatever party, can seize this as a real opportunity and, come the next election, they will be able to put on their leaflets, “We have delivered this for you in our community”.

**Q306 Andy Sawford:** I have some questions about information sharing, but, on the first question, Baroness Hanham, what role does your Department see for itself and for any of the agencies within it, or perhaps organisations outwith government, such as the LGA, to support local authorities in this new public health role?

**Baroness Hanham:** I think Anna is right. The lead is going to come from the Department of Health, and it will be up to local government to make sure that the director of public health is concentrating very firmly and clearly on the local area and any local schemes they want to run. We would want to borrow from the Department of Health any advertising that they are doing and any campaigns that they have, and take those locally as and when appropriate. The health and wellbeing boards will be crucial in deciding what needs to be done and where, so from the Department’s point of view we see this being passed down to local government but with local government being given the strength to know that it can take advantage of what the Department of Health is doing.

**Tim Baxter:** PHE will be crucially providing evidence and data at a very granular level, so people will be able to see at ward level, for example, how they are doing and compare themselves with comparators and then, as the Minister said, provide health expertise and so on, but we will not be in the business of lots of prescriptive central guidance, which was the point Duncan was trying to make. We are there to help, encourage and so on but not to tell.

**Q307 Andy Sawford:** On the point of data-sharing information, we have looked at Caldicott and so on, but Kent County Council said in its evidence that “a crucial outstanding issue relates to information governance and the ability to share non-patient specific information between the NHS and local authorities.” Yet, in your remarks you are assuming that that is relatively straightforward and it will work. It is an assumption on which the relationships among Public Health England, local authorities and health bodies is based. Perhaps you could say what your Department is doing to break down the barriers that local authorities have told us they perceive between the organisations in the health arena.

**Baroness Hanham:** Can I just intervene on this? Information sharing across government and Departments is fraught. We could spend the whole day discussing information sharing. Everything I go to has the same problems, and it is an issue. The issue is that local authorities do not know what they can pass on to the health service. If somebody comes into the A and E department, for example, the NHS has no idea whether it can tell somebody. We were talking earlier today about people who are sexually assaulted. The health authority does not know whether it can pass that information back to the police, for example. There is a huge area here that we need to get to grips

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with in government. We need to involve the Information Commissioner, but the whole issue of information sharing, particularly now within the Department of Health and public health, will hold us up.

**Q308 Andy Sawford:** Local authorities will be pleased to hear you being so frank about that challenge, but they would want to know what you, as the Minister, are doing to address it given how far down the line we are in implementing the health and wellbeing boards.

**Baroness Hanham:** We are quite a long way down the line of discussing it. Look at some of the issues, like community budgets. It does not sound very relevant, but every single aspect of what has to be done in the community budget needs information sharing. My Department is talking to every single Department that would be involved in community budgets about the problem of information sharing. We are all doing all we can to open it up. I think we ought to have a national view across government as to what we can do in terms of giving advice about the information that can be shared.

**Anna Soubry:** Speaking very much with my Department of Health hat on and now sounding a little bit obstructive, as other Departments might seem, confusion often arises; when we talk about information sharing, we all get quite agitated in the Department of Health because often we think that means names, addresses and medical details. I am sure that at that point everybody says that we are not talking about that, because we all understand and agree that there is an important bond between the medical professional and the patient of absolute confidentiality.

**Q309 Andy Sawford:** That was why my question was about non-patient specific information; that is what we would like to hear about.

**Anna Soubry:** You are absolutely right, but a good point made at an earlier meeting, I think by the Home Secretary, was that often you can share information where the details of the person are anonymous. For example, if you are in an A and E you can say that last night five women presented who claimed they had been victims of domestic violence. You do not need to know their names and addresses; you just need to know that five presented. You might need to know some of the detail of the injuries; you might even need to know where they were in a particular area. Nevertheless, the problem is that, frankly, at times there is a lot of ignorance; there is also often a lot of resistance to sharing information, but it comes in different ways.

On your point about non-patient specific information, one mistake we often make is that the real test should be about outcomes. In cardiovascular work, one thing we have seen—it may have been under the last Government, but none of this is anything to do with party politics—is that in order to drive up outcomes so people got the very best treatment we began to publish what was going on. While that is very interesting for actual and would-be patients, in truth the real driver is the rivalry between surgeons. I used

to be a barrister and so I was a professional. There is no greater drive in any profession than the thought that so-and-so might be doing a better job than you and it is out there in the public domain, so we are going to publish outcomes. As Tim has explained, we can get down to interesting levels, such as CCG level. Therefore, you as the local MP could say to your CCG, “Hang on. Why are you not doing as well as that one?” and then you can go to your councillors and say, “Guys, why is this happening and why is that not happening?” and get the health and wellbeing boards to start to drive things as well.

**Q310 Andy Sawford:** That is an indication of how you might monitor or measure performance, so when might you intervene on poorly-performing health and wellbeing boards? What might trigger an intervention, and what form might that intervention take? What you have described sounds somewhat like the comprehensive area assessment of a few years ago and the ability of the public to see by the collection of data from local authorities the performance in a particular area of work.

**Anna Soubry:** I am talking about the publication of outcomes drilled right down to CCG level. In any event there are enough systems in place to monitor what is going on in the delivery of health care under the new system. I do not think you would have health outcomes coming from the health and wellbeing board. It is the job of the health and wellbeing board to look at the outcomes in their area and start to take action, if they need to.

**Q311 Andy Sawford:** But will central Government intervene if there is poor performance?

**Anna Soubry:** At what level?

**Andy Sawford:** At a health and wellbeing board level.

**Baroness Hanham:** Performance monitoring is going to come partly through the local authority. All of them will have health scrutiny committees. They will want the information in their local area. The director of public health is going to need to know what the comparisons are across the piece. He will need to know to report that back, so the local authority will have a really significant role here in doing the scrutiny and monitoring.

**Q312 Andy Sawford:** If a health and wellbeing board is evidently performing poorly relative to other health and wellbeing boards, you do not envisage an intervention being made?

**Baroness Hanham:** In this case, it would not be the health and wellbeing board; it would be the director of public health who would be responsible for making sure the scrutiny committee knew. We need to be really clear that the direction from the centre is going to be light touch; it is for local authorities and local CCGs to apply their own standards.

**Anna Soubry:** But you have still got Public Health England.

**Q313 James Morris:** Tim talked about central prescription. Do you expect to have less central

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guidance coming out in this area—50% less, 80% less?

**Tim Baxter:** I have written quite a lot of the stuff that has been published in the last two years. Generally, we are trying to move to a place where there is a pull for it, if people at local level say, “It would be really helpful if you gave us guidance on X, Y and Z”. Indeed, on the data issues we published guidance on the local public health intelligence system back in September, so if there is a demand for it, yes, but increasingly we are trying to co-produce it—to use a horrible phrase—with the Local Government Association and others and so make it something that people find useful.

**Q314 James Morris:** With all due respect, DCLG’s definition of “light touch” may be different from that of the Department of Health who historically may have had a culture of wanting to prescribe parameters, not really subscribing so much to the philosophy of localism.

**Tim Baxter:** I have been in the Department of Health for 21 years, and it is true that historically the relationship we have had with the NHS has been a more top-down prescriptive model. However, we are moving to a new system and the relationship we need to build with local authorities fits in very neatly with the relationship we need to build increasingly with other parts of the health and care system, such as the NHS Commissioning Board, which cannot be directed by the Secretary of State. I would certainly appreciate that we definitely need to learn different ways of working.

**Baroness Hanham:** Prescription has gone, but, for example, the Local Government Association is now doing more and more in advising local authorities on having a grip on what they need to do and then mentoring and helping them through. That is probably where we see most of the influence coming from now, because that is not only one local authority; it is a number, and in bringing together all the things that have been raised by local authorities, they are going to be able to iron them out more or less for themselves.

**Q315 James Morris:** Picking up Andy’s point, the central test will be if there is a significant systemic failure at some point. Anna, would you be able to resist intervening ministerially in a situation where it is clear there has been some sort of systemic failure?

**Anna Soubry:** Would it not be the same as a systemic failure in the local authority that could happen at the moment? I have already mentioned directors of public health. Directors of public health have their own professional body and standards. They used to work in the NHS and now they are moving over to local authorities. Obviously, they will not be stand-alones because they will be working for the local authority; they will be accountable to the chief executive and other senior officers and so on, but in the interests of public health they will attend the sorts of seminars or conferences you would expect them to attend. There will be that sharing of information and a desire—I have no doubt, based on conversations I have had with a number across the country—to drive forward success within their local authorities. Like many

people who work in local authorities, in my experience, at a senior level they are proud of their local authority; they want it to do well and make sure it succeeds. I am confident that that sort of attitude will now be engendered in the delivery of public health. Do not forget there is also the role of Public Health England in the guidance it can give and all the checks and balances they put it into it.

**Tim Baxter:** The important point about the role of the local government sector and the sector-led improvement, which has been working in children’s service and adult social care, is that they do not want to see this fail, and peer improvement is very powerful. The alternative, if you rush into central intervention, is that you have to own the problem at the centre, which is not a very comfortable place to be. As the Minister has said, local people wanting to do a good job and the support of Public Health England and the local government sector will be very powerful.

**Q316 Chair:** I understand that we hope everything goes well and that authorities perform well and public health is delivered well at local level. If things are not going quite so well, we hope for peer assistance through the LGA. Public Health England is there to offer guidance. If things go really badly wrong, and despite all this guidance and help they are not being put right, whose job is it to say, “We need to do something about it, and it is our job”?

**Tim Baxter:** The local authorities are statutory bodies; it is their responsibility to manage themselves. If they are not managing we think sector-led will be the way in which issues will be raised. In the final analysis, central Government can intervene, but that is a very heavy stick that is very rarely used. The evidence we have seen is that where sector-led improvement and Public Health England can increasingly spot problems early and put in support, that is the likeliest way of sorting out problems.

**Q317 Chair:** I agree, but if it does not work is it the job of Public Health England to say to Ministers, “We’ve tried; it’s not working, and we need to do something else”?

**Tim Baxter:** Yes. If it was a matter of central intervention, obviously we would need to be talking to DCLG as well.

**Anna Soubry:** To make things absolutely clear, as things roll out after April my relationship with Duncan Selbie is such that we have meetings and those will continue. They are separate; they have their own role to play and they do not want Ministers bossing them about and telling them what to do. On the other hand, there is an absolute relationship there which in my view is absolutely critical.

**Baroness Hanham:** The idea that Ministers are going to get involved, unless there is an absolute crisis, is probably unreal these days. Local authorities now are accustomed to managing themselves for every service for which they have a responsibility. They do not get people crashing down on their heads every five minutes. Even if something goes very seriously wrong, they are by and large helped to sort it out. The Department’s role, if something went really wrong,

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would be to liaise with the Department of Health and between them give advice and help, but it would not be dictatorial; it would be to say, "Who would be the best people to help them out?" whether it is peer help or peer monitoring. If it is a wholesale disaster, I am sure the Departments would have to intervene.

**Q318 Bill Esterson:** In circumstances where national Government intervention becomes essential, have you put in place ways of rolling that out and how you will communicate with the local authorities? Does that structure exist between the Departments and local authorities?

**Tim Baxter:** Various legal powers would need to be invoked.

**Q319 Bill Esterson:** It is a formal process?

**Tim Baxter:** There would be a formal process. If you would like a detailed note on this, we are very happy to provide it. Coming back to the power of informal arrangements, if the chief executive of the LGA were here she would say that what the LGA can do as peers, without any formal powers but through the power of suggestion, is a lot quicker than what central Government can do, and arguably, certainly in the short term, a lot more effective.

**Bill Esterson:** Do you have anything to add?

**Anna Soubry:** No.

**Q320 Bill Esterson:** Coming to the point about the balance between prescription and persuasion, when the Health Committee looked at smoking it found that the ban on smoking was effective, whereas lifestyle initiatives—Dr Mike Grady made this point—were ineffective, certainly with the bottom 50% of the social gradient of health. Do you accept that there are some public issues, whether it is smoking, alcohol misuse or obesity, that may inevitably require central Government action, including legislation, as the only effective way of changing behaviours in the population? If local authorities are to make a big difference to the health of the population, is the money going to be available for them to follow through on that sort of legislation?

**Anna Soubry:** If legislation is passed the money must follow; otherwise, the legislation would be meaningless. The debate between legislation and persuasion is a really good one to have. No doubt this is not the time to have that debate.

**Q321 Bill Esterson:** Do you accept there are times when it works?

**Anna Soubry:** Absolutely. I was always very sceptical about the ban on smoking in open places, but I was a smoker. I was proved absolutely wrong. The way we have changed as a nation and the whole cultural attitude towards cigarettes is phenomenal. Every time you see a film where everybody is puffing on a fag you think, "My God. Did we actually used to do things like that?" We did. Banning smoking in restaurants was one of the huge achievements of the last Parliament. Today, we have shown that the incidence of asthma in children has plummeted. All those people who voted for the smoking ban can say they played their part in reducing asthma in children,

because we think it is directly related to the ban on smoking in open places. As you know, our consultation about standardised packaging of cigarettes has finished, and we are now waiting for the evidence to be published. Unfortunately, if I had a view I am not allowed to share it with you. You did notice I said, "If I had a view". You are not allowed to have a view; those are the rules, and all the rest of it. You get judicial reviews and all sorts of things. If there is a proposal it would have to be legislation, and that would go through the usual process; it would come before Parliament and debate would be had. I cannot talk about that, but I can talk about minimum unit pricing.

**Bill Esterson:** I was going to ask when you were going to do that.

**Anna Soubry:** I am more than happy to talk about it. It is a matter of public record that I was very cynical about it; I thought it was a pretty average idea, even though it was put forward by my Prime Minister. I was not convinced of the argument. Then I met a whole load of liver specialists and doctors who, in terms of argument, frankly blew me away and completely convinced me that it is a thoroughly good idea. I am allowed an opinion because it is a Home Office lead, not a Department of Health lead, and I am absolutely up for it.

**Q322 Bill Esterson:** Do you know when it is going to come in?

**Anna Soubry:** No. We are consulting at the moment. The consultation finishes on 6 February. As a constituency MP, I publicise it in my constituency and ask my constituents to write in and join in the consultation, because there is a good debate to be had about it. I am in favour of it, and I think it will have an influence on drinking habits; certainly that is the view of doctors.

As to obesity, which you quite rightly touch on, at the moment we are trying to work with industry, getting them to sign up to something called the Responsibility Deal whereby they undertake to do certain things, like reducing salt. That is one of the reasons we have some of the lowest salt levels in the world. Our levels of trans fats in food have come down to just under 1%.

**Q323 Bill Esterson:** But the real issue is sugar, isn't it?

**Anna Soubry:** I struggle with the idea of not allowing children's cereals to have more than a certain percentage. I am an old lawyer, so my first question would be: do you mark cereal packets "Adults only"? Then you stop mothers at check-outs and say, "Excuse me, Madam, but are you buying that for your own consumption or will you give it to a child?" But seriously, you can see the logistical issues of making that happen. Let's say you said that cereals with 30% sugar should be banned. The danger is that for those at 29%—Mr Stevenson gets the point already—people say, "It's all right. The Government haven't banned it, so you can have three bowls of it." One bowl of sugary cereal will not do you any harm if you have it once a year, but if you have it as part of a diet that is full of other sugar, fat and other rubbish and too many carbs, obviously it will do you a considerable amount

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of damage. That is the problem when you start to micro-legislate in that way. I am not saying that at the moment the Responsibility Deal is perfect by any means; it needs a lot more beef going into it.

**Bill Esterson:** Beef does not have sugar in it.

**Anna Soubry:** Beef with sugar—that is quite a good concept. The debate that was had, even if it was in the press and it was a short one, was a good one in the sense that it fired a very big, loud shot across the bows of manufacturers and retailers. It says to them, “You know what? If you don’t get your house in order, we may well legislate.”

**Q324 Bill Esterson:** So if the manufacturers just carry on as before, you will legislate?

**Anna Soubry:** At the moment, we have a carbohydrate or calorie Responsibility Deal, and so far a good number of people have signed up. In terms of our Responsibility Deal, some people have not signed up to the right things. For example, Greggs are not signed up to the salt Responsibility Deal. If they are, I apologise to them. I have asked for meetings with some of the high street suppliers of good fast food, except that some of the food they produce has the sort of stuff in it that is not great for this nation’s health, and I want them to sign up to the Responsibility Deal. A bit of naming and shaming is going to start to happen, because we make it clear that, unless we begin to see substantial changes, we will consider legislation. At the end of the day, the ultimate responsibility has to be—because it is—of each and every one of us, especially what we as parents feed to our children. The state can do only so much.

**Baroness Hanham:** It picks up the point as to whether the directors of public health are going to have responsibility for education. I do not mean general education but education of the public on things like obesity and drinking. It takes a long time to get legislation in place. In the meantime there is definitely a responsibility to make sure people understand what the difficulties, limitations and dangers are. That will fall squarely on the directors of public health.

**Q325 Bill Esterson:** Mike Grady told this Committee that these initiatives do not work for the bottom 50% of the social gradient of health. While what you say is great when it comes to personal responsibility, what about those people who do not take the responsibility?

**Anna Soubry:** But you cannot have fat police or sugar police, which is the next logical step. On salt, we have achieved some of the lowest levels in the world. We are very proud of what we have achieved on front-of-package labelling. For the first time ever, all the supermarkets have agreed to have a standardised form of the traffic lights, but I accept that it is only as good as the ability of somebody to read it and then, most importantly, act on it. As politicians, you cannot tell people, and certainly cannot force people, to eat a healthy diet. You can make sure they are properly informed and encouraged to take responsibility for their diet. In my own constituency I already have schools taking this really seriously and working with parents. One of my schools had a week of just cooking and looking at food, with all the children in the school,

and the parents came in to help in the classes to learn how to cook. It is small stuff, but I honestly think that is the stuff that will be delivered in these changes in public health.

**Tim Baxter:** It also comes back to the director of public health trying to use what is available nationally and targeting. You are absolutely right that with the more hard-to-reach groups you are going to have to do different things; you have to be more imaginative and probably put a bit more resource into it and do things differently, but that is part of the strength of the director of public health in local authorities.

**Q326 Bill Esterson:** Finally, the Cabinet sub-committee on public health was disbanded on 8 November on the basis that it would allow public health issues to be discussed and decisions taken by a wider group of Ministers across government. Can you say how many times and by what mechanism this has happened since the sub-committee stopped operating?

**Anna Soubry:** I do not know of any.

**Q327 Bill Esterson:** Do Ministers know that is supposed to happen?

**Tim Baxter:** We have plans for engaging with the Home Affairs Committee. The brutally frank answer is that we have not done so yet, but the advantage of the Home Affairs Committee is that that brings together the same sort of range of Departments as the Public Health sub-committee at Secretary of State level, and it is a very good forum to drive through public health. One of the challenges for us in the next couple of years is to use that effectively. There is also a senior officials group that is chaired by the director general in charge of public health in the Department, and the Minister meets her colleagues on a bilateral basis.

**Anna Soubry:** I do. I went to see Edward Timpson in the Department for Education to talk about sport, for example. One of our Responsibility Deals is about physical exercise—we cannot call it sport—and the lack of physical activity in too many of our youngsters. I went along to talk to Edward Timpson about that and what could be done about funding, initiatives and so on.

**Q328 Bob Blackman:** Minister, no doubt we will see you at the inauguration of the national kebab awards later.

**Anna Soubry:** Mr Blackman, there is nothing wrong with kebabs, as you well know. Mr Blackman and I go back over 30 years, so it is not a new problem, is it?

**Q329 Bob Blackman:** One of the frustrations that I experienced as a councillor before being elected here was having targets thrust upon us by central Government to say, “You will get this number of people to cease smoking, and you will get money as a result of achieving that.” I note that the data will be available, and that is good news, but have you got any concerns about the role of councillors and local councils in encouraging smoking cessation, reducing alcohol dependency and so on? Have you got any concerns that people will be able to do this?

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**Anna Soubry:** Of course I have concerns at an individual level that perhaps some councillors will not get it, to put it in those terms, but two things give me heart. One is the appointment of the directors of public health who will be the leads, the steers, and who will be putting the evidence in front of a council and saying, "Look, just look at our smoking rates and obesity levels, and look at it in your ward, councillor." I am not saying they will be as aggressive as I am being, but that is the evidence they could put forward, and make the case to councillors who will know and understand their statutory obligations and duties in any event through all the various mechanisms we have described. They give me good heart.

The other thing that gives me heart is I honestly believe that, as this begins to unroll, being the political animals that we and a large number of councillors are, we will begin to see it in the same way. I may be wrong—you will tell me if I am—but they have got recycling. I confess, Mr Betts, that I am one of those who helped my councillors write a leaflet about recycling rates in my borough versus the recycling rates in another borough, championing the rates in the other borough that happened to be controlled by my political party and criticising my local borough council because it was another political party. I am not saying it became a competition, but it almost was. You could see that politicians suddenly grasped the fact that there were really good reasons for increasing recycling rates: first, because it was a really good thing to do in any event, but, secondly, the public liked it and got it, and it could be an important feature.

**Q330 Bob Blackman:** I agree with you on the point about recycling, but the key challenge coming here for councils is that you knock on the door and say, "I'm telling you you have got to give up smoking, and, by the way, you're overweight; you've got to take more exercise, and will you vote for me on Thursday?"

**Anna Soubry:** No; you would never do that.

**Q331 Bob Blackman:** There is a clear dilemma here for people at a local level, who clearly can encourage healthy lifestyles. There is a challenge particularly in the areas we are talking about where people are going to be reluctant to take the message.

**Anna Soubry:** Yes.

**Q332 Bob Blackman:** Is the Department of Health or DCLG putting information in the hands of councillors and councils on the type of initiatives they could launch and assisting those campaigns?

**Baroness Hanham:** This is going to become very important. There are enough councillors who are interested in health. Bringing the director of public health back into local government has been very widely welcomed, for the reason that local councillors can get involved now in a much more local way in the sorts of initiatives that we are talking about. Local councillors who are interested will probably need some training, but that will have to come from the local councils themselves, although I am certain that training programmes will be set up that they can take advantage of. It is just making sure that that

encouragement is there and is not directional. I do not think there is any point in us sitting in the Department for Communities and Local Government and saying, "You will have a training scheme". Local councils themselves will say, "We don't know enough about this; we need to find out." I am confident that this is a popular enough policy to get local councillors engaged in what is going on. I also think that there are problems of deprivation in all local authorities. There is a variety of things—poor housing and poor eating—that nobody has known how to grip, and probably having this localised will make it much easier.

**Anna Soubry:** Nobody in their right mind would ever knock on anybody's door and say, "You've got to stop smoking", and all the rest of it. It does not work like that, but what the Baroness has just said about health inequalities, for example, would be a huge driver at local level. I went to Coventry to see a project and met a number of people right through from local councillors to the director of public health. They told me about the huge inequalities in health in Coventry and their absolute determination to reduce them. Then they showed me what they were doing at a local level. This was just simple stuff in a local library, bringing people in from different communities and doing some work with them on all sorts of things. It is a great opportunity, as the Baroness quite rightly said, and it has been greeted in a lot of areas.

**Tim Baxter:** On the particular issue of smoking, ASH—Action on Smoking and Health—has produced a guide for local authorities on some very practical steps they can take.

**Bob Blackman:** I know; I launched it as secretary of the all-party group.

**Tim Baxter:** There is a lot of really good guidance like that, and it is really good that that has come from the voluntary sector; it is not a central Government prescription.

**Q333 Chair:** If we turn to the guidance around on the system, last year the Department of Health said to local authorities that it expected them to ensure that partners, including the NHS and Public Health England, had effective health protection plans in place. There was a clear onus on local authorities; it was their responsibility. But the regulations we have now seen say that local authorities should provide only information and advice to partners. It is a watering down of the language. Is it a watering down of the responsibilities of local authorities in this regard?

**Tim Baxter:** The regulations reflect the legal range of responsibilities, as one would expect. The Secretary of State has the duty to protect the health of the population. The duty on local authorities is to take steps to try to ensure, in effect, that plans are in place. What the local authority cannot do is require, in the sense of legally insist. If they decide that an NHS trust, or whatever, is not doing what it should do, they can raise the issue with that trust, but the regulations also say that they should advise Public Health England who fulfil the health protection duty on behalf of the Secretary of State. The regulations are saying that you escalate the issue to the person in the



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system who has the final responsibility for protecting the health of the population.

**Q334 Chair:** What we are saying is that the Health and Social Care Act was not written in such a way as to allow the initial intention of a responsibility to ensure on behalf of local authorities to be implemented.

**Tim Baxter:** If you read the guidance in that very literal way, it is perhaps slightly unhelpful. I take responsibility for that. I drafted that. I am quite happy to say we will look at it again. We have already said that we will look at the guidance in the light of the regulations. The way that the Act is drafted means that, as we say in the guidance, statutory bodies retain their responsibility to respond to the advice and challenge they receive. The point is that if they ignore advice they are receiving from a public health professional they had better be pretty clear that they are doing it on the right basis.

**Q335 Chair:** But basically it amounts to the fact that you would have had to write the Act in a different way to enable that “ensuring” role to be implemented.

**Tim Baxter:** It would not have worked, essentially, because the Secretary of State has the duty, and then in effect giving 152 local authorities almost a similar duty would not have worked. I think my colleague will back me up.

**Q336 Chair:** So it is not quite as localist as we might have thought it was?

**Tim Baxter:** For some things it is right for central Government to be responsible for protecting the population, because there are all sorts of threats. There are lots of things we can do to protect ourselves. Washing your hands frequently is probably the single most important protection against infection, but there are lots of things where it is central Government’s responsibility to ensure that the population’s health is protected. It is right that the Secretary of State has that final responsibility and duty. The role of the local authority, giving them this duty to advise and challenge, is to make sure that the director of public health sitting in a local authority has a clear function in relation to health protection; otherwise, he or she would not have any clear role in health protection. The public health stakeholders whom I have talked to about this for the last two and a half years are very clear that they like the fact that the director of public health will have a responsibility around health improvement, commissioning services and so on, and giving advice to clinical commissioning groups, but also will have a role in health protection.

**Q337 Chair:** But it is about advice and information, so it is slightly more nebulous in terms of responsibility.

**Tim Baxter:** I come back to the fact that if you are advised by a highly trained professional who knows what he or she is talking about that arrangements you have in place to protect the local population are not secure, reasonable and robust, that is a fairly clear and influential bit of advice.

**Baroness Hanham:** It is important that we position the director of public health in the right place in local authorities.

**Chair:** I was going to ask about that, but please go on.

**Baroness Hanham:** The director of public health needs to be answerable to the chief executive, if possible. Some local authorities will not work like that; they will have slightly different arrangements, but the director of public health has got to be at the top of the tree and able to direct or advise on all the other aspects of local government. He is going to take in housing, social services, education, waste and all the rest of it. He has to be in a position where people listen because he is at such a level that they cannot ignore him. We hope and expect that all local authorities will have the director of public health at the second tier under the chief executive, at the very least.

**Q338 Chair:** But if they do not, essentially that is a matter for them, is it?

**Baroness Hanham:** It is a matter for them, but any authority with commonsense will want to make sure that the director is in a position to take the blame, if nothing else, at that level.

**Q339 Chair:** I am very much involved in national parks. I know that the English National Park Authorities Association wrote to the Department of Health as part of the consultation about the guidance to health and wellbeing boards about what issues they should take account of. They asked that in relation to the offer available from national parks, particularly in terms of healthy living, outdoors and that sort of thing, the health and wellbeing boards should be statutorily obliged to take account of that in drawing up their strategies. Is that something the Department has had a look at or has a view on yet?

**Anna Soubry:** I do not know whether they looked at it. It is a great idea, but we always get a bit nervous about putting statutory duties on people when, at the end of the day, we are all about localism and letting health and wellbeing boards determine their own composition and work, based on their own strategic needs assessment of their area.

**Q340 Chair:** Guidance is going to be issued to health and wellbeing boards about what they should look at, so is one of the things they ought at least to consider looking at the role of national parks?

**Anna Soubry:** It sounds like a good idea to me.

**Chair:** If you have not got an answer now, is it possible to give us a note?

**Tim Baxter:** I do not think we can give you a categorical answer to that one way or the other.

**Baroness Hanham:** In reality, if you make it a statutory responsibility by definition it means you have areas of outstanding natural beauty everywhere, and you do not. They are going to be related very much to authorities that border them, or you may be able to take children out to them on a daily basis, but they have to be within reach, so a statutory responsibility might be a bit tricky.

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**Q341 Chair:** I am referring to guidance; that is all. Perhaps you could have a look at that.

**Anna Soubry:** You have raised a very good point in the public arena, and we shall take it away.

**Q342 Bob Blackman:** Moving to the financing of this, the final settlement seems to have increased by about 20%, which is quite a large increase on the original proposal. Why is there such a big increase?

**Tim Baxter:** Last February we published estimates of what the baseline spending on public health would be. At that time we knew that it was not going to be completely right, partly because of late changes.

**Q343 Bob Blackman:** The baseline was 2010–11, was it?

**Tim Baxter:** Yes, but uplifted to allow for inflation. We knew, because of late changes to responsibility for commissioning for abortions and sterilisations, that there would need to be some changes. What the publication of the baseline allowed the people to do was then, in various places in the country, say, “No, that cannot be right”. We had actually done two surveys before then. The first survey we thought, “No, these cannot be right. There are too many implausible zeros.” We did the survey again and it was better, but still we knew that it was not going to be right. What you see with the increase in the baseline is a very constructive process of local authorities working with their PCTs saying, “Let’s get this absolutely right”. We have now reached a point where the baseline has increased to £2.5 billion, roughly, and that is as accurate as it is going to be. On top of that, Ministers made the strategic decision that they wanted to put more money into prevention.

**Q344 Bob Blackman:** Witnesses have suggested that actually there was a reduction before 2010, where money was being switched out of public health into other health programmes. Did you have evidence of that?

**Tim Baxter:** I would say that whatever year you took, somebody could say, “That is the wrong year because we just made a decision that we were going to defer spending”, or something like that. It would have been swings and roundabouts. There might have been some things happening in some areas that made 2010–2011 not a great year. Equally, in other areas, it might have been the reverse. Overall, it was a process that allowed us to get as good a sense as humanly possible of the baseline for public health. As I say, we did promise we would look at representations from local authorities around the baseline, and we did. It is actually very good news.

**Q345 Bob Blackman:** Obviously, the announcements were made on 10 January, 79 or 80 days before local authorities take over responsibility. Local authorities always complain that they do not get enough money, but when they get a huge increase like this, without the expectations, at such short notice, it does cause problems in terms of planning what work they can do. What are the Departments doing to assist local authorities to make sure this money is spent wisely and with good value for money?

**Tim Baxter:** We have been working with local authorities right from the word go on this process. We would have liked the settlement to have been announced before Christmas but because it was a two-year allocation that was not possible. The principle of localism is, of course, that local authorities should make the decisions and we are not going to tell them exactly how to do it. We have published guidance around various things. There is a lot of working going on with the Public Health England transition team and Local Government Association, working with local authorities. So, where people need assistance and help, generally speaking, that is there. What is very pleasing is that the general reaction to the allocation has been very positive from the Local Government Association, from SOLACE, even from the Local Government Chronicle and, indeed, from public health stakeholders.

**Q346 Bob Blackman:** What about making sure that there is proper value for money for the spend?

**Tim Baxter:** That is interesting because I am not aware of any local authority saying, “You have given us far too much money. We cannot possibly spend it.”

**Q347 Bob Blackman:** One of the problems is that if you give people lumps of money at relatively short notice there is a panic view that, “Oh, we must spend this money”, and you do not necessarily get value for money.

**Tim Baxter:** They do not have to spend it all.

**Anna Soubry:** There is a ring-fence.

**Tim Baxter:** It is a ring-fenced budget. They can put it in a public health reserve. It is a good point but they do not have to spend it all in, say, 2013–2014. The fact that we have also got that two-year allocation, and that capacity to carry it over, means that I do not think that the problem that you have identified should be a major issue.

**Q348 Bob Blackman:** At the moment, the money is ring-fenced. It is ring-fenced for the first two years. A lot of the witnesses have said, “Actually, we would much rather want it community-based or place-based, rather than ring-fenced”. What are the Government’s plans for changing the position?

**Tim Baxter:** There are no plans in this spending review. It is an important point that the money can be pooled; that is specifically in the grant conditions. We are very much wanting to learn from the community budgets work that has done a number of pilots looking at health and social care. That is the short answer. Baroness Hanham may want to add to it.

**Baroness Hanham:** Yes, local government does not like ring-fenced grants, as you know very well, but I think it sees the advantage of having it ring-fenced at the moment, until things begin to work out as to how this whole area of public health is going to work. I would expect and hope that in due course it will become un-ring-fenced. As you were saying, with things like community budgets where everything is slightly different because every area you are working in has different priorities in different areas, it will make sense. I am sure that, for the Department for Health money, they will decide where they are going

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to put it. I think actually you pass it to local government to parcel out, because that is part of the grant.

**Q349 James Morris:** You said that, under the arrangement, the grant will be able to be pooled? Could you explain what you mean by that?

**Tim Baxter:** Pooled with other budgets.

**Baroness Hanham:** Yes. It also means pooled across local authorities, because in some areas the director of public health will not be the director for just one local authority; he will be director for maybe two or three. If you taken Kensington, Hammersmith and Fulham, and Westminster, they have got one director of public health for all three local authorities. The money can come in and be pooled to help across the three authorities.

**Q350 James Morris:** I detected some degree more enthusiasm from you, Baroness, than from the Minister with regards to the potential of this being a place-based budget. Does it not make a lot of sense to think about this in terms of place and community budgets? I will give you an example of particular interest to me, which is mental health. Mental health might generally not be defined as an issue that is related to public health but clearly, if we get mental health policy right, that is going to have a very direct impact on public health in terms of early intervention and so on. There are clear linkages for which it would surely be better if they were expressed in terms of the way that the funding is allocated. For example, some of the money that goes into public health could be used—off the top of my head—to improve local community mental health services.

**Baroness Hanham:** The Total Place plans that are happening now have demonstrated that actually budgets that are fluid are really very helpful. They can be used to influence. On your point about whether mental health comes into it, mental health at the moment is not public health; it is health. You would have to be looking at mechanisms such as education to bring that in. Certainly, to have a budget that can be used across a wide spectrum, even within public health, is going to be very valuable.

**Anna Soubry:** Can I just pick up on this? Of course, if you look, say, at smoking, one of the most difficult groups and one of the groups we know smokes more than other groups comprises people with mental health issues. We also know that alcoholism and mental health are extremely linked. It is thinking out of the box. Because, if you are looking at smoking, as a local authority, right down even into a ward level, you might say, "Actually, let us look at people who have mental health issues. We want them to stop smoking because we want them to be better all round." So there could be real work to be done there, which would normally be called mental health or smoking, but actually it is completely interrelated. Local authorities have the freedom to think in a way that frankly we have never thought of, as a Department.

**Q351 James Morris:** Would it not be better if the way the funding worked reflected precisely the point you just made?

**Anna Soubry:** Exactly, because you will have a budget for public health; if you then decide to do some work on smoking with people who have got mental illness, you are already looking at mental illness. You are looking at it in a different way but you will still be achieving the same sort of results, which is to improve the services for people who are mentally ill and reduce smoking.

**Tim Baxter:** There are not any insuperable barriers to people actually sharing money around. With the ring-fenced grant, there are reporting arrangements; they are pretty light-touch. People can share the money across and, as the Minister said, look at using the money in innovative ways. It may be worthwhile to rehearse why the Government ring-fenced public health money. Essentially, they want to protect spending on prevention, because the experience in the NHS was when your local acute hospital was in trouble, the public health funds would be raided, to put it crudely. Also, the Government wanted to be very clear that it was meeting its commitment in real-terms spending on the health budget. The funding mechanisms are obviously very important but the shared objectives about how the money is spent are the most crucial thing.

**Q352 Andy Sawford:** I have some further questions about the funding formula. There has been some criticism of the use of the standardised mortality ratio in the funding formula. David Buck of The King's Fund told the Committee that the standardised mortality rate "tells you a lot about past problems in local authorities, but there is a real question about whether it tells you about the current problems" because behaviour changes. That struck a chord with me because the behaviours of people in their sixties and so on, who fall within the current formula, will be quite different from that of people in their thirties and so on. I wondered how you thought that you could address that concern about the current behaviour being reflected in the funding formula.

**Tim Baxter:** In terms of the funding formula, the Minister has asked the Advisory Committee on Resource Allocation, which has a long history of doing allocations in the NHS, to look at this. The fact is that in the NHS we have very good data on health services utilisation, so we know that someone in their eighties will use something like 20 times as much health service money, on average, than someone in their twenties. We do not have that for public health. When we consulted a couple of years ago on what the best basis for the allocation was, the general response was that an outcome-based measure, like the standardised mortality rate for the under-75s, was probably the sensible way to go, simply because better data was not available. The SMR for under-75s correlates very well with deprivation. Also, you get the data down effectively to ward level, to middle super-output level. You can then get very granular about identifying the most deprived parts of the population and directing more resource to them.

**Q353 Andy Sawford:** Westminster Council, for example, have recommended to us that we use the deprivation index. Why not do that?

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**Tim Baxter:** The short answer is that ACRA looked at it and felt the best data source to use was SMR. This is not to say that this is a long-term solution. They were very clear that—

**Q354 Andy Sawford:** They were not clear, actually, were they? What they told us was that health outcomes should not be the main driver because a local authority that improves its health outcomes would be risking losing future public health funding. There is a perverse incentive.

**Tim Baxter:** Yes, there is. ACRA know that and they want to do further work to try and get to a better—

**Q355 Andy Sawford:** Will you review it?

**Tim Baxter:** Yes, absolutely.

**Q356 Andy Sawford:** What is the timetable for a review of the formula?

**Tim Baxter:** They will be starting to look at it over the coming months. I could not tell you, sitting here today, when there will be a new formula. What I can say is that they are aware of the weaknesses, but it was a pragmatic decision that this was the best data that they have got, that correlates with deprivation and that gives data down to a very small area. They recognise the issue about the perverse incentive that, if you do really well, your money might get cut, and that you need a base level of investment to keep the outcomes for the population at the same level or improving.

**Andy Sawford:** I think the Minister was going to come in.

**Anna Soubry:** No, I was not. I was nodding in agreement.

**Q357 Andy Sawford:** There was one additional point that has been raised to the Committee. We had Cllr Nick Forbes from Newcastle, and we heard from other local authorities, such as Westminster, that, particularly on sexual health services, the services that they provide cater for a much wider population. What they have asked is whether there could be a way of recognising non-resident service users in the formula.

**Tim Baxter:** ACRA looked at that, and they found that the only local authority in the country where non-resident users of population was significant was the City of London, for obvious reasons, and they did not want to make an adjustment for that, because, in effect, you then lock in the existing provision levels. If a particular local authority is providing lots of sexual health services, it gets more money to do that, but then the authorities whose population is being treated in that place do not have an incentive to build up services themselves. ACRA decided that it would be better to try to give local authorities evidence, as far as possible, on patient flows—we have some good evidence on that—and then they should look into recharging arrangements, which in London they are doing.

**Q358 Andy Sawford:** So you would look at recharging. The evidence that we have is that it is not just the City of London but other local authorities.

**Anna Soubry:** Certainly, if they are pooling, as I think Westminster is, into a bigger group, that could help to overcome their problem with people using services outwith their borough area.

**Tim Baxter:** Sexual health services is an area that ACRA is going to have to continue to look carefully at.

**Anna Soubry:** You will find also that Nottingham's director of public health is also now the director of public health for Nottingham. I could completely concede that there will be people who would use city-based services, who live in the shire because of the ways our boundaries are drawn in Nottinghamshire. There may be other examples in the country, so we are not blind to it at all.

**Q359 Andy Sawford:** Just on that, would the Director of Public Health have the flexibility to use the funding across those two local authority areas as they felt appropriate in terms of need? I would have thought that the local authorities themselves would resist that, particularly if they were a net loser.

**Tim Baxter:** They would need to look at, as they do in London, the flows of patients, and try to come up with a sensible agreement about recharging.

**Q360 John Stevenson:** Minister, you quite rightly said at the beginning that the move of public health from the NHS to local government has been widely welcomed. At the centre of public health is going to be the health and wellbeing board. Like any organisation, where there are other organisations around, there will inevitably be some tensions. The danger for the health and wellbeing boards is that they become preoccupied with the commissioning services, rather than concentrating on their own issues of public health. How do you ensure that this does not happen?

**Anna Soubry:** I think through the way we have described the role of the director of public health. I have to say, with the varying compositions of the health and wellbeing boards across the country, one of the things that is coming out is the influence of CCGs and other medical professionals. They get public health. When you speak to a lot of GPs and other doctors, there is wide agreement that prevention is invariably better than cure, and the opportunity to do more preventative work at a local level is welcomed. Many of them are seeing the potential and the possibilities of doing that work. The structures are all there, as we have described, and I think the will is there as well.

**Q361 John Stevenson:** Some health and wellbeing boards have expressed concern about the lack of ability to influence NHS commissioning boards locally. How would you respond to their concerns?

**Tim Baxter:** In the Health and Social Care Act, clinical commissioning groups have to consult the health and wellbeing boards on their commissioning plans, or if they are revising them. They also have to publish the opinion of the health and wellbeing board, when they publish the commissioning plan. There is also recourse to the commissioning board if they feel that their opinions have not been taken account of.

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There is not a veto, which I know that some people wanted, but there is strong influence.

**Q362 John Stevenson:** Do you think that is strong enough influence?

**Tim Baxter:** Of course.

**Q363 John Stevenson:** Turning to the Baroness, the present Government is a very strong supporter of localism and local government. We want to see strong local leadership but also accountability. On the CCGs, there is now going to be a restriction that local councillors cannot be on those boards. Why is that a good thing?

**Baroness Hanham:** I do not know, because I am afraid that I did not realise that they could not be on the boards. They are certainly going to be on the health and wellbeing boards, and are entitled to be on those. With the commissioning, I am going to have to pass on this because I did not know that they could not be on the boards.

**Anna Soubry:** It was to remove the political influence in what should be clinical decisions.

**Q364 John Stevenson:** Do you not think you are taking away local political, elected-by-the-people, involvement?

**Anna Soubry:** No, because of the health and wellbeing boards. They will be the overseers, the checks and the democratic process. I do not have any problem at all with the fact that local councillors should not be able to sit on CCGs.

**Q365 John Stevenson:** So you are completely happy with that?

**Anna Soubry:** Absolutely. To have party politics or just politics involved in CCGs would be a bad idea. The checks and balances are there in the health and wellbeing boards and the national NHS commissioning board. You have all the other organisations and all those other structures to make sure that the CCGs are doing what they should be doing, but the accountability is through the health and wellbeing boards. Of course, there are still the overview and scrutiny committees; they will continue to play a very important role.

**Q366 Chair:** But John's point is right, surely? It is about accountability. You only have true accountability if you are elected by people to exercise it. The checks and balances within the system are the health and wellbeing boards within the remit of the local authority and the scrutiny committees of the local authority, but what happens if the clinical commissioning groups just decide to ignore them?

**Anna Soubry:** They cannot just decide to ignore.

**Q367 Chair:** They can, can they not? What happens if they do?

**Tim Baxter:** The commissioning board can take action on that.

**Q368 Chair:** The commissioning board can take action by doing what?

**Tim Baxter:** We ought to give you a note on that. Rather than misremembering something, I would like to give you a detailed note.

**Q369 Chair:** It would be helpful to know what they can do and how their doing it would be triggered.

**Tim Baxter:** Effectively the commissioning board looks at the performance of clinical commissioning groups, and they can earn extra money through effective performance. If they are ignoring the views of their health and wellbeing board, they are certainly not going to get that.

**Q370 Chair:** It would be helpful to know what they are going to do and in what way it is going to be triggered.

**Tim Baxter:** We will give you a detailed note on that, absolutely.

**Q371 John Stevenson:** You are potentially taking it away from local government.

**Anna Soubry:** Do you mean commissioning?

**John Stevenson:** No, their inability to be on that board. The only sanction that you are appearing to suggest is through the commissioning board. It is not through the local elected officials.

**Anna Soubry:** The CCGs are deciding how to deliver the health service to people, and one of the whole thrusts of the Act was to take out the politics that is in too much of the health service. Instead of having decisions being based on sound clinical judgement, it was often being based on political opportunism.

**Q372 John Stevenson:** You are also putting a large chunk of health back into local government.

**Anna Soubry:** That is public health. CCGs are commissioning services. While I accept that some of the role of local authorities will be to commission some services, it is not on the scale and not on the nature of CCGs. It is just a really bad idea to have councillors involved in those sorts of decisions, because I believe those decisions should be taken by health professions and the clinicians.

**Q373 John Stevenson:** I am surprised that you do not have, at least, some form of local representation.

**Anna Soubry:** But why would you need a councillor to tell a doctor which particular pathway or service they should buy for their people? I take the view that the clinicians are the people to make those decisions, not councillors.

**Tim Baxter:** The joint strategic needs assessment and the joint health and wellbeing strategy will be delivered through the health and wellbeing board. That has a minimum of one councillor, but generally there are more elected members, so there is a mechanism for proper democratic accountability.

**Q374 Chair:** Is there is a role for councillors in preventing ill health but not for curing it?

**Baroness Hanham:** I think that is probably correct, actually.

**Anna Soubry:** I think that is right. I absolutely do agree with you on that. You are talking about deciding, for example, where you are going to get

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your physiotherapy from. I am sorry, but I think the people who are more able to decide whether to get it from this provider or that provider, who know the quality of service, the value for the money and all the other things, are clinicians, frankly, not politicians.

**Tim Baxter:** The detailed commissioning work will be led by the director of public health, who will be a specialist public health person in line with the JSNA and the joint health and wellbeing strategy, but I do not think he or she will be particularly expecting elected members to take very close interest in the very detailed commissioning arrangements but more about being accountable for how you are actually going to have an impact on the population.

**Anna Soubry:** An example would be that some people might say that you should not be commissioning services for people with HIV because they have a particular view about HIV sufferers. The politics then become terribly involved and muddled in decisions that should be clinical and not political.

**Q375 Chair:** That approach does not show the highest regard for local councillors, but never mind. Looking at services for the elderly, local authorities are commissioning those. Are you saying that they should be involved in that but once that elderly person becomes ill and is in hospital, the local authority does not have a role anymore?

**Baroness Hanham:** I do not think that the CCGs will be commissioning anything other than the hospital services, the x-rays, and the physiotherapy. The CCGs will do that. Local authorities instead are commissioning elderly care in homes—their own services' community support. They are different. Having said that I had not appreciated that local people were not on the CCG, I do think it is right that they should not be. This is because they are commissioning how many beds and how many services they are going to need in the in the hospital, spending on drugs and things—that is all clinical.

**Q376 John Stevenson:** A councillor can end up on the board of the hospital.

**Anna Soubry:** They do not make clinical decisions as a member of the board.

**Baroness Hanham:** That is correct. They do not.

**Anna Soubry:** They do not decide which procedures will be used within the hospital.

**Q377 John Stevenson:** I accept that, but they are still involved in the decision-making of the hospital.

**Anna Soubry:** Yes, but not clinical decisions. Forgive me, but I do think there is quite a difference.

**Q378 Chair:** For some of the services around sexual health—which are now part of the public health remit and come under the health and wellbeing boards—there are surely clinical decisions there. You do not expect an individual councillor to be involved in prescribing for a particular patient but the overall service delivery is a public accountability, is it not, which you are denying in other aspects of the health service?

**Anna Soubry:** Public accountability is through the health and wellbeing boards. Clinical decisions on

what treatments to provide should be made by the health professionals.

**Q379 Simon Danczuk:** Ministers, you can talk as much as you like about the dangers of not washing your hands, eating too many kebabs, drinking too many glasses of Chardonnay perhaps, or sitting too long on the couch.

**Chair:** Who are you looking at?

**Simon Danczuk:** I am not looking at anyone in particular. But is it not the case that recent research suggests that the best way of improving life expectancy is getting people back into work? What are your Departments doing to help local authorities develop employment schemes?

**Baroness Hanham:** The DCLG is doing this all the time. We are part of the thrust. We all know that one of the biggest things that we need to do is to get employment up and to ensure that people do have jobs because that is one of the things that gives them the best route in life. That is not just local government; it has got to be across the piece. We are dealing with the DWP and the job sector. The whole question of employment is a wider government issue. I accept what you say: that a person's lifestyle might lead them to not be very employable. Again, that is about education, social services and what the benefits are. It goes much wider than just public health.

**Q380 Simon Danczuk:** To summarise the question, the best way of increasing life expectancy—according to this quite extensive piece of research that has been done—is to get people into employment and increase their wage levels. That is the best way of doing it. Even from a public health perspective, why not devolve more responsibility and power to local authorities to improve and increase employment in their locality instead of doing it from up on high, through Work programmes?

**Baroness Hanham:** I think they already have. They already take that responsibility.

**Q381 Simon Danczuk:** Do they?

**Baroness Hanham:** Local authorities are supporting apprenticeship schemes and looking after people who are not well, and encouraging them back. There is a role for local authorities but I do not think that there is a determined responsibility that they should be the only people involved in getting people back into employment.

**Anna Soubry:** I have to say that I am very surprised that the best way to improve our mortality rates is to get people into work. My understanding is that the best way to make sure that people live longer, happier and healthier lives is if we reduce our smoking levels, cut back on the alcohol and improve our diets.

**Q382 Simon Danczuk:** I am referring to a study that was published in the British Medical Journal: "Decreases in unemployment and increases in average income in an area explained, to a large extent, why some local authorities 'performed' better than others", in terms of life expectancy.

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**Anna Soubry:** I am not decrying that it is important for people to work, but I think some of those so-called lifestyle choices are the bigger determinants.

**Q383 Simon Danczuk:** Looking forward 10 years, how will you measure whether the changes that you introduced on 1 April this year have been a success? How will you know?

**Baroness Hanham:** From the local government point of view, it is going to be from the director of public health. It is going to be the Director's responsibility to check the figures, get the figures and know now what his limitations are and then, within 10 years, you ought to be able, on a data basis, to work out whether or not things are improving. It is just a matter of benchmarking where you are and then looking forward.

**Q384 Simon Danczuk:** How will you know, Baroness? Never mind the individual directors of public health; how will you measure your success in terms of introducing this?

**Baroness Hanham:** The Department will measure success on the basis of the figures that will be presented, and will show and demonstrate whether this has actually been effective or not in terms of all of the things that we have been talking about today: the campaigns, the education and the director of public health's role within the community. That should be easily demonstrated.

**Anna Soubry:** I agree. I would only add this. The test to me will be whether it is on the leaflets of people campaigning in the equivalent of the May elections, when councillors can proudly say what they have achieved on behalf of the people whom they want to serve or do serve, and their opponents will say, "These outcomes are not good enough and we will make them an awful lot better. Here is a similar authority under a particular political leadership and that is what they are achieving." When that happens, we will know that it

has actually begun to work, in addition to everything the Baroness was saying.

**Q385 Simon Danczuk:** Tim, have you got any more systematic ways of measuring it, rather than just political leaflets?

**Tim Baxter:** The public health outcomes framework, which has an overall vision of improving and protecting the nation's health and wellbeing, and improving the health of the poorest fastest. That has two outcomes around increasing life expectancy and reducing the differences in healthy life expectancy and life expectancy between communities. It is focused on whether we can see people living longer and better, and there being lower health inequalities. That would be two ways of approaching it.

The framework has 66 indicators, which are very wide-ranging. It includes things like reoffending rates, school readiness, smoking prevalence, vaccination rates, and premature mortality. The Secretary of State for Health has made it clear that he sees that the UK—or England, which is of particular interest to him—in relation to other countries, in terms of preventable mortality, is relatively poor. In 10 years' time, we would want to see that position having changed quite significantly.

The point that the Minister has made about leaflets is important. Duncan Selbie has this mantra that in a number of years—I forget the exact number—it will seem unimaginable that we would do anything differently. So in 10 years' time, we will think, "Great, local authorities do public health. They lead on public health. They do all sorts of things and they do not do it in the way that the NHS used to do them. They do it in different ways, imaginative ways and they get better outcomes." That is what we want to see in 10 years.

**Chair:** Thank you very much, Mr Baxter and Ministers, for coming along this afternoon.



# Written evidence

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## Written submission from the King's Fund

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

### INTRODUCTION

1. The Health and Social Care Act (2012) fundamentally alters the relationship between local government and the NHS. Responsibility for considerable public health and health improvement functions will be transferred from the NHS to local government, giving local authorities new responsibilities in relation to specific health functions. Local authorities will be required to appoint Directors of Public Health, in partnership with the Secretary of State. Health and wellbeing boards have been created in upper tier and unitary authorities to improve integrated working across local health, social and wellbeing services, using tools such as joint strategic needs assessment, pooled budgets and joint commissioning to improve co-ordination of service planning and delivery. The health and wellbeing boards will also have new responsibilities to develop a local health and wellbeing strategy.

2. We are fundamentally optimistic about these changes, and have followed the development of health and wellbeing boards and the transfer of public health functions with interest. The research we have completed in these areas provides the basis for this evidence submission.

### HEALTH AND WELLBEING BOARDS

*The intended role of health and wellbeing boards in co-ordinating the NHS, social care and public health at the local level*

3. Our report into the development of health and wellbeing boards (Humphries *et al* 2012) highlighted the following:

- (a) The creation of health and wellbeing boards is one aspect of the NHS reforms that enjoys overwhelming support. The boards offer new and exciting opportunities to join up local services, create new partnerships with GPs, and deliver greater democratic accountability.
- (b) Boards need to be clear about what they want to achieve. We found potential tensions between their role in overseeing commissioning and in promoting integration across public health, local government, the local NHS and the third sector.
- (c) Despite the rhetoric of localism, many shadow boards are concerned that national policy imperatives will over-ride locally agreed priorities and are uncertain about the extent to which they can influence decisions of the NHS Commissioning Board. Roles and responsibilities of all new bodies need to be defined much more clearly.
- (d) Although some shadow boards are taking an imaginative approach to engaging with stakeholders, the exclusion of providers could undermine integrated working. Local authorities should look afresh at ways of working with local partners rather than re-badging previous partnership arrangements.
- (e) Our view is that the creation of health and wellbeing boards will not automatically remove many of the barriers to effective joined-up care. For boards to succeed, a stronger national framework for integrated care is needed with a single outcomes framework to promote joint accountability.
- (f) The discretion given to local authorities in setting up boards means that different approaches will emerge, and some will be more effective than others. Capturing and sharing lessons learned from shadow boards will be vital to avoid simply adding a further layer of unacceptable variation to the system.
- (g) Our findings suggest that the biggest challenge facing the new boards is whether they can deliver strong, credible and shared leadership across local organisational boundaries. Unprecedented financial pressures, rising demand, and complex organisational change will severely test their political leadership. Board members need time and resources to develop their skills and relationships with other stakeholders.

4. *Health and wellbeing boards have great potential to bring together local agencies to work in integrated ways. However, it is important to remember that these partnerships are new, and they will need time to develop into successful strategic bodies. An assessment will also be needed on whether boards have the levers they need to fulfil their principal roles effectively.*

*Barriers to integration, including issues in multi-tier areas*

5. Legal powers for joint commissioning and pooled budgets have existed for some time but few local authorities have used them. There are many examples of poorly executed commissioning in health and social care, and the current skills gap in commissioning remains a challenge for many local areas as the reforms begin to be implemented (The King's Fund 2011a). Different commissioning cycles also exist for local authorities and the NHS—they will need to be reconciled where possible, to enable health and wellbeing boards to drive joint commissioning forward.

6. The use of pooled budgets is another means of aligning resources, but currently these represent less than 5% of total NHS and social care expenditure (Audit Commission 2009a). However, adult social care commissioning actually contributes around 25% of its budget towards these joint arrangements, whereas the NHS invests a lot less. The imbalance in investment between social care and health in joint commissioning presents a bigger challenge than the overall total investment is small.

7. There are lessons for health and wellbeing boards from the history of local partnership arrangements. Joint consultative committees and joint care planning teams, and, more recently, local strategic partnerships have achieved mixed results in delivering jointly planned services. A recent review of the experience of local strategic partnerships also offers some relevant insights for health and wellbeing boards, namely that:

- (a) important lessons can be learned from other local strategic partnerships despite their unique features;
- (b) they must seek to influence partners' mainstream spending and activity despite not having control of the resources;
- (c) there is a need to develop strong cultures to achieve shared goals; and
- (d) in multi-tier areas, there are greater challenges for these partnerships arrangements than for those in single tiers; despite the fact that they are voluntary, unincorporated associations, they must recognise their strategic, executive and operational roles (Audit Commission 2009b).

8. Scotland's community health partnerships, which were established to integrate health and social care services and to shift provision from acute care into the community, have also recently been hindered by persistent siloed management of resources, staff and information (Audit Scotland 2011).

9. More broadly, our joint report with the Nuffield Trust published in January this year outlined a number of priorities for action and barriers to developing integrated care at a national level (Goodwin et al 2012). Little progress has been made in addressing these and there is a risk that momentum is lost during the transition as the government's reforms are implemented and that integrated care is not given sufficient priority. The Social Care White Paper outlined a number of proposals that will form the basis of an integrated care delivery plan due to be published by the Department in the coming months. This provides an opportunity to generate momentum—it should be the catalyst in moving integrated care from a subject for policy debate to making it happen at scale and pace across the country.

10. *Health and wellbeing boards will need to explore a range of ways to develop a more integrated approach to commissioning and the use of resources across organisational boundaries. The Committee should consider whether boards will have all of the levers and support they need to pursue integration effectively, in light of the evidence from previous arrangements about challenges in integrating resources across organisations.*

## PUBLIC HEALTH

*The introduction of a public health role for councils*

11. The transfer of greater responsibility for public health to local authorities provides an opportunity to improve the co-ordination of public health with other local services. The closer proximity of health improvement teams to other local authority teams and effective relationships between them will be key to delivering good public health outcomes in addressing the wider determinants of health (The King's Fund 2011b).

12. However, it is important to realise that the NHS will continue to play a huge role in public health (only around £2 billion of roughly £5 billion funding for public health will be in the hands of local authorities, the rest will lie with the NHS through the NHS Commissioning Board and Public Health England). It is of paramount importance that existing and future services that rely on collaboration between local authorities and the NHS (such as sexual health services) are not fragmented by the move to local government.

13. The move must also not isolate the skills and expertise that a large number of public health specialists have in clinical care and clinical service design. The support and intelligence that public health teams can offer to both clinical commissioning groups and local authorities will need to be carefully managed and resourced if it is to deliver the intended benefits. The right balance needs to be struck between ensuring that clinical commissioning groups don't over-rely on public health teams to deal with public health issues and health inequalities, and making sure that clinical commissioning groups don't break away from local public health teams and duplicate their own public health functions internally, or fail to collaborate with their local authority partners.

14. *While it is important that clinical commissioning groups benefit from the expertise of public health teams in local authorities, they should not become dependent on them. Clinical commissioning groups should be discouraged from seeing public health simply as a bought-in service, rather than as a core part of their own population responsibilities. Monitoring the development of these local relationships will be important, to ensure that those responsible for public health and the NHS collaborate and share responsibilities proportionately.*

*The financial arrangements underpinning local authorities' responsibilities*

15. Ring-fencing the public health budget should be a decision taken after the system has been designed, not taken beforehand as it seems to have been done. Ring-fencing is most appropriate in a system that requires for specific services to be delivered; a system more focussed on outcomes, strong accountability and innovation is more suited to non-ring-fencing. The rhetoric around public health reform, and certainly the role of local authorities has been focused on the latter. Over time, the ring-fencing debate will need to be revisited.

16. The Department has not to our knowledge made any estimate of how much in total *should* be spent on public health. However, it has prescribed some mandatory functions to the sector. Arguably, there should be a bottom up assessment of how much a specified service should cost and it should then be resourced accordingly. There is no guarantee that the existing overall pot of £2 billion is adequate to deliver the specific services required and broader responsibilities designated to public health.

17. The Department has however decided to allocate funds through a “needs formula” based on each area’s standardised mortality rate in the under 75s. In the long term, such an approach is reasonable in terms of fairness based on the *national* distribution of need—although there will inevitably lots of debate about the specific measure chosen, and how different levels of standardised mortality rates relate to different levels of funding.

18. However, in the short term, the critical decision is how fast to move towards the new arrangements. Funds are not currently allocated according to where the formula suggests they should be, because PCTs have previously made their own decisions about resourcing public health via larger NHS budgets. Moving to the formula quickly could lead to areas that have invested in public health in the past receiving less than they have had previously, and those who have under-invested receiving windfall gains, which would clearly be unfair. On the other hand, not moving to the formula quickly is also unfair from a different perspective, ie, the distribution of needs in the overall population. Getting this balance right will not be easy, particularly given there is no increase expected in overall public health budgets.

19. Finally, the evidence of securing better outcomes and value for money from the Total Place initiative was relatively underdeveloped, but did show promising improvements for local populations (Humphries and Gregory 2010). The continued focus on place-based service planning and delivery through the community budgets pilots offers a real opportunity to use money more flexibly across services to improve outcomes for patients and populations.

20. *The government needs to be much clearer on how much funding is required for public health in total. At the moment, there is no sign it has undertaken such an assessment. Without this, even if it manages to design a perfect allocation formula for distributing that total to local authorities, there is no guarantee they will be able to deliver the appropriate services to fulfil their responsibilities.*

21. *Public health should be a central partner in driving forward place-based initiatives, as it should help focus attention across local services on health prevention and health inequalities. However, there will be significant challenges facing areas as they develop these approaches, not least because it will require significant cultural change in ways of working to break down current organisational boundaries.*

*How the impact of the new arrangements can be measured*

22. We welcomed the development of the public health outcomes framework. This has bought much needed clarity on the outcomes that the public health system is expected to deliver. However, there is much less clarity on where the accountability for meeting these public health outcomes lies in the new system. Whilst there are plans for sector-led improvement, accountability for poor performance—for instance on high level outcomes such as life expectancy—remains worryingly weak, and constitutes one of the greatest risks to the success of the reforms.

23. In addition, a lot of emphasis is being placed on the power of the incentive payment for good outcomes (to be introduced in 2015–16), which will reward for progress against specific public health indicators to drive success. However, there appears to be very little consideration of what system will be in place to penalise poor performance and/or failure in the delivery of these indicators.

24. *Public Health England will need to be transparent about the consequences of poor performance against public health indicators.*

25. The Department has also recently consulted on the arrangements for local authority scrutiny in improving the process of reconfigurations of local health services. The Department has taken on board the recommendations from our briefing on reconfiguring hospital services (Imison 2011), to ensure local authorities

take account of financial issues when considering reconfiguration plans, and for the timescales for local decision-making to be regulated.

26. The consultation also proposed that the full council of the local authority had to approve referrals to the Secretary of State. However, the use of a separate local health scrutiny function within local authorities allows for necessary impartiality in the decision-making process. Forcing collective decision-making between the full council and the scrutiny committee is unlikely to be helpful—if anything it is likely to disempower both groups.

27. Further, the proposal for the NHS Commissioning Board to act as an intermediary body for referrals about some service reconfigurations before they reach the Secretary of State poses conflicts of interest that we think should be avoided. The Board will have more than likely approved reconfiguration plans with clinical commissioning groups before these plans are escalated. It is therefore unlikely that they will be able to remain impartial in their decision to refer plans to the Secretary of State.

28. There is an alternative role the clinical senates and clinical networks, as hosted by the NHS Commissioning Board, could fulfil that could add significant value to the overview and scrutiny process. Local authorities need technical skills, support and capacity in order to perform their overview and scrutiny functions well, rather than simply as an exercise in the process (The Kings Fund 2012).

*29. To improve on what is currently in place, a system of peer arrangements should be established and overseen by the clinical networks and senates, in which the overview and scrutiny committee of a local authority in one area dealing with a particular issue provides advice and support to another. This would mirror the arrangements for services such as cancer, where peer networks have made notable gains in improving the quality of cancer services. The proposal to refer reconfiguration plans for approval from the full council should also be dropped, to avoid disempowering both groups.*

*How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

30. The existence of the public health outcomes framework will help local authorities take a strategic look across their responsibilities. However, our recent report on multiple behaviours (Buck and Frosini 2012) suggested that the government has to date primarily tackled unhealthy behaviours in silos (ie, producing separate strategies for obesity, smoking and alcohol that do not link to each other or to policies on health inequalities). We believe this is necessary but not sufficient in light of the findings in our report that unhealthy health behaviours co-occur and cluster in population groups, particularly in the most disadvantaged populations.

31. Whilst there have been real improvements in public health in recent times, this has not been shared equally in the population, and inequalities in health behaviours have therefore widened. For example, we found that in 2003 people with the lowest levels of formal education were three times more likely to not adhere to government guidelines on all four chief unhealthy behaviours (smoking, alcohol, diet and physical activity); by 2008 they were five times more likely to not adhere to the guidelines.

*32. Behaviour change policy and practice need to be approached in a more integrated and focused manner with a core objective on reducing inequality that is based on individuals' experience of joint unhealthy behaviours, not simply on separate campaigns on each behaviour. Local authorities, with their greater knowledge of local communities—and their greater control over some of the economic and social conditions that shape behaviours—should be in a better position to do this than the NHS. This will be a key test for them as they take on their responsibilities.*

October 2012

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### **Written submission from the Chartered Institute of Environmental Health (CIEH)**

#### **1. EXECUTIVE SUMMARY**

1.1 The period of transition from existing public health arrangements to new ones which are not yet completely clear, is fraught with danger, especially in respect of the uncertainty of the arrangements for health protection.

1.2 It is right for local authorities to be responsible for leading the local delivery of England's new public health service. They have the democratic legitimacy and accountability and they are capable of the necessary strong leadership.

1.3 Environmental health practitioners, who are working in all sectors and in all communities, are well placed to help make key contributions to the successful implementation of the new public health arrangements.

1.4 In those parts of England with multi-tier arrangements for local government, it is essential that the efforts of all the councils are engaged in improving the health and wellbeing of their communities.

1.5 The proposed ring-fenced funding for local authorities for their new public health responsibilities is insufficient for the purpose and at risk of being unfairly distributed.

#### **2. RECOMMENDATIONS**

2.1 It is essential that four things should happen quickly:

2.1.1 Local authorities must be assured that the funding being transferred from the NHS for commissioning additional public health services will be adequate to meet local need and that the move to the fair share allocation will be through an agreed and fair process.

2.1.2 Public Health England must establish and publish its "standard offer" which must match, at the least, the current level of support provided to local authorities by the HPA and its health protection units.

2.1.3 A mechanism such as a Service Level Agreement should be developed and put in place to ensure that Directors of Public Health have a binding commitment from NHS organisations to respond when called on for technical support and planning and emergency capacity.

2.1.4 All local authorities should consider the nature of the current services they provide in the context of public health gain and how resources for the new public health service, deployed alongside existing services, will be allocated and managed.

2.2 In the absence of the above immediate actions, local authorities will not be able to plan for effective arrangements to keep the public safe from health threats, which by their nature are unpredictable and may be "unknowns".

#### **3. *Health protection arrangements in England are crumbling, just when they need to be strong***

3.1 The transition from well-established, effective safeguarding arrangements to something still unclear and denuded of resources is filled with risk. We only need to recall last year's E.coli outbreak in Germany and this year's Legionnaire's Disease outbreak in Edinburgh, and more recently Staffordshire, to appreciate that the stakes are high.

3.2 The success of the current arrangements is built on a strong three-way partnership between:

- Local authorities.
- Health Protection Agency.
- NHS organisations led by Directors of Public Health and their teams.

3.3 Directors of Public Health and their teams are moving to local authorities. It is unclear if they will be able to lead or engage the same NHS response, as previously available to them, when they are no longer employed **within** the NHS.

3.4 The Health Protection Agency (HPA) is being abolished, although its staff and other assets will form part of the new executive agency which will comprise Public Health England. The Department of Health has stated that the HPA's premises (its four remaining laboratories and twenty five health protection units included) will be retained by Public Health England, although the latter's organisational design sets out plans for four regional offices and 15 centres.

3.5 In addition, the HPA is managing substantial budget reductions and there is no clarity yet about the "offer" that Public Health England will make to local authorities.

3.6 Local authorities are therefore in the position of "last man standing" in the provision of an effective health protection service. It can be anticipated that with environmental health teams at its core, and reinforced by the arrival of Directors of Public Health and their teams, the service will hold. However, local authorities are also managing major budget reductions causing them to shed staff including those providing this service.

3.7 In addition, the CIEH doubts that the total pot of money, out of which the new ring-fenced grant will be paid to local authorities, will be adequate to maintain the service. This we believe will be a significant cause of tension between (1) the bedding down of the new arrangements and (2) the consideration of wider public health improvement strategies. Of course local authorities should be preparing to incorporate existing and new commissioned services into their forward planning.

#### *4. The CIEH consistently supports the Government's proposal for local authorities to lead England's new public health service locally*

4.1 The CIEH is convinced by the variety of evidence available that health inequalities are long-standing, are determined by a "social gradient" of health and can only be tackled effectively by addressing all the causes, including the social causes, in a holistic and co-ordinated way as well as the proportionate universalism advocated in the Marmot Review. This is in accordance with the Government's own views expressed in the documents supporting the new arrangements for the organisation of public health management and delivery.

4.2 Similarly, it is right that local authorities should lead this new approach locally because of their democratic legitimacy, their public accountability and their knowledge of local conditions. These attributes make local authorities ideal leaders of a more determined population-wide effort to improve health and wellbeing and reduce health inequalities. Councillors will readily grasp the social injustice of differences in life expectancy and lives lived free of disability determined by wealth and where people live.

4.3 Environmental health services in local authorities today perform a wide range of public health-related activities which include: air pollution control; emergency preparedness, resilience and response; food safety and promotion of healthy eating; supporting health improvement programmes such as smokefree environments, sensible drinking and increasing physical activity; health protection; housing conditions (in the private rented sector in particular); occupational safety and health; pest control; waste management and water safety. They often also lead on activities to address issues of climate change (adaptation and mitigation) and sustainability.

4.4 More important than the individual services provided by environmental health teams in local authorities, is their ability to make things happen. They have exactly the right skills needed to achieve the stated aims of the new public health service: seeing the holistic solutions to population-wide problems; putting together appropriate partnerships and working collaboratively with them; engaging with relevant communities (including communities of SMEs); managing service delivery and monitoring and evaluating outcomes.

4.5 Despite the Department of Health's stated commitment to the recommendations contained in the Marmot Report (2010), the Government does not appear to appreciate the scale of what is achievable by local authorities, their communities and their partner organisations in tackling the "causes of the causes" of ill-health, both the mental and physical aspects.

4.6 What the local authority lead makes possible is the industrial-scale application of "prevention" being better than "cure". This requires a multi disciplinary approach, with health and well being boards taking account of not just the topical headline issues but integrating the existing health and environmental protection functions into cohesive programmes which will require longer term leads-in and planning with budget certainty over a period of time to enable the results of such programmes to be evaluated.

4.7 There is therefore an opportunity to create the synergy between new and existing programmes of work under a meaningful public health banner. Health and wellbeing boards must be forceful in establishing that the joint health and wellbeing strategies will determine the future of all relevant local services. This means local authorities, CCGs and the wider NHS integrating their own services, shaping the services provided by others

and securing widespread public involvement in order to achieve the necessary higher gains with reduced resources.

#### 5. *Environmental health practitioners have a proven track record in directing population-based interventions*

5.1 Environmental health practitioners (EHPs) have been involved in the design and delivery of interventions that address the wider determinants of health for centuries. They have done this by working holistically in partnership with others which is one of their strengths.

5.2 A modern-day example of this ability is their contribution to both developing the arrangements and securing compliance with the requirements for smokefree workplaces and enclosed public places. This measure has been described by a previous Chief Medical Officer as representing a “footprint in the history of public health” and is now being followed by other countries around the world. EHPs worked in partnership with many others to achieve not just the acceptance of this public health policy but also the incredibly successful implementation of these measures with virtually complete compliance in a very short space of time.

5.3 A current example of EHPs leading a large multi-agency public health programme is Liverpool’s *Healthy Homes* initiative. Liverpool’s award-winning programme is a very effective environmental health-led approach to improving health and wellbeing and reducing health inequalities in parts of the City of Liverpool where residents experience a range of disadvantages, including in relation to their housing conditions. Major activities of the programme include:

- Access to medical practitioners (GPs and dentists).
- Benefit maximisation and employment access advice.
- Energy efficiency measures.
- Housing condition improvements.
- Specialist Advocates using a bespoke Single Assessment Process.

5.3 It is this central role within local authorities that led a former Chief Medical Officer in 2001 to describe EHPs as the only local government professional considered to be a full-time public health practitioner, evidenced in his description of the environmental health practitioner as: “*Professionals who spend a major part, or all of their time, in public health practice*”. It is a role that has not changed; indeed it has been enhanced by focussing on increased joined-up working between and within local authorities.

5.4 Hence in England’s local authorities EHPs provide a unique capacity to co-ordinate this “upstream” public health activity in every community. It is an ability demonstrated by the joint Memorandum of Understanding between the CIEH and the Health Protection Agency in respect of health protection arrangements for responding to incidents and outbreaks of communicable disease and harmful pollution.

5.5 EHPs are not only active in local authorities, they also work in many business settings where they bring the same science-based, problem-solving knowledge and skills to bear. This is particularly relevant for the key aspect of the Government’s approach to improving the nation’s health, namely the emphasis on behaviour change and acceptance that public health is everyone’s responsibility.

5.6 Nationally, the Government is pursuing this aspect in part through its engagement with businesses in the Public Health Responsibility Deal. There is every reason for the new Health and Wellbeing Boards to pursue a similar strategy with businesses locally, for example in workplace wellbeing, healthier food products and warmer, safer homes.

5.7 EHPs working for those businesses can contribute to the development, implementation, monitoring and evaluation of responsibility deal-type pledges. They already work in the key areas of occupational health and safety, food hygiene and nutrition and housing conditions in the private rented sector.

5.8 EHPs in the private and public sectors are well placed to harness these approaches through existing structures where businesses and local authorities work together, including community safety partnerships and local enterprise partnerships, for example.

5.9 Leicestershire’s “Better Business for All” is an excellent example of businesses and local authorities sharing local responsibility for achieving commonly agreed outcomes. That particular initiative has its roots in a shared desire to improve business compliance and the approach taken by regulatory services and there is good reason to expect that it can apply equally effectively in respect of public health.

#### 6. *A joined-up approach in multi-tier areas is essential*

6.1 Leicestershire is an example of the one-third of England with two-tier county and district local government arrangements.

6.2 In two-tier local government areas of England, the CIEH believes that district councils should have representation on, or some equally effective means of influencing, their county’s health and wellbeing board. In keeping with the spirit of localism it is essential that the district councils are engaged in determining the best arrangement for their involvement. This is particularly relevant at a time when a county’s total resources



for its public services, including its public health service, will be scarce and there is such a pressing need for synergistic service provision.

6.3 The Secretary of State has said that the challenge of co-ordinating public health services in two-tier local government areas will be through the health and wellbeing boards. This intent clearly does not take into account the wider opportunities for joining up public health strategies and interventions across all tiers of local government because the health and wellbeing boards will be, as we understand it, focussed on the management of commissioned services. While it will be open to county and district councils to agree for there to be a number of subsidiary health and wellbeing boards in the county—this should not be a reason for excluding the district councils from the county’s health and wellbeing board.

6.4 The CIEH’s evidence to date tells us that practical experience of co-operation at this local level is mixed. Some district councils have excellent joint working arrangements with their counties for public health service delivery, including representation on the health and wellbeing board and good channels of communication. Others have no direct involvement yet in their county councils’ shadow health and wellbeing boards. As a result, some elected members and officers in district councils express frustration that they do not know enough about the public health plans of their county councils.

6.5 The CIEH will actively support any work to devise the most effective ways for county and district councils to work together in order to deliver an effective public health service for all their citizens.

### *7. The funding is in danger of being too little and unfairly distributed*

7.1 The proposed formula for determining and distributing the new public health grant allocations to local authorities has been advised upon by the Advisory Committee on Resource Allocation (ACRA) and informally consulted upon by the Department of Health.

7.2 It is well recognised that standardised mortality ratio statistics are not closely related to deprivation. Yet the Public Health Outcomes Framework says we are to improve the health of the poorest fastest. Resources must be targeted towards deprivation, while not losing sight of Marmot’s “proportionate universalism”.

7.3 The Department of Health has given assurances that no local authority’s ring-fenced grant will be lower than the current level of spending on public health services in their area (by primary care trusts). However, for a local authority with high levels of deprivation and poverty, a formula which does not explicitly distribute the grant funding by reference to such matters will see its ability to address health inequalities decline over time.

7.4 In the longer term we need a formula based directly on underlying drivers of need including measures of deprivation, population growth, population churn, numbers of older people and morbidity levels.

7.5 The CIEH believes that the forecast of £2.2 billion available for local authorities is insufficient by an order of magnitude of 50%. As councils establish and initiate the operation of their public health services they are in danger of being set up to fail.

## 8. CONCLUSION

8.1 The CIEH asserts that the work of environmental health as currently practiced in local government is a primary preventative public health improvement and health protection function, addressing food safety dangers, controlling the sources and tracing outbreaks of infectious disease, improving and enforcing safe working practices, preventing environmental pollution and protecting the vulnerable from the effects of poor housing condition.

8.2 Such essential functions must be maintained and taken into account when determining what resources a locality has available to it to address public health need. Our concern is that health and wellbeing boards as currently envisaged and without, in some cases, adequate representation from second tier authorities, will only focus on the commissioning of new services and fail to take account of these existing ones.

8.3 With further reductions to Council budgets to come, such existing services could become reduced to such a level that public health protection will suffer and with it the health of the population both short term and long term. By increasing representation on health and wellbeing boards, widening their scope and addressing the wider opportunities of tackling the causes of inequalities in health there is a real possibility that improvements to public health can be achieved. We fear however that the structures being created under the current arrangements will not be bold enough or wide enough in scope or representation to be able to succeed.

## ABOUT THE CIEH

As a **Chartered professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a registered charity with over 10,500 members across England, Wales and Northern Ireland.

August 2012

### Written submission from the UK Faculty of Public Health

#### ABOUT THE UK FACULTY OF PUBLIC HEALTH

The Faculty of Public Health (FPH) is the standard setting body for specialists in public health in the UK. FPH is the professional home for more than 3,000 professionals working in public health. Our members come from a range of professional backgrounds (including clinical, academic and policy) and are employed in a variety of settings, usually working at a strategic or specialist level.

FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). In addition, FPH advocates on key public health issues and provides practical information and guidance for public health professionals, aiming to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement.

#### *The introduction of a public health role for councils*

The Government's policy of "empowerment of local communities" offers great potential for health improvement through embedding public health expertise in local authorities, opportunities to work across the full range of Council and local authority issues and determinants of health such as housing, education and planning; and increase the focus on population health. It is critical that this new public health role addresses the following key challenges:

- Ensuring clear lines of accountability and communication for protecting and improving the health of the local population—and that statutory guidance is followed.
- Enabling the public health workforce to challenge powerful interests whose actions risk the health of the population.
- Providing clarity as to how professional standards will be maintained for staff who will undertake the public health functions that are moving out of the NHS system.
- Fully recognising the health service domain of public health and creating explicit mechanisms for public health input and advice to the commissioning and provision of healthcare services.
- Addressing the fragmentation of the public health workforce, limiting opportunities to share scarce skills, maintain and develop capacity and assure competence.
- Ensuring that the HPA is not inhibited in its trading activities, resulting in a loss of funding for key members of staff, ultimately affecting its ability to deliver high quality services.
- Ensuring that ring-fencing of the public health budget does not result in its redistribution for activities other than fulfilling Public Health outcomes, and that the funding formula reduces inequalities.
- Ensuring safe, equitable and appropriate health and health services at a time when the traditional levers for strategic oversight are being removed.
- Ensuring that the potential loss of public health staff during the transition period is mitigated.
- Ensuring that the terms and conditions of public health teams in local authorities reflect their health background—and maintain an equivalence to NHS T&Cs.
- FPH continues to believe that Public Health England is an SHA within the NHS—Executive agencies, whilst being semi-independent are constitutionally part of their parent body.
- SHAs however are independent bodies with greater assurance of freedom from political interference.
- PHE as an SHA enables further development of academic collaboration with service public health for teaching and research.
- This will also encourage local authorities as strong venues for public health specialists and practitioners.

#### *The adequacy of preparations for the new arrangements*

- The order of these reforms has left the public health workforce in limbo for over two years.

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- The organisations that currently employ public health specialists (Strategic Health Authorities, Primary Care Trusts, the Health Protection Agency, Public Health Observatories) have had their budgets cut prior to their being disbanded.
  - Many of those working in public health are still uncertain as to where they will be employed in April 2013—or even, indeed, whether they will be employed at all.
  - The position is variable. In some areas, county councils seem well prepared, whereas in others—especially metropolitan councils and across London, there are still substantial problems.
  - These include problems with regard to staff transferring contracts or contracts being terminated by primary care trusts; information governance, practical considerations including accommodation and IT; and due diligence.

*The objectives of the new arrangements and how their impact can be measured*

- In the short term, it will be important to demonstrate that safe systems are in place. In the medium term, evidence of local authority health policies in practice will be required, and in the longer term it will be important to be able to measure achievements and outcomes.
- It is important that local areas are given autonomy to allocate their resources according to local priorities, whilst recognising the tension between the localism agenda and the need for national priorities to be resourced and addressed.
- We would support the idea of there being both core indicators and locally decided indicators which would be selected from a national basket.
- As described, the outcomes framework suggests that there will be national collation of data and evidence to support reporting against these indicators and measure local authority performance.
- Experience from previous approaches has illustrated that performance reporting places a significant burden on local areas in the collection and extraction of data.
- It is essential, therefore, that the local Director of Public Health has adequate public health specialist support at a local level to support this delivery.
- If the outcomes framework is to be deliverable, the DPH must be able to hold commissioning bodies to account independently for their performance in relation to a particular population in order to ensure delivery.
- The Director of Public Health annual report is an provides an important means to measure the impact of the new arrangements against their objectives.

*The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level*

The Health and Wellbeing Board—General Principles

- HWBB should not become “talking shops”, but be able to robustly hold to account stakeholders and enable the NHS and local government to make real improvements to health and wellbeing.
- Potential political tensions between their overseeing commissioning and promoting integration across public health, local government, local NHS and the third sector need consideration.
- Potential political tensions between their overseeing commissioning and promoting integration across public health, local government, local NHS and the third sector need consideration.
- National policy imperatives must balance with local priorities, via co-production and dialogue.
- National policy Imperatives must be in accordance with agreed findings from the JSNA.
- Roles, responsibilities and membership need clear definition to ensure the Board is robust.
- Stronger national framework for integrated care with a single outcomes framework needed across health, social care and public health.
- Lessons and best practice from shadow Boards, supporting local determination of arrangements to best meet the requirements of local conditions must be considered.
- Must deliver strong, credible and shared leadership across local organisational boundaries.
- Where services are not meeting needs the Board should be able to challenge and hold to account, and take a broad and holistic view of determinants of health.
- Essential that duties underpinning JSNAs/JHWSs undertaken by CCGs and local authorities via HWBBs are robust.
- It is important to give HWBBs maximum freedom to determine the context of JSNA and JHWS.

Health and Wellbeing Boards, JSNA and JHWS—Addressing Health Inequalities

- The JSNA and JHWS will need a strong focus on inequalities across the social gradient (proportionate universalism) in addition to the needs of disadvantaged and vulnerable groups.
- JSNA are the key to addressing inequalities.

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- Health and wellbeing boards will need to consider their organisation's Equality Duties.
  - JSNAs can address the health needs of specific disadvantaged groups with protected characteristics if this is the agreed priority of the HWBB.
  - Each agency has a statutory responsibility to address these needs, and Local HWBBs should be able to determine the HWBB priorities they need to address.
  - The major inequalities in health faced by HWBBs are economic and social rather than inequalities solely related to the protected characteristics.
  - The HWBBs responsibility to take an overview of the social as well as health care needs of the local community living in the board area must not be overlooked.
  - The JSNA/JHWS guidance must make consistent reference to health inequalities.
  - The recommendations from Fair Society Healthy Lives need to be embedded in the JHW.
  - Equal weight should be give to physical and mental health and wellbeing—parity of esteem between mental and physical health is vital.
  - It will be important for boards to have mechanisms to monitor their own outcomes and measure the effectiveness and impact of JHWSs (see the HWB self assessment tool).

#### Health and Wellbeing Boards, JSNA and JHWS—Integration, Autonomy and Leadership

- The DPHs independent annual report should be emphasised strongly—this key resource for identifying local priorities should underpin the JSNA.
- Successful HWBB members will behave supportively and collaboratively, and have capacity to challenge one other where they find that one or other partners is not committing its resources towards agreed joint priorities, programmes and care pathways.
- Strong HWBBs will also be vocal and successful lobbyists of central government.
- Public health will benefit from DsPH as leaders within the HWBB and within local authorities.
- Whilst CCGs and LAs have joint and equal responsibility for the development and delivery of the JSNA and JHWS strategy, the DPH is best placed to lead on the JSNA and JHWS on behalf of the HWBB.
- This follows from their role delivering public health advice to the local authority on needs and policy and in delivering the core offer of PH advice to the CCG.
- JSNAs should result in a shared understanding locally between all partners not just local authorities and the NHS; but also other public sector bodies, voluntary and private sectors.
- They will set out communities' needs but also community assets, and where there are inequalities in outcomes and access to services, as well as identify the causes of inequalities.
- JSNAs/JHWSs should be owned jointly by all members of health and wellbeing boards.
- They should involve ongoing dialogue with communities, to ensure their needs, assets and experiences are understood, and that priorities reflect what matters most to them.

#### *Barriers to integration, including issues in multi-tier areas*

##### Health and Wellbeing Boards—A Mechanism for Integration

- Health and Wellbeing Boards provide a useful mechanism for integration.
- CCGs, the NHSCB and local authorities' commissioning plans must be informed by JSNAs/JHWSs.
- Where plans are not in line with JSNAs and JHWSs, CCGs, the NHSCB and local authorities must be able to explain why.
- Agreeing a JHWS must involve a two-way dialogue that allows for challenge by local commissioners where they feel the JSNA and JHWS have been ill thought through.
- Local authorities should be held to account for the public health funding that will be disbursed to them by PHE and made explicitly accountable for the delivery of an agenda through commissioning, policy and management that addresses the social determinants of health.
- Health and wellbeing boards will need to engage partners, stakeholder and communities in different ways than in the past, and communities themselves will need to proactively take part.
- Engagement should be continuous, recognising that JSNAs/JHWSs go beyond health and care.
- Evidence from multiple sources will be needed, including input and views from the community.
- HWBB members need to provide collective leadership, with members working together to jointly agree upon needs and priorities, as well as translating the priorities into action.
- Individual board members will need to influence their own organisations, as well as others across the health and care economy and wider existing partnership arena.

#### Upper Tier and District Councils

- The JSNA/JHWS are the equal and joint duty of LAs and CCGs, through the HWBB.
- LAs in this context are top tier, but much of the local government spend which is equally or more relevant to population health, is by district councils in two tier authorities.
- There is no statutory requirement for them to be involved or even have a place on the HWBB.
- There must be explicit requirements for their active engagement, as they will have a crucial role in promoting public health.

#### The NHS Commissioning Board and Integration

- The NHSCB commands a considerable expenditure in local areas and is required to have a place on the HWBB—this is essential.
- The NHS Commissioning Board is the major public health budget holder and needs to be held to account as any other Health and Wellbeing Board partner.
- The NHSCB, as Commissioner of pharmacists, GPs, opticians, dentists has major front line role.
- The NHSCB's responsibilities complement but do not duplicate those of CCGs and it is unreasonable to expect CCGs to have a comprehensive understanding of the specialised services that the NHSCB commissions and which all local populations need.
- The NHSCB commissions primary care and might reasonably be expected to offer an informed view on the quality of that care delivered locally and the appropriate response to unmet need.
- It follows that the NHSCB should be party to every single JHWS in England, to agree to them, and to be held to account by them.

#### The Outcomes Frameworks and Integration

- The draft JSNA/JHWS guidance, which states that the three Outcomes Frameworks should help form priorities, but shouldn't overshadow local evidence.
- They may prove problematic in practice, given that, for example, health services will be required to take account of the NHSCB mandate, likely to draw heavily upon the NHS Framework, and the funding available to local authorities is likely to be determined to an extent by their response to the PH outcomes framework.

#### Other Sectors

- Drug and alcohol services and "homeless" charities are surprising omissions from the list of organisations Health and Wellbeing Boards need to work closely with.
- Early years providers and parenting coordinators should also be mentioned since these have a key role in life course health promotion.
- The potential role of universities should be acknowledged in JSNA/JHWS guidance.

#### *How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level*

- There must be clarity over who, within the various local agencies involved, has lead responsibility for ensuring the response to an emergency/outbreak is effective and appropriate.
- There should be local responsibility with the DPH, beyond ensuring that plans are in place.
- The picture at local level for this response is fragmented, with responsibility across it, the NHS and PHE—This fragmentation places public safety at great risk.
- It is imperative there is a clear delineation of responsibilities for health protection at the local, sub-national and national levels, including those of the LA, DPH, NHS and PHE local outposts.
- The Act does not articulate lines of responsibility or accountabilities for co-ordinated action.
- This lack of clarity at local level on who is operationally responsible for ensuring that an effective response is put in place at the local level will result in delay and confusion.
- Grave risk that emergencies, outbreaks and epidemic situations, will not be properly managed or responded to, may escalate, and the public—and economies—will be come to serious harm.
- Under the Act, local government takes on a substantial share of the responsibility for public health, alongside PHE, across the three pillars of public health.
- It follows that a primary leadership role and central port for emergency preparedness and for ensuring effective management of the local response should rest with the local authority.
- PHE needs a clear leadership and coordination role when emergencies cross local boundaries.
- The relationship between local hubs of PHE and the DsPH needs clarification.
- FPH is concerned that the current proposals do not address the need to establish and maintain an effective health protection workforce at the front line (ie local authority level).

- FPH is concerned that the other functions of PHE will be overlooked and poorly resourced as PHE becomes in all but name the national functions of the Health Protection Agency (HPA).

#### *The accountability of Directors of Public Health*

To provide effective strategic leadership for public health, the DPH must be able to influence all aspects of the work of the local authority and the local health economy. The public must also be confident that the DPH is able to provide informed, independent professional advice.

- The DPH must be the local strategic leader and Chief Officer for health and wellbeing within the local authority, trained and registered with broad range of PH expertise.
- This ensures that those responsible for providing vital advice of a technical nature are appropriately qualified to do so and that the public can be assured of that competence.
- The DPH must be a Chief Officer of the LA.
- The DPH must have direct access to the Council, Cabinet, elected members and Board, and direct accountability to the head of the organisation (CEO, Mayor or equivalent).
- The DPH must have day to day responsibility for management of the ring-fenced PH grant; be a statutory member of the HWBB; and have lead responsibility for planning and leading the local response to outbreak and emergency situations
- The DPH must be subject to statutory guidance on their responsibilities, in line with that for Directors of Children's Services and Directors of Adult Services.
- The DPH must be able to produce a robust and truly independent annual report on the current health and future health needs of their population (and how well they are being met).
- The DPH (and all consultant level posts) must be jointly appointed by the LA and PHE through a statutory appointments process (or equivalent consistent with FPH standards).
- The Secretary of State should have a veto over the termination of employment of the DPH.
- Forthcoming statutory guidance must reflect good practice.
- Must be able to promote opportunities for action across the whole "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.
- FPH is concerned by reports some local authorities wish to have their DPH report to, for example, the Director of Adult Social Services, not giving the DPH the required status to be effective.
- FPH is concerned to hear of examples where the AAC process is not being followed correctly.
- The DPH must have the ability to work with all executive members across all functions of the council—considering the wider determinants of health including "place" as well as "people".

#### *The financial arrangements underpinning local authorities' responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets*

##### **The Proposed Public Health Funding Formula**

- FPH is concerned by the way the proposed public health funding formula redistributes funding from areas whose residents have the worst health to areas where residents have better health.
- The formula uses as an indicator the standardised mortality ratio for those aged under 75.
- This allows the existing allocation to remain in areas where it is now higher than this minimum.
- This minimum allocation will have the effect of levelling up those areas giving too little priority to public health, rather than rewarding those areas taking action to reduce health inequalities.
- If the proposed formula is used to redistribute the existing pot it will reward the lower spending less deprived and increase inequalities.
- It is a core public health value that inequalities in health should be reduced.

For a detailed overview of FPH's analysis of the proposed public health funding Formula, please refer to FPH's *response to the engagement process on @Healthy Lives, Healthy People: Update on Public Health Funding*, which you can find at the following link: <http://tinyurl.com/9aabcz3>

##### **The ring-fenced budget**

- The "ring-fence" needs to be protected at a local level as well as at a national level.
- It is important there exists robust and external monitoring of the ring-fenced budget, in particular for those situations where the Director of Public Health should be able to give an independent view (but this may not be possible).
- Additionally, Public Health England and the relevant CCG should have a role in monitoring the integrity of the ring-fence.

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- Clarity is needed over what services will be funded from the public health budget and how these monies will be routed from the DH to service providers.
  - Clarity is also needed about how decisions need to be made to redistribute the ring-fenced budget—who needs to be involved?
  - This is vital in assessing the adequacy of the budget in relation to the infrastructure it is required to support and the services it is intended to deliver.
  - The DPH should have final control over these monies and be accountable for their use and have a right of veto over a cabinet decision.

For future consideration

- FPH believes that as the formula is refined, weighting should consider reflecting those aspects of public health spend which reflect younger people.
- This could include child poverty, preparation for school age and adolescent years.
- FPH underscores the relevance of a marker for mental health and wellbeing need/provision.

The Health Premium

- Payment of the premium will be based on historical activity so it is difficult to see how it will support innovation and development in public health approaches.
- To be effective, it must be directed not at simply supporting good health status in areas where health is already good, but at a true reduction in health inequalities.
- It must reflect the number of people whose health has been improved, as well as the extent of the improvement.
- It is hard to envisage how it might account for population migration since emigrants are often replaced by a poorer and unhealthier population it could be that a local authority consistently doing excellent work goes unrewarded, while an already affluent neighbour reaps the financial benefits.

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### Supplementary written submission from the UK Faculty of Public Health

Protecting the population from infectious disease outbreaks, natural disasters or environmental hazards is a critical public health function.

An effective response to any outbreak or hazardous event is dependent upon: accurate and timely information; a robust and effective response plan appropriate to the context and the available resources; and a timely coordinated response, guided by the plan, from all relevant agencies.

Strong and effective leadership is vital to a successful outcome. Under the present arrangements in England, local leadership under such circumstances is normally provided by the local Director of Public Health.

It is now unclear, however, where this leadership will lie in the new system. Guidance from the Department of Health issued on 31 August 2012 states clearly that:

*“the DH does not expect local authorities to produce a single all-encompassing ‘health protection’ plan for an area, but rather to ensure that partners have effective plans in place. This includes commissioning plans aimed at prevention of infectious diseases, as well as joint approaches for responding to incidents and outbreaks agreed locally with partners.”*

However, the draft statutory instrument recently laid before parliament—The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012—appears to translate this into a purely advisory role, with no requirement for organisations to accept or act on the advice provided:

*“8.—(1) Each local authority shall provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority’s area, with a view to promoting the preparation of appropriate local health protection arrangements (“health protection arrangements”), or the participation in such arrangements, by that person or body.”*

This lack of clarity presents a *significant risk* to the health of the population.

The Communities and Local Government Committee is conducting an important inquiry into local public health arrangements. Would the Committee consider exploring with witnesses whether the Government intends the local Director of Public Health to have a leadership role in local outbreaks and similar health related emergencies? If so whether this is to be supported by regulation and expressed clearly in guidance? If not, where will the leadership role lie and what will be its basis in law?



The Department of Health may argue that there exists no legal authority for the Local Authority, through the Director of Public Health, to ensure that health protection plans are in place, and rather that the Director of Public Health may escalate concerns where they arise to Public Health England (exercising the Secretary of State's duty to health protection).

However, we feel it vital that as a minimum the Director of Public Health should have responsibility for ensuring plans are in place, and that the existing guidance stands and is reflected within the forthcoming Regulations. Our strong advice would be that the guidance should also be strengthened to give the Director of Public Health a coordinating role for the implementation of local health protection plans. In emergency situations, the ability to act immediately is of critical importance to increasing the opportunity for a successful outcome. Escalation to Public Health England risks unnecessary delays in responding to emergencies and puts the public at risk.

January 2013

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### **Written submission from the Local Government Association and Association of Directors of Adult Social Care**

#### *1. The introduction of a public health role for councils*

The LGA and ADASS have consistently supported the transfer of significant public health responsibilities to local government. We are convinced that the most effective use of resources to improve public health is to combine the public health professional workforce, with its specialist expertise and intelligence, with mainstream council plans and services to develop public health services that are locally appropriate, efficient and effective in improving public health outcomes.

Single and upper-tier councils, through their health and wellbeing boards (HWBs) will have a mandatory responsibility to address health inequalities. They can't do this if they maintain a narrow focus on health services, though of course improving access to health services is also extremely important. We agree with Professor Sir Michael Marmot's analysis that the crucial determinants of health are: "... the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."<sup>1</sup>

It is also important to remember that a key component of the public health workforce has remained in local government: environmental health officers and other local government staff play a vital role in public health and health protection through the operation of regulatory services.

#### *2. The adequacy of preparations for the new arrangements*

Preparations for the transfer of public health to local government are going well in the majority of places. In April 2012, the Department of Health (DH) undertook an assessment of the progress of transferring public health. The overall picture was that the transition was well underway in almost every area. It was also clear that some interesting and innovative new approaches to public health were emerging and that there is an appetite for sharing this information to stimulate further innovation and transformation.

The LGA and the DH agreed that it would be helpful to have a further opportunity to take stock of progress to identify and disseminate good practice and innovation. It will also identify areas that would benefit from further support to ensure a smooth transition of public health. The stock-take is currently underway. It is a light-touch self-assessment of progress undertaken by local authorities, which will be submitted at regional level. The regional core group receiving and collating the reports comprises a lead local authority Chief Executive, the LGA Principal Adviser, the Regional Director of Public Health (RDPH) and the RDPH Transition Lead. They will summarise the regional position and feed this into a national consolidated picture, to be drawn together in early November.

The deadline for submitting self-assessments was 10 October. If the regional core group identify significant and specific barriers and risks to a successful transition in a particular locality, they will work closely with the local authority and health partners to ensure that there is a full understanding of the issues and what might be done to mitigate them. The position of individual councils will not be reported to government as part of this exercise.

Any issues that need to be resolved at a national level identified by the stock-take will be addressed by the joint local government/Department of Health transition arrangements.

#### *3. The objectives of the new arrangements and how their impact can be measured*

From a local government perspective, there are three key objectives:

- to identify and take effective action to address local public health priorities;

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<sup>1</sup> Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, published by The Marmot Review, London, February 2010.

- to provide local accountability for health priorities, through health and wellbeing boards and their engagement with local communities; and
- to secure lasting improvements in health and health inequalities, in order to enhance local health and wellbeing and to reduce the cost of preventable ill-health.

We support the Government's commitment to move away from top-down performance management that measures processes and outputs, towards local accountability for improved outcomes. The joint strategic needs assessment (JSNA) process, led by health and wellbeing boards and clinical commissioning groups, will be an inclusive and comprehensive process for identifying the local health needs and assets of the community in the short, medium and long-term. The joint health and wellbeing strategy (JHWS) will draw on the evidence from the JSNA identify the local priorities and will, in turn inform the commissioning plans of clinical commissioning groups and other commissioners of health and social care services.

The three national outcome frameworks for public health, the NHS and adult social care will also be helpful to local areas in measuring the progress in improving health. However, the LGA are clear that while the outcome frameworks are useful in helping to inform joint priorities, they should not overshadow local evidence. Forthcoming statutory guidance on JSNA and JHWS will need to underline the message that local priorities identified in the JHWS will be the key drivers of commissioning plans.

#### *4. The intended role of Health and Wellbeing Board in coordinating the NHS, social care and public health at the local level*

Health and wellbeing boards will be the local leaders of the new health system. For councils, health and wellbeing boards are *the single most important* component of the new health landscape created by the Health and Social Care Act 2012. They will be the engine house that drives a new system-wide approach to health improvement based on a shared understanding of health and wellbeing needs, developed through the joint strategic needs assessments, a shared understanding of priorities outlined in the joint health and wellbeing strategy and deployment of shared resources to achieve lasting health improvements.

This is a radical new approach, which will need to shift partnership working and integration from a marginal activity to the main way of doing business. Integration and shared priorities have been an aspiration for health and social care for many years. It is an approach that has received overwhelming support from councils and their partners. Over 90% of all single and upper-tier councils opted to join the DH "early implementers" group for health and wellbeing boards and many are already making steady progress in:

- building relationships at local level;
- engaging with their communities and stakeholders to identify local priorities;
- refreshing the JSNA process;
- developing their JHWSs; and
- looking at innovative ways of commissioning integrated services that will improve quality, improve health and wellbeing outcomes.

The LGA is delivering a comprehensive programme to support the leadership and development of health and wellbeing boards. Funded by the DH as part of the overall National Learning Network for health and wellbeing boards, the programme focuses on the critical leadership role of HWBs and is aimed at equipping board members with the leadership behaviours, skills and knowledge to help them operate effectively in a complex cross-organisational environment.

The programme comprises an "offer" to health and wellbeing boards that includes national, regional and board specific activity.<sup>2</sup>

**Nationally**—We have developed a tool for use by all HWBs that challenges them to consider their position now and their ambitions for the future. It encourages board members to think about their role and vision, their behaviours within the partnership, governance arrangements and the achievement of outcomes for their communities. The LGA working with key partners to develop a shared concept of system leadership to identify what good system leadership looks like and how boards can embed effective leadership throughout local health and care systems.

**Regionally**—A programme of simulation workshops is being delivered to test how boards will deal with big and difficult issues. Each board will be encouraged to produce an action plan identifying learning and development needs.

We are also supporting HWB Chairs Networks across each region to share their experience and learn from and support each other.

**Locally**—The LGA and ADASS are working with the NHS Leadership Academy to provide customised support to a small number of boards facing particular challenges, those that are further forward in their journey and where boards have made a specific development request.

<sup>2</sup> More information on this offer is available at: [http://www.local.gov.uk/web/guest/health/-/journal\\_content/56/10171/3510973/ARTICLE-TEMPLATE](http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3510973/ARTICLE-TEMPLATE)

5. *How all local authorities can promote better public health and ensure better health prevention [sic] with the link to sport and fitness, wellbeing, social care, housing and education*

The LGA has consistently highlighted the important contribution of mainstream local government plans, services and programmes in protecting and promoting improved health and wellbeing. Many local government services—housing, planning, leisure and recreation, children’s social care, education, adult social care, environmental services etc—are crucial in keeping people fit and healthy and a growing number of local authorities have wide ranging strategies for “making health everyone’s business”.

The LGA and DH have jointly produced a web resource to support the transition of public health to local government. *From Transition to Transformation in Public Health* aims assist local authorities and public health to develop a local public health system that is designed to have the greatest potential for improving health, not just in councils but with all local partners. The focus is on transformation, showing how councils and public health are going beyond the practical steps of transition to develop a local vision public health, supported by new models for implementation. One of the resource sheets specifically considers the role of local government in health improvement and includes many examples of councils who are taking a broad approach to health improvement.<sup>3</sup>

The key messages from councils on identifying the contribution of other council services in improving health and wellbeing are summarised below.

- All council directorates need to be involved from the beginning in systematically embedding public health across the council.
- A strategic approach is needed to developing the mutual understanding of public health specialists, councillors and council officers and new health commissioners in CCGs about the potential of local government for improving health and wellbeing.
- A place-based budgeting approach to health means that the system benefits collectively, both in human and financial terms.
- The Council’s self-assessment and performance management systems provide opportunities to incorporate public health indicators across all functions.
- In two-tier areas, district councils can be supported in developing their contribution to public health, and involved in developing JSNAs and joint health and wellbeing strategies.
- The new arrangements provide significant opportunities to develop a policy on systematic health impact assessment of major council decisions and to embed equality and health equity in all council policies.

However, it is fair to say that some local government services have historically had more awareness of their health role than others. Adult social care, environmental health and leisure services have always been aware of the contribution they are able to make to improved health. However, other departments, such as those concerned with urban planning and housing, are perhaps less aware, although the situation is beginning to change.

In the case of leisure services, the LGA and local councils are working with Sport England and others to increase the opportunities for links to be made between physical activity and health improvement. Councils are the biggest public sector funders of community sport, spending £1.8 billion annually. They are also uniquely placed to encourage greater connectivity locally between National Governing Bodies, County Sports Partnerships, voluntary sports clubs and schools.

Many councils are keen to build on the Olympic and Paralympic legacy to encourage people to be more active in the long-term. After the Olympic and Paralympic Games councils reported to the LGA that their leisure facilities were bursting with people wanting to get involved in sport.

In addition, the LGA works in partnership with Sport England to support leisure portfolio holders to lead the transformation and improve the efficiency of sports provision, including the positioning of sport in local commissioning conversations about public health, children and young people and adult social care.

6. *Barriers to integration, including issues in multi-tier areas*

We do not agree with the implication of the Select Committee’s question that two-tier areas represent a barrier to integration. It is clear that district councils have a vital contribution to play in the new public health system. We are currently working with DH to produce a further set of resource sheets to build on our existing web resource, *From Transition to Transformation in Public Health* and we will be publishing a resource sheet specifically on public health in two-tier areas in late October 2012. The key messages from the resource sheet are summarised below.

- District councils’ functions and relations with their communities make them vital partners for public health in two-tier areas.

<sup>3</sup> Resource Sheet 3: Understanding the health role of local government. *From Transition to Transformation in Public Health*, LGA, February 2012 [http://www.local.gov.uk/c/document\\_library/get\\_file?uuid=efcd26e6-7201-4990-922e-def6630ee5e1&groupId=10171](http://www.local.gov.uk/c/document_library/get_file?uuid=efcd26e6-7201-4990-922e-def6630ee5e1&groupId=10171).

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- Many County councils are using the health reforms as an opportunity to review their public health governance and operational relationships with district councils and build on existing partnerships.
  - We believe it is up to counties and districts to work together to decide how districts can contribute to public health planning and activity. In some areas they have decided that district councils should be represented on health and wellbeing boards (HWBs) while in others they are exploring other ways of involving district councils. HWBs and CCGs have a statutory duty to involve districts in developing joint strategic needs assessments (JSNAs), to ensure that the assessment and strategies are sensitive to variations across the county.
  - Districts need to find a way of cooperating among themselves to develop and present a “district perspective” and collective voice on HWBs.
  - Integration between district councils and clinical commissioning groups (CCGs) is as important as integration between county councils and CCGs—HWBs will need to consider this when carrying out their statutory role in promoting integration.
  - In many areas there is a third tier of local government. Parish and town councils have a role in community engagement and will need to be involved in developing joint health and wellbeing strategies and JSNAs.

*7. How will the transfer to local government of front-line health protection role and the creation of Public Health England affect resilience arrangements at local level?*

All single and upper tier local authorities will have duty to ensure plans are in place to prevent threats to their populations and to protect the health of their populations from all hazards and full-scale health related emergencies. Local authorities (and directors of public health acting on their behalf) will have a critical role in protecting the health of their population, both in terms of helping to prevent threats arising and in ensuring appropriate responses if things do go wrong.

The Emergency Preparedness Resilience and Response system is undergoing significant change in relation to the roles and responsibilities of individuals and organisations, including local authorities in respect to their new responsibilities for public health. The LGA believes that all key partners need to have a shared understanding of the new system, and clarity of roles and responsibilities within it.

Local authorities already have existing duties and powers to tackle environmental hazards. The move of local public health functions from the NHS into local government opens up new opportunities for joint work with environmental health colleagues to tackle areas where there are potential threats, including food-borne infectious diseases and environmental hazards.

*8. The accountability of Directors of Public Health*

From April 2013, directors of public health (DsPH) will be senior local government officers, jointly appointed by local authorities and Public Health England, acting on behalf of the Secretary of State for Health. They will be responsible for the professional leadership of public health at local level. They are statutory members of health and wellbeing boards and will also be “accountable officers” of their local authorities with specific statutory responsibilities.

*9. Views on the public health budget*

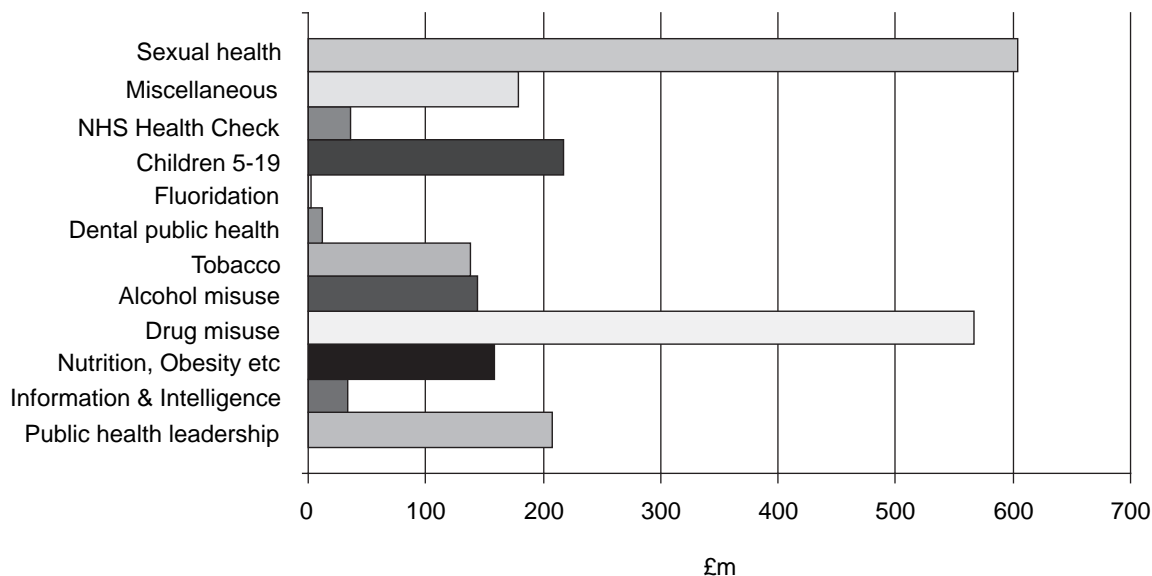
We see a strong case for increasing investment in public health. For example, London Councils said in its response to the DH consultation on Advisory Committee on Resource Allocation proposed distribution formula that: “It is important to get the overall quantum to be spent on public health right. There is a case to be made that this has historically been too low to achieve a significant and sustained positive impact on health outcomes and on health inequalities. Looking forward it will be important to ensure that the total resources available for public health are sufficient to meet needs”. Newcastle City Council made the same general point in its response and illustrated this by reference to the significant reduction in early mortality rates from cardiovascular disease, highlighting that this would not have been achieved without investment in public health measures.

This kind of evidence demonstrates the value of increasing the level of public health spending devolved locally. There does not appear to be any comparable evidence suggesting that equivalent value would be derived from centrally allocated spend (estimated at £2.2 billion in 2012–13 for the NHS Commissioning Board and £620 million for the Department of Health), or from that allocated to Public Health England (estimated at £210 million for 2012–13).

The LGA was able to see analysis prepared by the Association of Directors of Public Health examining the consequences of the distribution formula proposed in the Department of Health consultation. This analysis showed that the formula as currently published was regressive and areas with the best health outcomes were likely to be the biggest beneficiaries in comparison to their current spend, with those with the worst outcomes (likely to be the biggest losers). LGA officers sought to test this analysis further and found that, if the DH’s recommended formula were to be applied, there would only be a 3% correlation between the funding allocated to an individual authority and the extent of deprivation in the authority. By contrast, at current levels of

spending there is a 30% correlation. This finding strongly suggests that some adjustment to the proposed formula is required to incorporate a more appropriate weighting for inequalities.

Within the public health functions transferring to local government, there are two dominant categories of expenditure: sexual health services and drug misuse services. Details of the latest available analysis are given in Chart 1 below.



Officers concluded in the light of this analysis that the proposed funding requires further adjustment, because it clearly did not lead to an effective resourcing allocation for sexual health services. The LGA Community Wellbeing Board's response to the DH consultation made the following four points:

- The adequacy of the funding formula cannot be assessed without reference to the quantum of funding. Councils in some areas have serious and well-founded concerns that the future public health investment in their communities could fall well behind likely need. The LGA calls for a clear commitment from the department for an increase in resources to a level that will maximise the value for money available from well targeted investment in public health.
- Whilst the standardised mortality ratio (SMR) for those aged under 75 years may be a reasonable starting point for the construction of a needs based formula, the weighting suggested to help reduce inequalities must be reconsidered. The suggested weighting does not appear to be based on adequate objective evidence and, as has been pointed out by the Association of Directors of Public Health, is regressive.
- The formula requires further adjustment to provide an effective resourcing allocation for sexual health services.
- Considerably more work is needed to establish the correct baseline level of public health spending. Some local authorities have expressed concerns about the exercise to identify PCT baseline spending on public health, notably in relation to administration and support costs and in specific cases where health budgets faced more general pressures.

October 2012

### Written submission from the District Councils Network

#### EXECUTIVE SUMMARY

- The DCN welcomes the reintroduction of the public health function to local government. Local authorities have the powers, expertise and experience to promote better public health/health equality and ensure more effective health prevention with the link to sport and fitness, well-being, social care, housing and education.
- The embracing and extension of the “prevention” agenda motivating the reforms shows a welcome commitment to refocus the health agenda from the prevention of ill health to the treatment of its causes.
- Local authority led Health & Wellbeing Boards are the logical bodies to lead on this new public health agenda, providing the focal point for local stakeholders to work together on prevention and integration of services.

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- The DCN is disappointed, however, at the level of attention given to district authorities' role in official guidance and the lack of statutory status for district councils in two-tier areas. We believe that this is inconsistent with the overarching principles of the reforms (ie prevention) and does not reflect the positive and constructive contribution which District Councils do and will make to their success.
  - Despite this, the vast majority of two-tier areas are embracing the reforms and proactively collaborating to establish the new arrangements in their areas.
  - The DCN believes that funding for public health will need to be increased if there are to be real reductions in health inequalities.
  - The funding framework for the health premium must be designed so that it incentivises both county and district councils to make progress against the indicators, acknowledging the contribution of districts statutory and discretionary services and fairly allocating any reward-based grant.

## 1. INTRODUCTION

1.1 The District Councils' Network (DCN) welcomes this opportunity to respond to the CLG committee call for evidence. The DCN is a Special Interest Group of the Local Government Association (LGA) representing 194 district councils in England.

1.2 Given our area of expertise we will concentrate our response on the health reforms in two-tier areas.

*2. The introduction of a public health role for councils & how all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

2.2 Overall, we welcome the transfer of public health responsibilities to local authorities. The reforms go with the grain of over two decades of health reforms that have focused on greater collaboration between the NHS and local government, and a policy shift away from a narrow focus on health services towards a more holistic, multifaceted approach to tackling poor health.

2.3 The policy principles contained within the Public Health White Paper, namely tackling the "wider determinants" and focusing on health improvement, show a welcome extension of this approach. There is widespread agreement with Professor Marmot's conclusions that bad health does not arise by chance and is not simply attributable to genetic make-up and access to medical care, important as these factors are. Instead, differences in health status are largely shaped by our socio-economic and environmental surroundings.<sup>4</sup> To tackle rising geographical health inequalities, as well as detrimental health related behaviours, there is a need for a radical acceleration in this prevention agenda.

2.4 We welcome the selection of local authorities as the agencies to lead on this agenda. Local government has always had a fundamental and far-reaching impact on its residents' health. Through its wide-range of statutory and discretionary powers across housing, environmental services, leisure, planning, social care and economic development, the sector has the greatest local impact on the wider determinants and the ability to encourage healthier lifestyles, through our many and varied contacts with families and individuals in our communities.

2.5 Through its statutory and discretionary services, local government is best placed to promote better public health and ensure better health prevention with a link to physical activity, well-being, social care, housing and education. This will be achieved both by focusing on how to deliver and commission these services more efficiently and effectively during a period of downsizing and organisational transformation, and by ensuring that all activities of councils are involved in systematically embedding public health across organisations; using the opportunities of service reconfiguration and the transfer of public health to continue to break down policy-silos and commission joined-up services.

2.6 Alongside having the duty to provide many of the aforementioned services, district councils already have a recognised frontline public health workforce including Environmental Health and Housing Officers. Under the new system, officers from across services such as planning, community safety and leisure should increasingly be seen as part of a much broader public health workforce. This is essential to achieving a more integrated and effective public health system within all local authority services—be they county, district or parish.

2.7 DCN members have long recognised their multifaceted role in health policy beyond their core functions. Districts have worked closely with NHS partners and county colleagues in delivering and commissioning a range of health initiatives aimed at tackling the underlying causes of poor health and encouraging behaviour change. The sector has both the experience and capacity to continue its role as a local needs identifier, priority setter, commissioner and frontline deliverer of new and existing public health services.

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<sup>4</sup> The Marmot Review (2010) *Fair Society, Healthy Lives*

### 3. *The objectives of the new arrangements and how their impact can be measured*

3.1 From the specific district viewpoint, the objectives of the reforms can be summarised as follows:

- **Prevention:** Shifting the focus of health policy from the “upstream causes” (ie treatment of disease, symptoms or sickness) to the “downstream causes” (ie socio-economic, environmental and lifestyle circumstances).
- **Localism:** Devolving and localising responsibility and power over the promotion of health and wellbeing to those organisations charged already with “local” wellbeing.
- **Integration:** Establishing a more collaborative, multi-agency approach to delivering health services.
- **Improved Outcomes:** ensuring lasting improvements to health outcomes rather than achieving short term targets.

3.2 The DCN has been a strong supporter of the government’s localism agenda and commitment to reduce the amount of government performance management and centrally dictated targets. The focus on high-level long-term outcomes, rather than short-term targets within the Public Health Outcomes Framework (PHOF), is welcomed, as is the commitment of the Chief Executive of Public Health England to allow HWBs to decide their own local priorities within the new national framework.<sup>5</sup> The indicators contained within the PHOF also demonstrate a commitment to the prevention agenda.

3.3 We believe that it is right in two-tier areas that county councils and districts work closely in identifying needs and priorities. The use of low-level quantitative and qualitative data in the Joint Strategic Needs Assessments (JSNAs) to inform Joint Health & Wellbeing Strategies (JHWSs) will be the key mechanism for achieving this.

3.4 However, during the recent consultation on the draft guidance for JSNAs and JHWSs, the DCN did raise its concerns that the guidance overlooked particular issues in two-tier areas and the role of district councils, including:

- A lack of specific references to districts as “experts” on whose knowledge HWBs should draw in exercising their duties.
- The need for HWBs to actively promote and work with district authorities in embedding health improvement within their own district organisations.
- The need for JHWSs to promote service integration, with services located at district level.
- The need for the HWB duty on JSNA development to relate to ALL, not “relevant”, district councils<sup>6</sup>—all districts are relevant!

3.5 Whilst a recent DCN survey of members showed that 88.8% of respondents had contributed to development of their local JHWS, we believe the importance of district council services to the future success of the reforms is so vital that there should be greater expectation on county councils to involve all, not just “relevant” district councils. This would ensure that going forward the importance of district authorities is uniformly recognised and there are not inequalities in representation and involvement.

### 4. *The intended role of Health and Wellbeing Boards (HWBs) in coordinating the NHS, social care and public health at the local level*

4.1 With local authorities’ experience of coordinating multi-stakeholder partnerships, the sector is the logical agency to lead on this vital part of the Health & Social Care Act. HWBs are the most important component in refocusing the health agenda from the treatment of illness to the prevention of its causes. With a multi-stakeholder membership, HWBs can lead a system-wide approach to public health. Key to achieving success will be the ability of HWBs to develop and maintain effective partnership work, pushing it from the margins to the mainstream across stakeholders.

4.2 Achieving this requires HWBs to set a strong strategic vision for local public health services and outcomes. Key local stakeholders need to be actively engaged in developing and implementing the JHWS, based on a much broader understanding of community health and wellbeing. It is therefore right that CCGs are statutory members of HWBs. This will help ensure that this key pillar of the local health service will buy-in to the new system and understand the need to work in partnership with stakeholders to tackle the causes, rather than consequences of ill health.

4.3 In two-tier areas it was disappointing that districts were not granted the same statutory status despite having an equal, if not more, important role in delivering a new approach to public health. In paragraph 2.6 we clearly outline how important district councils are to implementing the prevention agenda given the clear separation of powers in this area between county and district authorities, particularly housing, leisure and environmental services. It seems contradictory, therefore—given the prominence of the prevention agenda—that whilst CCGs have a statutory role, there is no obligation to involve districts beyond the production of

<sup>5</sup> *The MJ*, 06.09.12

<sup>6</sup> District Council Network (2012) *Consultation Response to: Joint Strategic Needs Assessments & Joint Health & Wellbeing Strategies—Draft Guidance*

JSNAs. It is inconsistent with the overarching principles of the reforms and has contributed to some unnecessary confusion over the role of district authorities (see section 5).

4.4 Although agreeing that it would be highly impractical to have statutory representation for every district council on each HWB, at least one district council representative should have been included under Section 194 (2) of the Health & Social Care Act. This would have ensured that vital public health services, including housing and environmental services, have a statutory right to be involved in the new public health system avoiding any potential service fragmentation. This position has been supported by a number of public health specialists, including the Chartered Institute of Housing<sup>7</sup> and Chartered Institute of Environment.<sup>8</sup> Moreover, the Health Select Committee has concluded districts should have had a statutory role in the new public health system.<sup>9</sup>

### 5. Barriers to integration (including issues in multi-tier areas) & the adequacy of preparations for the new arrangements

5.1 Two-tier areas need not present barriers to integration, given both the right statutory framework and proactive local partnerships amongst engaged and commitment stakeholders. District councils have a strong record of working with community partners, including county councils and the health sector, to deliver multi-stakeholder partnerships including Local Strategic Partnerships, Community Safety Partnerships and more recently Local Enterprise Partnerships.

5.2 However, our research amongst our members leads us to identify two potential barriers to integration:

- 5.2.1 Resistance or reluctance to full and/or sufficient district council representation and involvement on HWBs
- 5.2.2 We have stated above that, whilst welcoming the overall framework of the public health reforms, the lack of statutory recognition for districts has contributed to some unnecessary local confusion over the role of district authorities. This has in some cases affected the adequacy of local preparations for the new arrangements.
- 5.2.3 Our members public health survey showed that whilst negative views amongst district councils on positive relationships/engagement with HWBs has reduced from 36% in October 2011 to 14% in September 2012, it is clear from accompanying qualitative data that there are localised examples of resistance and reluctance to fully represent and acknowledge the role of districts in local public health systems. In our October survey, 63% of our members felt they had specific and unique barriers in engaging and contributing to the development of HWBs. The primary concerns focused on:
  - Restricted opportunities for districts to engage in the process, reinforced by the lack of representation.
  - The need for the incorporation of specific mechanism to enable effective and regular inclusion.
  - Lack of communication, engagement and feedback.
- 5.2.4 Our latest research suggests that as the reforms have progressed, many of these problems have been addressed at a local level, allowing implementation to proceed unimpeded. However, issues still remain. In some county areas, there continues to be reluctance to have sufficient representation on boards (including voting rights) or to effectively communicate HWBs developments and the role of district councils locally. Moreover, it is clear that current levels of representation have only been reached due to considerable pressure being applied by local districts themselves. This has in some cases led to the impression that districts are not equal or valued partners, creating confusion over communication channels, structures and governance and delaying the process of engagement, despite the vast majority of counties being early implementers of the reforms.
- 5.2.5 Going forward, HWBs need to be mindful of these issues to realise the long-term benefits of the reforms. The DCN recognises that, by its very nature, localism inevitably leads to a variation in local responses and has the potential to encourage innovative local solutions. The DoH, therefore, was right to point out that “local variations in public health call for locally tailored solutions”.<sup>10</sup> However, the need for district council input must be a constant, not variable factor. Districts will continue to provide key services such as housing, environmental, planning and leisure services; these services must be integrated into the wider public health system. Inequalities in involvement at district level cannot afford to be tolerated if sustainable reductions in health inequalities are to be achieved.

<sup>7</sup> Public Bill Committee (2010–11) Health & Social Care Bill. *Memorandum submitted by the Chartered Institute of Housing*

<sup>8</sup> Public Bill Committee (2010–11) Health & Social Care Bill. *Memorandum submitted by the Chartered Institute of Environmental Health*

<sup>9</sup> Health Committee—Twelfth Report (2011–12) *Public Health, Volume One*

<sup>10</sup> Department of Health (2010) *Healthy Lives, Healthy People*



5.2.6 It is clear from our research that the ability of districts to overcome barriers such as these shows a strong reliance on what the New Local Government Network (NLGN) call “soft” levers of power being exercised by both county and district councils (see diagram).<sup>11</sup>



5.2.7 Whilst we believe a statutory obligation on county councils would have ensured that counties apply these soft powers downwards earlier and more systematically, these powers need to be applied proactively upwards by districts. The lack of statutory role does not divest the sector of its key responsibilities in the new public health system. Our research shows that in the majority of cases, district and county councils have been active in exercising soft powers, particularly in two key areas:

- **Districts proactive internal preparation:** our research shows that 84.6% of district respondents have undertaken detailed work or preparation for their role within the new public health arrangements. Work includes building links (97.1%), evidence gathering (66.2%), identifying local needs & priorities (80.9%), indentifying PH services (57.4%), cost-departmental impact assessments (36.8%), designing local strategies and plans (41.2%).
- **Districts cooperating among themselves to develop and present a “district perspective” and counties being receptive to this collective voice on HWBs:** Our evidence suggests that the increase in “positive” engagement between districts and counties is largely due to counties being gradually more receptive to district council views. Alongside direct district representation, sub-locality or sounding boards are vital to this process, allowing districts a mechanism to feed information upwards to HWBs representing large geographical areas. Our latest public health survey showed that 64.9% of respondents were in some form of sub-locality, district or multi-stakeholder health & wellbeing partnership.

5.2.8 Our research has identified many examples of partnership work either well established or beginning to develop. We have also gathered a plethora of best practice material from districts on their on-going public health activity and preparations with partners. It is vital that this work is supported by the sector; the DCN’s on-going projects will continue to highlight the work of districts in the new public health system. This will help build on the work undertaken by the LGA and DoH (both past and on-going) to highlight the role of district councils in the public health system.

### 5.3 Partnership work between districts and CCGs

- 5.3.1 Overcoming any potential barriers to integration in two-tier areas will rely heavily on the relationships between clinically led CCGs and local authorities.
- 5.3.2 In two-tier areas, it will be equally important that districts, as well as county councils, form close working partnerships with CCGs to integrate and commission joint services, where appropriate. In our consultation response on the powers and duties of HWBs we stated our belief that HWBs should be required to specifically consider district and CCG integration when carrying out their statutory role in promoting integration.<sup>12</sup>
- 5.3.3 Our research has shown that districts have positively engaged with the sector so far, with 85.5% engaging with the sector in the lead up to the transition and 84.2% reporting this engagement to be positive. Moreover, 82% of districts which have formed a sub-locality HWB had local

<sup>11</sup> New Local Government Network (2012) *Healthy Places: Councils leading on public health*

<sup>12</sup> District Council Network (2012) *Consultation Response to: Joint Strategic Needs Assessments & Joint Health & Wellbeing Strategies—Draft Guidance*

CCG(s) as stakeholder on these boards. Examples of work already developing between the two sectors include forming local priorities and commissioning plans, managing joint assets and developing joint procurement plans. However, HWBs need to be aware that potential barriers do still remain between the sectors. Our members provided 51 additional comments on the potential barriers to integration at a local level, focusing on;

- Lack of interest/understanding of district council role amongst CCGs.
- CCGs lack resources & capacity to engage effectively.
- Cultural differences between two sectors (ie CCGs very clinically focused).
- CCG boundaries not aligned to district boundaries creating competing priorities for CCGs.

#### 6. *The financial arrangements underpinning local authorities' responsibilities*

6.1 In line with other bodies including the LGA, we believe that the overall funding levels for public health are comparatively low compared to the overall spend on healthcare services in England. To achieve radical acceleration in the prevention agenda and sustained reductions in health inequalities will need the policy rhetoric on system change to be matched by a commitment to make up for the historical short fall in public health funding the government recognised in the Public Health White Paper.<sup>13</sup> This must also be put in the context of the funding challenges facing local government, particularly the LGA funding projections up to 2020.<sup>14</sup> Nonetheless, the dedication of a ring-fenced public health budget is a step in the right direction.

6.2 The DoH has previously made it clear that they see “some devolution of the public health budget down to the second tier, without a doubt”.<sup>15</sup> We welcome this acknowledgment that in two-tier areas districts are well placed to deliver and commission public health services within their locality. Ultimately, this will be a decision for local HWBs in close consultation with district authorities. However, the DCN believes that it is inevitable that some form of funding devolution will occur, given districts' expertise in vital areas such as housing.

6.3 A key part of any potential funding devolution will be related to the incentive payment—the health premium. When introduced from 2015, HWBs will be paid additional funds for progress against the PHOF indicators. In two-tier areas the responsibility for achieving improvements in the outcomes framework will rely heavily on district council services, both directly and indirectly. For instance, indicators on homelessness, air and noise pollution form part of districts statutory duties, whilst district services significantly impact on community safety, physical activity and housing related indicators on injuries, falls and excess winter deaths.

6.4 It is our understanding that discussions are on-going at the DoH on how the health premium will be allocated in two-tier areas to take account of this issue. In many cases, especially in areas such as housing, environmental services and leisure provision, districts will continue to fund key public health interventions from their core revenue budgets. We agree strongly that this should be the case. However, the funding framework for the health premium must be designed so that it incentivises both county and district councils to make progress against the indicators, acknowledging the contribution of districts statutory and discretionary services whilst fairly allocating any reward-based grant. The DCN is committed to working closely with DoH, and other bodies, such as the LGA and County Councils Network, in agreeing a funding formula that is both fair and operationally practical.

October 2012

#### **Written submission from Professor Gabriel Scally**

##### **SUMMARY**

Improvement in the health of the population is one of the key tasks of civil society and it is appropriate that it is again going to be the task of local government in England. There are however serious concerns about the circumstances surrounding the transfer of some public health responsibilities from the NHS to local government. None of these are insuperable but unless they are recognized and dealt with it is unlikely that the transfer will be a success and, at worst, it may mark a deterioration in some aspects of public health.

##### **SOURCE OF SUBMISSION**

Professor Gabriel Scally is a senior public health physician who was, until March 2012, a Regional Director of Public Health in England. As the longest serving RDPH in the almost 40 year history of the post he is well placed to comment upon the current changes. Professor Scally's current post is Director of the WHO Collaborating Centre for Healthy Urban Environments at the University of the West of England. He has published widely on public health and, along with Sir Liam Donaldson, is joint author of the standard textbook “Donaldsons' Essential Public health”.

<sup>13</sup> Department of Health (2010) *Healthy Lives, Healthy People*

<sup>14</sup> Local Government Association (2012) *Funding outlook for councils from 2010/11 to 2019/20: Preliminary modelling*

<sup>15</sup> Health Committee—Twelfth Report (2011–12) *Public Health, Volume Two (Public Health Minister Oral Evidence)*

## COMMENTS ON THE KEY POINTS IDENTIFIED IN THE CALL FOR SUBMISSIONS

*The introduction of a public health role for councils*

The return of public health responsibility to local authorities is to be welcomed. There is a necessity for local authorities to examine their entire operation in respect of the duty to improve health. For example; the vast majority of local authority pension funds have significant holdings in tobacco companies. This will shortly be in conflict with the new duty. The new responsibilities will useful compliment current responsibilities such as environmental health, transport and planning.

*The adequacy of preparations for the new arrangements*

The preparations have been handled adequately given the uncertainties surrounding the structure and organisation of public health services.

*The objectives of the new arrangements and how their impact can be measured*

Given the split in responsibilities it is difficult to see how progress will be measured. There are substantial gaps in available data and the incorporation of the previously independent Regional Public Health Observatories and Cancer Registries into Public Health England (which is part of the Department of Health) does not provide reassurance that data and support around information will be forthcoming and free of central government interference.

*The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level*

The remit of Health and Wellbeing Boards that has been consulted upon recently by the Department of health is very disappointing in that it concentrates on the commissioning of services. This will have the effect of concentration attention on the Social Care/NHS interface and lead to the relative neglect of health improvement and the importance of action on the wider determinants of health.

*How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

At the centre of the answer to this question should be the Director of Public Health and his or her team of public health specialists. They should have a broad remit in regard to the full range of determinants of health in local areas and form effective partnerships dealing with major public health issues such as alcohol, tobacco, obesity, air pollution etc. It will be important that they are not seen as a peripheral component of local authority functioning and placed in a subservient role to other Directors within the management structure.

*Barriers to integration, including issues in multi-tier areas*

District Councils have important public health roles, such as environmental health, and should be full partners in broad based public health programmes.

*How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level*

There remains considerable and unacceptable uncertainty about the health protection function and failure to clarify arrangements may place local populations at considerable risk in the event of a major health protection issue occurring.

*The accountability of Directors of Public Health*

There has been a failure to learn from history, and Directors of Public Health are not placed appropriately in many local authorities. In some places the public health function has been seen as a minor concern because of its limited budget and the highly trained staff as a threat to other professional groups. This bodes ill for the future expertise upon which local authorities will be able to call.

*The financial arrangements underpinning local authorities' responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets*

The split of services and budgets between the NHS National Commissioning Board and local authorities may turn out to be disastrous for some important public health services and responsibilities. The areas of concern include screening, immunisation, health protection and sexual health. There are further genuine concerns about the allocation formula that is proposed for allocations to local authorities. If this is not handled properly the effects on services available to local people may be very severe.

### Written submission from the British Medical Association (BMA)

#### ABOUT THE BMA

The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of over 150,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

#### EXECUTIVE SUMMARY

- The BMA welcomes steps taken to move responsibility for public health into local authorities but is concerned that if reforms are not implemented properly it will lead to the fragmentation of the public health system.
- Clear guidance is required on what public health activities a local authority is expected to undertake and how ring-fenced funds for public health can be used by local authorities.
- For public health to remain an attractive specialty for the medical workforce there needs to be a unified set of terms and conditions, including pension rights, for those working in the new health service—whether they are based in local government, the civil service or the NHS.
- Directors of Public Health (DPH) need to be directly accountable to the Chief Executive (or their equivalent) of the local authority. All public health consultants should be employed on terms and conditions that, like their current NHS contracts, enable them to give, and be known to give, independent advice.

#### BACKGROUND

1. The BMA supports an increased role for local authorities in the delivery of public health, but there are serious concerns about some aspects of the reforms and how they will be implemented. Local government is ideally positioned to take on responsibility for aspects of public health, using the powers it has over housing, social services and schools as vital tools in improving the health of the population.

2. However, the scope of the public health system goes beyond this and the BMA is concerned that aspects of specialist public health work will not be adequately recognised in the fragmented public health system after 2013. The BMA has concerns that some local authorities do have not an understanding of public health as a distinct health specialty. Instead, they define public health as being any activity that improves the health of the population. This has led some authorities to view the public health reforms as a package of measures that gives them more money, and requires them to take on some staff to simply do more of the public health work which they already do. Some local authorities may fail to adequately address the new responsibilities that the Health and Social Care Act 2012 gives them.

3. Public health is a broad term which encompasses many activities and aspects of health policy. Public health activity can be described as any activity that in some way improves the health of a population. In order for local authorities to adequately lead on public health issues, the BMA believes that there needs to be clear guidance on what public health activities a local authority is expected to undertake and crucially limits the use to which ring-fenced funds for public health can be put by local authorities. The BMA also thinks it is vital that it is Directors of Public Health (DPH) that make decisions on what the budget is spent on at a local level.

4. The Faculty of Public Health's definition of public health is the 'science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society'.<sup>16</sup> The Faculty sets out three domains of public health: health improvement (including people's lifestyles as well as inequalities in health and the wider social influences of health), health protection (including infectious diseases, environmental hazards and emergency preparedness) and healthcare public health (including service planning, efficiency, audit and evaluation).<sup>17</sup> All three domains need to be addressed actively if the public's health and wellbeing are to be protected and improved. It is important to recognise the diversity of the public health workforce. The BMA represents many public health consultants who specialise in various aspects of public health. This highly specialised workforce have undertaken at least seven years of medical training in addition to five years specialist training required by the Faculty of Public Health. Many of these consultants will also have additional qualifications, such as a Masters or a PhD in public health.

5. The public health medicine consultant workforce provides expertise on all aspects of public health. They are not only committed to, for example, reducing childhood obesity, but are also able to use their years of training and experience to design a whole range of interventions based on local circumstances.

6. The BMA is concerned that local authorities will not be able to offer terms and conditions of employment that will be attractive to someone considering entering the public health consultant workforce, and thus there is a real risk that the expertise of this group will be lost in the future.

7. In recent years public health has developed as a medical and multi-disciplinary specialty that has become embedded within the NHS. It is important that moving public health responsibilities into local authorities does

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<sup>16</sup> Taken from [www.fph.org.uk/what\\_is\\_public\\_health](http://www.fph.org.uk/what_is_public_health)

<sup>17</sup> Taken from [www.fph.org.uk/what\\_is\\_public\\_health](http://www.fph.org.uk/what_is_public_health)

not mean that the NHS stops undertaking any public health work or that public health specialists stop having a role in the health service. Healthcare public health (HCPH)<sup>18</sup> specialists have a vital role in ensuring that Clinical Commissioning Groups (CCGs) offer a service that is cost effective, population based and patient oriented. A local authority that fails to appreciate the vital role given to their HCPH specialists by the Health and Social Care Act will be failing in its duty to improve the health of the population they serve.

#### THE INTRODUCTION OF A PUBLIC HEALTH ROLE FOR COUNCILS

8. Local government has always played a central role in the delivery of activity that impacts on the public's health and a strong case can be made both for very close working links between public health specialists and local government and for basing director level staff within local government. Prior to the implementation of the Health and Social Care Act 2012, this was achieved by making directors of public health (DPHs) joint appointments between primary care trusts (PCTs) and local authorities. The BMA, and a number of other organisations, expressed an initial conditional welcome to the idea that local public health teams would be located within local authorities.<sup>19</sup>

9. The BMA has concerns about moving the public health specialist workforce into local authorities without it being given the proper status and independence that is required for success. Whilst the BMA is aware of many examples of local authorities which embody integrated public health approaches<sup>20</sup> we also have concerns about some local authorities which appear to place little value in public health as an independent health specialty.<sup>21</sup> The importance of recognising that public health specialists operate within essentially a professional model and not an administrative or managerial model must be better understood.

10. If public health, as a distinct health specialty, is to be a success in local government, then it will be because its move will be seen as a widening of the "health system" so that this system incorporates work done by local authorities to improve the health of the population they serve.

11. The BMA is concerned that these reforms, rather than leading to a widening of the health service, could lead to its fragmentation—with public health experts leaving the NHS largely due to unattractive terms and conditions. This would deny the NHS expertise in the designing and commissioning of healthcare systems.

12. One way to counter this potential fragmentation is for there to be a unified set of terms and conditions, including pension rights, for those working in the new health service—whether they are based in local government, the civil service or the NHS. A failure to offer such equitable terms and conditions will undoubtedly lead to local authorities not being able to recruit the best public health doctors, who will instead seek jobs in Public Health England (PHE), CCGs the NHS Commissioning Board, or outside the publicly funded health service.

13. The reforms to the health service will also give local authorities a vital role in the training of the future public health workforce. Although public health registrars (those on the Faculty training programme) will be employed on NHS contracts, they will be training and working across the whole of the new public health system, including some local authorities. The BMA is hopeful that many authorities will recognise the added value that the trainee workforce can bring to their organisations, and will aim to offer a working environment that is attractive to both trainees and their trainers.

#### THE ADEQUACY OF PREPARATIONS FOR THE NEW ARRANGEMENTS

14. The current reforms to the public health service are the largest in over a generation and are being undertaken as the rest of NHS is undergoing reform and restructure. At the same time, the entire health service is trying to achieve unprecedented levels of savings<sup>22</sup> and local government funding has also been significantly reduced.<sup>23</sup>

15. The recent health service reforms have involved the disbanding of the main NHS organisations that employed public health staff—Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). These organisations have also been tasked with supporting the transfer of public health staff to multiple new employers (eg local authorities, PHE, the NHS Commissioning Board) whilst disbanding.

16. The result of this is that these reforms have left the public health workforce in limbo for over two years, with many uncertain as to where they will be employed in April 2013—or even whether they will be employed

<sup>18</sup> Healthcare public health is the domain of public health that focuses on using population health knowledge to improve health care systems by ensuring that they are clinically effective, efficient, and equitable.

<sup>19</sup> <http://bma.org.uk/-/media/Files/Word%20files/Working%20for%20change/healthyliveshealthypeoplemainresponse.doc>

<sup>20</sup> One such example is the plans for public health in Stockport County Council where the DPH will have a direct line of responsibility to the CEO and access to Councillors. In addition, plans have been made for a HCPH specialist employed by the local authority embedded into the local CCG.

<sup>21</sup> In each of Berkshire's six unitary authorities, there will not be an independent public health team under an independent DPH. Instead, there will be an Assistant Director of Public Health reporting to the Director of Adult Social Services.

<sup>22</sup> These savings, often referred to as the "Nicholson challenge" are a set of mandates that the current (2006–12) leader of the National Health Service in England, Sir David Nicholson, has put forth to the entirety of the NHS in a drive to find "efficiency savings". The parameters of the "challenge" by Nicholson to the NHS collectively add up to a demand for the NHS to find £20 billion in "efficiency savings" by 2015.

<sup>23</sup> Annual funding for local government from Whitehall is due to fall by 7.1% between 2011 and 2015 as part of the coalition's deficit reduction drive—[www.bbc.co.uk/news/uk-politics-15761117](http://www.bbc.co.uk/news/uk-politics-15761117)

at all. The BMA is aware that some public health doctors have recently received letters informing them that they will either be transferring to PHE or local authorities. However, other public health doctors have not yet been given the job description of roles in PHE into which they are hoping to be transferred. This means that they are unclear whether these are posts that they will fill automatically or whether they will be expected to compete with other doctors for these new posts. If these posts are subject to competition, the unsuccessful candidates are not guaranteed other posts in PHE.

17. Historically, reorganisations have always meant that consultants have left the specialty in large numbers. It should not be surprising therefore, that this uncertainty is having a significant negative impact on staff morale or that so many staff, and particularly senior staff, are leaving the English public health system.<sup>24</sup>

#### THE OBJECTIVES OF THE NEW ARRANGEMENTS AND HOW THEIR IMPACT CAN BE MEASURED

18. The Government's public health whitepaper *Healthy Lives, Healthy People*<sup>25</sup> provides a response to Professor Sir Michael Marmot's report *Fair Society, Healthy Lives*.<sup>26</sup> In particular it argues for a need to tackle the wider social determinants of health. It recognises that public health expertise must not be limited to within the health sphere, but should impact upon the decision making process in both local and national government. As such, it reflects the maxim that Parliament is the pharmacy of public health—most clearly shown by the significant gains to the nation's health brought about by the 2007 decision to ban smoking in the workplace.

19. The BMA welcomes this increased opportunity of public health teams to impact upon local and national government policies. However, as mentioned above, this opportunity must not be to the detriment of specialist public health's ability to influence and shape the health service as a whole. In particular, DPHs and their teams must be able to act as the bridge between the NHS and local authorities if the health system is not to become fragmented.

20. The ability for public health teams to have an influence on local and national policy making is also dependent on the status and independence of those giving the advice. For this reason, the BMA has been arguing for DPHs to be directly accountable to the Chief Executive (or their equivalent) of the local authority and for all public health consultants to be employed on terms and conditions that, like their current NHS contracts, enable them to give, and be known to give, independent advice.

#### THE INTENDED ROLE OF HEALTH AND WELLBEING BOARDS IN COORDINATING THE NHS, SOCIAL CARE AND PUBLIC HEALTH AT THE LOCAL LEVEL

21. Health and Wellbeing Boards (HWBs) will be vital to the coordination of the new healthcare system. They will need to take a broad and holistic view of the health and social care system and must deliver strong and credible leadership across local organisational boundaries. As such, the input and advice of a fully-trained and properly regulated DPH will be vital in ensuring that HWBs are seen by CCGs as credible organisations with an understanding of healthcare commissioning.

22. It is also vital that they should not become just "talking shops", but are instead given powers to hold to account robustly all of the various stakeholders across the fragmented health and social care system.

#### HOW THE TRANSFER TO LOCAL AUTHORITIES OF THE FRONT-LINE HEALTH PROTECTION ROLE AND THE CREATION OF PUBLIC HEALTH ENGLAND WILL AFFECT RESILIENCE ARRANGEMENTS AT THE LOCAL LEVEL

23. The BMA recognises the merits of having a single central agency, like PHE, as the hub for national level health protection and fully support this approach. However, the BMA has concerns that the current proposals do not address the need to establish and maintain an effective health protection workforce at the front line (that is, at the local authority level).

24. The BMA believes that the reforms have failed to appreciate that the primary role of the Health Protection Agency is not to deal directly with individual health protection cases, but is instead to provide advice and support to health protection staff working in PCTs. There is a real danger that this failure to recognise how health protection incidents are currently managed will result in local authorities not being provided with the resources—both in terms of finances and staff—to deal with the new responsibilities they are being given to protect the public.

25. The fragmented nature of the new health system will require that each organisation (including the NHS Commissioning Board, PHE, local authorities and CCGs) are aware of the plans in place to deal with potential outbreaks of ill health, such as pandemic flu or legionnaires disease. Such an outbreak would also require a clear delineation of responsibilities across these organisations at local, national and regional levels. However, the Health and Social Care Act 2012 is not clear on these lines of responsibility. As such, it is possible that

<sup>24</sup> The lack of recent surveys of the workforce make it impossible to state with certainty the numbers of doctors who have already left the system. However, it is notable that of the 18 doctors on the BMA's Public Health Medicine Committee (PHMC) who were working in the English public health system in October 2011, six have since left it. Of these, two have been made redundant, two have left the UK to practice abroad, one has joined a Clinical Commissioning Group and one has gone to Wales.

<sup>25</sup> Department of Health (2010) *Healthy Lives Healthy People*. London, Department of Health.

<sup>26</sup> The Marmot Review (2010) *Fair Society, Healthy Lives*. London: The Marmot Review.

different areas of the country will develop different ways of dealing with outbreaks. This will be problematic for those organisations that have a national role and who will therefore have to tailor their responses to local plans. This could lead to inefficiency, duplication of effort and ultimately put lives at risk.

#### THE ACCOUNTABILITY OF DIRECTORS OF PUBLIC HEALTH

26. The BMA welcomes the recent clarity given over the roles and responsibilities of Directors of Public Health.<sup>27</sup> The role of a DPH will be to shape the culture and practice of local government to deliver services in ways that support the health and well being of the local population. Their importance is derived not from the size of their budget or the staffing of their department but from the nature of their task—improving and protecting the health of their patients—the population they serve. The BMA believes that in order to be able to effectively advocate for their patients the DPH must report directly to the Chief Executive Officer (or equivalent) and have the right of access to elected members.

27. We are concerned to hear reports that some local authorities wish to have their public health teams report to, for example, their Director of Adult Social Services. One such example is the planned structure in Berkshire, where the county's six unitary authorities would share a strategic director of public health. Each authority would also have an assistant director of public health, who would be managed by their respective director of adult services. It is our view that these arrangements effectively make these public health teams a subcategory of adult services in each of these local authorities, stopping them from being effective across the full remit of their responsibilities.

28. The BMA believes that all public health specialist post holders, including DPHs and consultants, should, as a minimum, be registered either with the GMC or with the UK Public Health Register (UKPHR) and be competitively appointed through an advisory appointment committee (AAC). This is to ensure that those responsible for providing vital advice of a technical nature are appropriately qualified to do so and that the public can be assured of their competence. Ideally, the BMA would like there to be statutory regulation of all specialists in public health, as recommended by the Scally Review.<sup>28</sup>

#### THE FINANCIAL ARRANGEMENTS UNDERPINNING LOCAL AUTHORITIES' RESPONSIBILITIES, INCLUDING THE RING-FENCING OF BUDGETS AND HOW THE NEW REGIME CAN LINK WITH THE OPERATION OF COMMUNITY BUDGETS

29. The BMA is concerned that there still remains a lack of clarity over what services are to be funded from the public health budget and, most fundamentally, how much money will be allocated to local authorities. This lack of clarity is causing understandable and significant concerns within many local authorities. It is also leading some local authorities to state that they cannot afford to employ the public health teams due to transfer to them in just over five months time.<sup>29</sup> This is, in turn, causing further concern among those staff due to transfer.

30. The idea of a ring-fenced budget is attractive to the public health workforce. However, due to the nature of public health practice (in which, for example, a good case can be made for spending "public health" money on housing) it is also vital that it is the DPH who decides what the budget can be spent on. This will ensure that public health money can be added to other departments spending when the DPH thinks that doing so will have a significant impact on the health of the population. Such examples of integrated spending are vital if public health is to be a success in local government. Public health advice cannot be sought at the end of a project, when it can make only cosmetic and peripheral differences. Instead, public health advice must be involved from the very beginning and must be embedded within the work.

31. It is also important that there exists robust and external monitoring of the ring-fenced budget. As such, the BMA believes that PHE and the relevant CCG should have a role in monitoring the integrity of the ring-fence.

October 2012

<sup>27</sup> Department of Health (5 October 2012) *Directors of Public Health in Local Government*, London, Department of Health

<sup>28</sup> Department of Health (2010) *Review of the regulation of public health professionals*. London, Department of Health

<sup>29</sup> NHS Surrey recently told health unions it cannot state whether existing PCT staff will transfer to exactly the same jobs when public health moves, as the county council refuses to confirm its plans before government funding is announced in December. Councils on the south-east coast have told the BMA there is insufficient money to accept all public health staff when the final spending allocations are announced. Local authorities in London have called on PCTs to restructure public health before it is transferred, as they fear they will not be able to afford existing services. See <http://bma.org.uk/news-views-analysis/news/2012/september/public-health-panic-warning> for more details.

## Written submission from the Royal College of Nursing

### 1.0 INTRODUCTION

1.1 With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the UK Governments, the UK Parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes this opportunity to make a submission to the Communities and Local Government Select Committee inquiry into the role of local authorities in health issues.

### 2.0 EXECUTIVE SUMMARY

2.1 Nurses play a pivotal role at all levels of health care commissioning and provision. It is vital that their expertise is used by local authorities within the new system, both for service planning and delivery.

2.2 The RCN supports localised public health planning and supports local authorities to have the necessary autonomy to deliver on this.

2.3 During the transition period of responsibility for public health from the NHS to local authorities, skilled staff must be retained by local authorities. The RCN is concerned that many staff, and therefore their knowledge, are not being retained and are not moving to the new structures.

2.4 NHS staff have faced much uncertainty over their future, better efforts must be made to ensure good communication to keep staff on side.

2.5 The link between poverty and poor health outcomes must be acknowledged and taken into account by the public health funding allocations.

2.6 Without sufficient investment in preventative care and public health interventions the NHS will be left to deal with the huge cost of acute care and long term conditions.

2.7 The RCN supports a focus upon patient outcomes through a robust national outcomes framework that allows for local variations and relevant local decision making powers.

2.8 Health and wellbeing boards (HWBs) have the potential to play a very significant role in promoting integration of services and providing multidisciplinary oversight.

2.9 Directors of Public Health (DPHs) must be appointed with sufficient focus and autonomy to allow them to oversee effective services for their localities. To allow them sufficient authority they should report to the Chief Executive. However, the RCN is concerned that this is not happening.

2.10 Ring fenced public health budgets are to be welcomed. However, the RCN is concerned that in some situations public health budgets may be pooled with other budgets and then be subjected to cuts.

### 3.0 *The introduction of a public health role for councils*

3.1 Nursing staff carry out public health activities in nearly every context and at every level of health care provision, including public health services and health prevention. Nurses will, in fact, be carrying out the majority of the public health interventions that local authorities will be responsible for after April 2013.<sup>30</sup>

3.2 Nursing's presence at almost every stage and setting of care means they are engaged across a whole spectrum of public health interventions. Nurses are able to view individuals' needs and circumstances holistically to understand the full package of support and care required. Nurses reach deep into the heart of families and communities. They are confronted daily with the consequences of social conditions on the health and well-being of the communities they are caring for. The RCN believes that the unique perspective of nursing expertise should be fully utilised in the new Public Health system.

3.3 The RCN supports proposals for local authorities to have sufficient autonomy to develop public health services designed to meet local need. We also agree in principle with the new responsibilities assigned to local authorities for health improvement.

3.4 However, the RCN has concerns that during the period of transition staff working in public health have faced uncertainty about their future. Staff have faced restructuring, budgetary cut backs and uncertainty over transition arrangements. Every effort must be made to retain and develop the public health workforce and to clarify transition arrangements which are still outstanding to allow the public health community to move forwards within the new system. It is vital for the success of the transfer that staff are adequately engaged with and informed about the transition process.

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<sup>30</sup> Healthy Lives, Healthy People: Update on Public Health Funding Annex C



3.5 The RCN believes that in order to successfully deliver for the future public health needs of the country the Government must recognise the links between poverty, incomes and poor physical and mental health. The RCN has serious concerns that the welfare reforms currently being introduced may be counterproductive for the health and wellbeing of some vulnerable sectors of the population.

3.6 In the RCN response to the Public Health White Paper for England, *Healthy Lives, Healthy People*, we called on the Government to recognise the links between low incomes (amongst both the employed and unemployed) and poor physical and mental health. Poverty and low living standards are powerful causes of poor health and health inequalities.<sup>31</sup> The impact of the financial climate is having significant implications for the health status of the least well off in society. The RCN has concerns that the currently proposed funding allocations are not adequately weighted to address the health inequalities of the poorest the most expedient way.

3.7 Nurses recognise that until the root causes of illness and poor health behaviours are tackled, the NHS will constantly be required to deal with the long term health consequences. Strategies for reducing health inequalities will never be effective if they fail to address the endemic social and economic inequality in the UK.

#### 4.0 *The adequacy of preparations for the new arrangements*

4.1 It is vital that the transfer of skills is prioritised and facilitated alongside the transfer of money and financial responsibility for the commissioning and delivery of public health services.

4.2 We are still waiting for some Primary Care Trusts (PCTs) and local authorities to share their plans for the transition of public health services locally with trade unions. The transfers of public health responsibilities to local authorities is happening alongside wider and more complex health reforms and it is unfortunately not always clear how these are being managed.

4.3 In order to bring some consistency and support to the process the RCN, alongside other relevant trade unions, has suggested setting up a Staff Commission. This Staff Commission would be an independent body established to provide a route to resolve disputes for former public health staff on issues relating to their transfer from PCTs into local authorities. Such a commission would take on cases that thus far have not been resolved through the authority's internal grievance procedure.

4.4 The objective is that the majority of issues can be resolved locally and that the Staff Commission will not therefore be called upon too often. The purpose of the Commission is to consider appeals on issues arising as a direct consequence of the transfer of staff from the PCT into local authorities under the Health and Social Care Act 2012. The RCN believes the Commission would greatly help to facilitate what is a complex and sometimes difficult transition.

#### 5.0 *The objectives of the new arrangements and how their impact can be measured*

##### 5.1 Outcomes framework

5.2 The success of the new arrangements should be measured by the improving health of individuals and the population as a whole. Therefore, the RCN supports the focus on patient outcomes within a national framework that allows for comparisons, bench-marking and for local responses. This approach should help to ensure that populations across England are not disadvantaged through poor commissioning, poor delivery or inappropriate allocation of resources.

5.3 The RCN supports a model of explicit overlap between the frameworks for all levels of health and social care. Integration of services is key to improving efficiency and providing better patient care and outcomes. We believe isolating segments of health provision will be a barrier to service ownership and will fragment services.

5.4 Outcomes frameworks, although useful and important, do not always tell the whole story of a patient's care. It is important to recognise that outcomes are influenced by issues such as staffing and skill mix, internal processes such as team work, leadership, safety systems, supervision and the culture of the organisations in which people work.

5.5 The RCN believes that there would be value in including, within an outcome framework, measures that are linked to the health and wellbeing of the public health workforce. Such measures would include staff access to occupational health services, as these are now shown to have an impact on the quality of services and care delivered for patients.

##### 5.6 Health premium

5.7 The RCN supports the work of the Advisory Committee on Resource Allocation's (ACRA) expert group in considering the formula for health premium payments so that disadvantaged areas will see a greater incentive if they make progress. This recognises that they face the greatest challenge to attain an increase in outcomes. The RCN looks forward to the final recommendations of this expert group.

<sup>31</sup> [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html)

5.8 However, this greater incentive will be of little assistance to those areas that fail to make any progress as a result of the comparative greater disadvantage of their populace. This can only be remedied by including a weighting of the public health allocation to reflect the deprivation that an area experiences.

#### *6.0 The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level*

6.1 HWBs have a duty, established in the Health and Social Care Act, to encourage integrated working between all health and care providers and commissioners. This means, for example, encouraging the use of pooled budgets, lead commissioning and integrated provision. The RCN supports the boards' purpose.

6.2 Whilst supporting the role of these boards the RCN has identified a number of key challenges, which if not addressed, may prevent Boards being able to effectively carry out this duty. Furthermore, the legislation governing the boards is not prescriptive and their form and roles are likely to be subjected to a large degree of local variation.

6.3 Nursing insight is particularly important in any efforts to integrate care pathways, both within health and across the care systems. Nurses understand the holistic needs of patients and they play a key role in anticipating service gaps. If the reforms are to succeed, meaningful engagement and involvement with frontline staff is vital. Along with other professionals, nursing staff will need to be looked to for leadership and representation at all levels of decision-making in the new system.

6.4 The RCN is concerned that funds have not been allocated to the Boards, leaving local authorities to provide resources. This could mean they will struggle to act independently of the local authority, or to work in meaningful partnership with representatives from other organisations.

6.5 Alongside the issue of funding is accountability. It is unclear to whom HWBs are accountable. Government states that they will be accountable to local people through having local councillors as members of the board who are accountable through election. The RCN does not believe this is adequate.

6.6 Local Strategic Partnerships (LSPs) will continue to exist in some places, potentially causing confusion. These bodies are, not dissimilar to HWBs, composed of a range of representatives from local authorities, the NHS, and the voluntary, community and private sectors aimed at encouraging integrated approaches and joint working. As a result there are overlapping membership and purpose for some HWBs and LSPs, which may cause confusion and duplication.

6.7 Whilst their statutory existence is an important first, the strategic role and powers at the disposal of HWBs are, in truth, similar to those of previous arrangements. Indeed, the powers and influence of health and wellbeing boards, Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) in relation to Clinical Commissioning Groups (CCGs) may not be sufficiently robust in legislation. It remains to be seen whether health and wellbeing boards will have any real power in challenging commissioning decisions, or how or what action the NHS Commissioning Board will take in local disputes.

6.8 Early implementers and shadow HWBs have demonstrated many different approaches to their role in view of local priorities. The undefined scope of their role presents challenges. For instance, some boards are unclear about their role in relation to acute service provision whilst others see a very clear role for themselves in influencing hospital commissioning and play an active role in doing so.

6.9 The RCN is also concerned that there are not uniform measures to evaluate the success and impact of HWBs. Previous partnership arrangements had clear targets and data sets to measure their success and impact by. HWBs will, by comparison, determine their own evaluation mechanisms. Some may be tangible, for example monitoring success against the NHS outcomes frameworks. Some may be less tangible, such as evaluating whether partnership arrangements are working well. Local variations will make it difficult to compare their achievements and apply learning across the country. This also increases the very real risk of increasing the postcode lottery in service provision.

#### *7.0 How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

7.1 The RCN is clear that whilst there are opportunities for improving services at a local level, services do not operate in a vacuum. Central government policy is the largest influence upon people's economic and social circumstances. The links between low incomes, both amongst the employed and unemployed, and poor physical and mental health must be recognised in the development of any policy.

7.2 The RCN is concerned that the budget available for prevention work is relatively small. The desire to show progress against outcomes framework measures will divert resources from preventing ill health from occurring in the first place.

7.3 Local authorities will fund all prevention work out of their allocation of 42% of the Public Health Funding budget. However, our RCN Public Health Network understands that £2.2 billion, more than half of the Public Health money going to local authorities, has been identified as necessary spend for sexual health

and substance misuse services, which are demand-led services. This presents real problems and significantly reduces the funding available to invest in prevention work on issues like obesity and smoking.

7.4 The Public Health White Paper for England, *Healthy Lives, Healthy People*, clearly outlined the prevention agenda of increasing spend on public health issues before they become an issue for a population. The RCN has concerns that this agenda is being undermined and risks being neglected altogether if the importance of public health prevention work is not adequately reflected in the prescribed functions for local authorities.<sup>32</sup>

#### 8.0 *Barriers to integration, including issues in multi-tier areas*

8.1 HWBs will play a key role in facilitating integration and co-operation. However, if boards are too big, meaningful discussion and decision-making becomes difficult. If boards are too small, the views of appropriate representatives will not be heard and challenges will not be appropriately understood and acted on. Partnership working arrangements will, therefore, be tested more in larger local authority areas, with second tier district councils, urban and rural areas and potentially several CCGs to include.

#### 9.0 *The accountability of Directors of Public Health*

9.1 Directors of Public Health (DPHs) will have a critical role in the leadership and management of public health services and initiatives. They must retain the authority and independence to advise and guide public health decisions. The RCN believes that Directors of Public Health should be appointed on an executive level and be accountable to the local authority Chief Executive. We are aware that unfortunately in some localities this is not the case.

9.2 DPHs are to have control over ring-fenced budgets within local authorities and are to act as strategic leads for all public health services. Annual accounting must demonstrate that directors of public health have the freedom to act and implement their public health plans. Structures within local government must not adversely influence strategic plans or divert funding.

9.3 The Secretary of State for Health must, by virtue of the Health and Social Care Act 2012, have due regard to health inequalities. This will form part of the conditions of the grant for the ring fenced public health budget. The annual report of the DPHs should be underpinned by this commitment.

9.4 DPHs have a professional responsibility to produce an honest and unbiased annual report. Correspondingly, they should have the professional independence to speak out on public health issues within their area. The DPHs should be supported and empowered by their employing local authority to carry out all public health duties necessary.

9.5 It is concerning that there remains a lack of clarity regarding the role of DPHs in relation to the medical role of responsible officer. This should be clarified as soon as possible whilst also underlining the principle that the role of DPHs is a role suitable for candidates who are not from a medical background, ie are not a doctor.

9.6 The RCN believes there must be parity of pay for professionals who undertake a particular role. DPHs should receive salary based on skills and experience rather than on their professional background.

9.7 The RCN looks forward to the publication of guidance clarifying that the Public Health England, on behalf of the Secretary of State, will not authorise job descriptions that do not include an appropriate span of responsibility for improving and protecting health.

#### 10.0 *The financial arrangements underpinning local authorities' responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets*

10.1 The RCN welcomes the commitment to ring-fence public health spending. However, we also recognise that all public sector bodies currently have to make significant financial savings. To ensure the development of an effective public health service, it is imperative to have financial protection. The Public Health White Paper noted that "existing functions in local government that contribute to public health will continue to be funded through the local government grant".<sup>33</sup> The RCN is concerned that in reality this may not be honoured and this must be monitored.

10.2 The Secretary of State for Health has set the size of the budget available to the NHS Commissioning Board and Public Health England, as well as the size of the ring-fenced public health grants provided to Local Authorities.<sup>34</sup>

10.3 *Healthy Lives, Healthy People: Update on Public Health Funding* paragraph 3.6 makes reference to pooling the ring-fenced public health grant with local authority funds being used for a similar purpose. The RCN seeks assurances that financial reporting will examine these pooled funds closely and seeks further details

<sup>32</sup> Healthy Lives, Healthy People: Update on Public Health Funding, Annex F

<sup>33</sup> Healthy Lives, Healthy People: Our strategy for public health in England p. 58

<sup>34</sup> Baseline spending estimates for the new NHS and Public Health Commissioning Architecture [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132540.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132540.pdf)

of the safeguards that will be built into the financial reporting system to ensure that the ring-fenced public health grant is being used appropriately.

10.4 The RCN notes that in paragraph 3.8 of *Healthy Lives, Healthy People: Update on Public Health Funding* there is a commitment that the conditions for the public health grant will set out the reporting requirements that local authorities will need to adhere to, over and above the standard reporting requirements. We look forward to further details regarding the categories, the reporting arrangements and the final supporting guidance. We also seek a commitment that these reports will be public documents for full transparency within the public health system.

October 2012

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### Written submission from Age UK

From 1 April 2013 large local councils will assume responsibilities for public health, and Health and Wellbeing Boards will be established to help encourage integrated working and joint strategies on health and wellbeing. The House of Commons Communities and Local Government Committee has invited submissions from interested parties on the future role of English local authorities in health issues.

#### KEY POINTS AND RECOMMENDATIONS

- Local authorities will need to work towards producing accurate and representative joint strategic needs assessments that emphasise and support active ageing and participation for older people.
- Achieving integrated services is vital and must run alongside addressing long-standing issues such as social care reform and working cultures.
- Local authorities will also need to ensure their roles as commissioners and providers of care do not act as a barrier to joined-up work, for example by delaying discharge from hospital.
- Local authorities must have a robust approach to equality, particularly with regards to age, a protected characteristic for goods and services since October 2012.
- Approaches to public health must never exclude older age groups or be victim to attitudes that see later life as a period of decline rather than activity.
- Local authorities must undertake their new and existing duties with full support for shared decision-making and a rigorous approach to community involvement.

#### 1. INTRODUCTION

1.1 As the majority users of both NHS and social care services, older people have a huge stake in the performance of local authorities, particularly as authorities take on greater responsibilities in relation to public health. Delivering, and supporting, a better later life are fundamental purposes of public health. Improving the lives of older people must be central to the work of local authorities.

1.2 The need to achieve wide-ranging change to the NHS, social care and public health is well understood. Delivering coordinated and joined-up care; better service-user experience; age equal services; and long-needed reform of social care must be key priorities for national and local government.

1.3 We believe that local authorities' new duties with regards to health can make a significant contribution to delivering these aims. This response sets out how we believe local authorities should respond to these changes.

#### 2. HEALTH AND WELLBEING BOARDS

2.1 In principle, we believe that Health and Wellbeing boards have a very real potential to be transformative. At the very least, the duties of the Health and Wellbeing Boards will ensure that leaders in health and social care, along with other key stakeholders, will be meeting and discussing where before many have not previously cooperated.

2.2 However, while integration of health and social care will be an important component of their work, Health and Wellbeing Boards must place an equal emphasis on needs assessment and take a broad view of local services and the living environment, including housing needs and public spaces.

2.3 A key part of their work will be producing accurate and representative joint strategic needs assessments (JSNAs). Local Age UKs have told us that there has traditionally been an over-emphasis on health conditions and dementia when addressing older people's needs in JSNAs. While extremely important, this does little to influence policy to support active ageing and participation and those aspects of later life that are meaningful to older people.

2.4 Such an emphasis risks, as has happened in the past, concentrating on addressing health and support needs rather than helping to maintain as active a life as possible. There are serious deficits in the level of health and social care available to older people and we would expect Health and Wellbeing Boards to prioritise work

to fill these gaps. However, to be truly transformative they must incorporate four stages of activity for people of all ages: public health; prevention; meeting acute need; and managing long-term wellbeing.

2.5 With these stages in mind, it is disappointing that housing does not have a formal position in Boards' membership and that the role of primary care remains unclear.

2.6 We have seen some initial work from Health and Wellbeing Boards that is very encouraging in terms of delivering change in line with the principles of proactive support and prevention. Cultivating an environment in which good practice is shared and performance compared across local authority borders will be extremely important. For example, local Age UKs have been involved in "age-proofing" JSNAs. We would encourage the Department of Health and the Department for Communities and Local Government to help widen involvement of public and community groups in this way by promoting best practice examples and by incorporating such activity into assessments of equality duties.

### 3. INTEGRATION

3.1 Local authorities have a responsibility for delivering and overseeing coordinated and joined-up services. Many aspects of the healthcare reforms give local authorities, and Health and Wellbeing Boards in particular, a central role in achieving integration. This is a huge task and will need to be sustained as a priority for health, social care and communities policy—not just as a stated aspiration but as a future operating principle for the NHS and local authorities.

3.2 There are a number of immediate high-level challenges that will need to be overcome to achieve this:

- 3.2.1 a fair funding settlement for social care reform;
- 3.2.2 working principles and approaches that cross health and social care (social care uses a rights-based approach addressing individual, long-term outcomes whereas healthcare is based on need at a particular point in time);
- 3.2.3 differences in the professional ethos of health and social care professionals and leaders; and
- 3.2.4 transition points between services and agencies (and maintaining clarity around what is social care, and therefore means-tested, and healthcare which is free at the point of use).

3.3 We believe such barriers remain a fundamental block to achieving long-lasting change to the delivery of joined-up care. Structural and administrative approaches—such as pooled budgets; multidisciplinary teams; care coordinators—often dominate the debate on integration. Such approaches can have a role in delivering integrated care, but local authorities, alongside any targeted work on integration will need to build in long-term change to tackle the challenges set out above.

3.4 Local authorities, as a service provider and commissioner, will need to be better at setting appropriate outcomes and measuring these effectively. Older people can often be assessed with lower-level outcomes in mind when compared with other age-groups. For example, neglecting to account for a desire to maintain social relationships; a desire to work or volunteer; and wider personal fulfilment. Where local authorities have a role in defining how services are planned and delivered, they must define and work towards outcomes that are meaningful to older people and that fully align with their healthcare needs.

3.5 Local authorities will also need to ensure their approach as a commissioner of care does not act as a barrier to joined-up work. We receive reports that social care providers actively prevent discharge from hospitals because social care packages are not ready or they deliberately delay setting packages up to help spread their costs. Some health professionals have told us this has got worse since the recent spending cuts. Local authorities' responsibilities to promote health and wellbeing must stop this happening.

### 4. HEALTH INEQUALITIES

4.1 With widening health responsibilities, local authorities must have a robust approach to equality. Age was only added as a protected characteristic for goods and services in 2010 and implemented in October 2012. We are not yet confident that public bodies are fully aware of the requirements within the public sector equality duty with respect of age.

4.2 An initial analysis by Age UK has shown that awareness of the Equality Act 2010 with regards to age is mixed and the use of the public sector equality duty (PSED) is variable. There is evidence in some areas of the benefits of the PSED in planning, which we believe will help not only to promote equal outcomes but also reduce the risks of decisions being challenged later. Local authorities must accelerate their efforts to respond to age as a protected characteristic for goods and services.

4.3 In light of this, we are extremely disappointed by the guidance published by the Government Equalities Office (GEO).<sup>35</sup> We believe it sends out a counter-productive message on the new provisions of the Equality Act and risks undermining the principles of objective justification, for example by using what could be described as stereotypes to explain a "legitimate aim". Age as a new, and potentially misunderstood, protected characteristic could struggle in light of their approach.

<sup>35</sup> For example, *Equality Act 2010 Banning Age Discrimination In Services: An overview for service providers and customers*, GEO, 2012

4.4 We would also recommend that local authorities make an assessment of access to essential services such as primary care for residential care and nursing home residents. Evidence from the British Geriatrics Society, for example, suggests that access to healthcare in particular is restricted for this group of people.

## 5. PUBLIC HEALTH

5.1 Age UK welcomes the transfer of public health to local authorities as it presents an opportunity to address the complex needs of older people in the round. We believe that local authorities are in an ideal position to drive the creation of healthy neighbourhoods and community spaces that support a healthy and active lifestyle.

5.2 Participants in Age UK research defined a healthy lifestyle as:

- 5.2.1 a positive frame of mind;
- 5.2.2 a balanced diet;
- 5.2.3 keeping active;
- 5.2.4 mental stimulation; and
- 5.2.5 social contact.

5.3 Traditionally, public health initiatives have focused on similar outcomes but often focused on younger age groups. Meeting the needs of younger age groups is absolutely right and is essential for improving long-term population health. However, such approaches should never exclude older age groups or be victim to attitudes that see later life as a period of decline rather than activity. This may need to be re-emphasised with local authorities which have increasingly sought to address only critical needs through social care assessments. A wider health role will mean re-calibrating authorities' approach to ensure an equal focus on prevention and managing a wider spectrum of needs.

5.4 We support the ring-fencing of public health funding. However, past experience suggests that activities that are not strictly relevant to a particular budget are included to address a shortfall elsewhere. This could be justified, and to some extent encouraged, in supporting innovative and broad approaches to public health. However, we would expect the use of budgets to be carefully monitored.

5.5 This is also why it will be important to measure outcomes appropriately. For example, not only aiming to reduce X number of smokers but seeking to measure levels of participation in society.

## 6. PATIENT AND PUBLIC ENGAGEMENT

6.1 The Health and Social Care Act was prefaced by the principle of achieving “no decision about me without me”, to which many in the voluntary sector have sought to supplement with “no decision about us with us”. As will be the expectation for healthcare, so must local authorities undertake their new and existing duties with full support for shared decision-making and a rigorous approach to community involvement.

6.2 Local Age UKs have reported a number of barriers in helping to achieve a robust understanding of local needs when working with local authorities:

- 6.2.1 Sustaining relationships with key staff in the local authority can be challenging, for example because of changes in personnel and/or responsibilities.
- 6.2.2 The use of jargon and complex data can exclude people without special knowledge or expertise.
- 6.2.3 Pressures on time and cost as well as difficulties attending regular meetings act to exclude smaller local groups from participating in, for example, JSNAs. Often those groups represent some of the most marginalised people.

6.3 There are some simple measures which should be incorporated into local authorities' approach to local engagement. For example, financial support to help people to attend meetings or host local engagement events must be encouraged, particularly as funding for this activity is at risk of being deprioritised as part of wider cuts to local authority budgets. The cost is relatively small but developing an effective infrastructure for consultation (eg support for older people's forums) could help to rationalise any spending. At the very least, this kind of engagement must be valued by leaders in local authorities and not simply seen as an administrative milestone.

6.4 Some local Age UKs have already raised concerns about restricted opportunities to engage with the new bodies. For example, in some areas, Local Healthwatch is seen as the only realistic route to engage with Health and Wellbeing Boards. As patient and public champion, Local Healthwatch has an important role in supporting community engagement. However, local authorities must not be allowed to believe that Local Healthwatch are the sole conduit for working with the public.

6.5 Finally, to support effective engagement, local authorities must support access to and the use of data. Age UKs own experience is that important population data, for example, is extremely hard to get and not

always accurate (and subject to change after publication). Local authorities must have an open approach to data and maintain the consistency and integrity of the information they hold.

October 2012

### Written submission from the Royal Town Planning Institute

#### INTRODUCTION

The Royal Town Planning Institute (RTPI) is pleased to respond to the call for written evidence to the Communities and Local Government Committee on the future role of English local authorities in health issues. The RTPI is the largest professional institute for planners in Europe, representing some 23,000 spatial planners. The Institute seeks to advance the science and art of spatial planning for the benefit of the public. As well as promoting spatial planning, the RTPI develops and shapes policy affecting the built environment, works to raise professional standards and supports members through continuous education, training and development.

The RTPI has been engaged in building links across the planning and health disciplines since 1991 when we held our first conference on the role of spatial planning in the delivery of public health objectives.

#### EXECUTIVE SUMMARY

- Health improvements will not be achieved by improvements in just one part of the system alone, and a whole-system approach to health issues must be adopted.
- A holistic approach to measuring improvements in health issues needs to be introduced across local and national government.
- Vital that strategies prepared by health and wellbeing boards are fully taken into account into the commissioning plans of clinical commissioning groups.
- Good planning for health services with community involvement can help improve mental health and wellbeing of members of that community, and help to promote community cohesion, which will in turn help to reduce crime rates.
- Health services, when planned into town and district centres, will act as a springboard for the wider economic regeneration of an area.

#### *The introduction of a public health role for councils*

1. The RTPI broadly supports the return of the public health role to local government, as it has a powerful influence on the drivers of health such as spatial planning and transport. It is vital that the opportunity for local authorities to develop new relationships with GPs, dentist and other primary care professionals be fully grasped in order for integrated working to flourish.

2. In order to maximise the benefits arising from the transfer of public health, there is a need to ensure that other departments involved in shaping the wider determinants of health, such as planning and transport authorities, are given training on how to build up an effective dialogue with health and wellbeing boards. Sandwell's health and wellbeing board, which has been in place since June 2011, has structured its Joint Health and Wellbeing Strategy (JHWS) according to the six policy objectives of the Marmot Review,<sup>36</sup> including integrating public health, planning, transport, housing and environmental services. Sandwell's approach is a positive step to addressing the Department of Health's own concerns that "the ways that the NHS works with other services is often an issue that needs improvement to prevent hard-to-reach groups falling through the gaps. Partnership working with other public services should be seen as a core part of what the NHS does, not an optional extra."<sup>37</sup>

3. This is also an issue which is seen as one of the key recommendations in the UCL-Lancet Commission's report "Shaping Cities for Health: complexity and the planning of urban environments in the 21st Century",<sup>38</sup> which states that progress in alleviating public health will need to be achieved through involving "practitioners and communities in active dialogue and mutual learning".

4. There is also a need to ensure that public health professionals moving into local authorities are sensitive to the existing and ongoing work supportive of public health which many professions there such as environmental health and spatial planning are already doing. Local planning authorities are bound by the National Planning Policy Framework to "take account of and support local strategies to improve health, social and cultural wellbeing for all, and deliver sufficient community and cultural facilities and services to meet local needs" when formulating their Local Plans.

<sup>36</sup> UCL Institute of Health Equity (2010) Fair Society Healthy Lives: A strategic review of health inequalities in England post-2010 UCL: London

<sup>37</sup> Department of Health (2012) A Draft Mandate to the NHS Commissioning Board (Online) Available at: <http://www.dh.gov.uk/health/files/2012/07/A-draft-mandate-to-the-NHS-Commissioning-Board.pdf> Department of Health: London

<sup>38</sup> UCL-Lancet Commission on Health Cities (2012) Shaping Cities for health: complexity and the planning of urban environments in the 21st century UCL: London

5. Integrating healthcare services with planning for town and district centre areas can lead to the promotion of health and wellbeing for the whole community. This would echo the Marmot Review's call to fully integrate healthcare policy with transport, housing and environmental policy. The review states further that "strategies that only rely on intervention in one part of the system will be insufficient to make the necessary difference." Public Health England has called for further integration within authorities, saying in the Outcomes Framework for 2013–16 that "Local authorities with their partners, including the police and criminal justice system, schools, employers, and the business and voluntary sectors, will all have a significant role to play in improving performance."<sup>39</sup>

6. It is important that future service delivery is located so as to take account of wider considerations for the local population in order for there to be wide utilisation of services, and The Healthy Urban Development Unit (HUDU), based in London has stated, the "provision and access to good public services... has a direct positive effect on human health."<sup>40</sup> Their review of health service location goes further to say that the most vulnerable will be the most adversely affected if services aren't planned within reach of good transport links: "For those with mobility problems including the elderly localised access to public services is vitally important, public services located far away can cause significant problems not only in terms of accessing vital services but also preventing opportunities for daily social interaction which could contribute to isolation and depression."<sup>41</sup>

#### *The adequacy of preparations for the new arrangements*

7. The different versions of guidance from the Department of Health and Public Health England for the various new bodies that will be introduced from April 2013 is currently in various states of completion, and the Institute has been a little concerned that representations on drafts are having little impact on the final outcomes. There is a lack of recognition of the interlocking elements between the new bodies in the draft guidance, in particular how Clinical Commissioning Groups (CCGs) will work to deliver the JHWS prepared by the local authorities' Health and Wellbeing Boards. The Draft Mandate for the NHS Commissioning Board does recognise that there is a statutory duty upon CCGs to take into account the strategies planned by health and wellbeing boards, but doesn't prescribe any advice on how to do this successfully, or examples of good practice currently being undertaken involving the work of shadow health and wellbeing boards leading up to April 2013.

8. There is no mention in either versions of the draft guidance to Foundation Trust hospitals. This seems puzzling going forward as the Department of Health has stated that it hopes all NHS trusts will achieve foundation status by 2014,<sup>42</sup> and it is necessary to include them into any guidance for future commissioning plans.

#### *The objectives of the new arrangements and how their impact can be measured*

9. The RTPI believes that a holistic approach to measuring performance should be introduced, encompassing aspects of improvement across society, brought about through improvements in the provision of public health. Improvements in public health will lead to wider improvements in areas such as economic recovery for an area, increased employment, and reduced crime rates. The latter has been recognised by the Department of Health, who have noted that "good cooperation between health services, the criminal justice system, and policing organisations can help reduce the risk of crime and reoffending."<sup>43</sup> There is a recognition that the direct involvement of health services in improvements in these areas would be difficult to measure, however, and there would need to be more investigation into how this would work.

10. The two sets of draft guidance for the new national bodies involved in the delivery of Public Health in England, the NHS Outcomes Framework published by Public Health England<sup>44</sup> and the draft mandate of the NHS Commissioning Board,<sup>45</sup> are in many ways pulling in different directions. This confusion from higher level guidance will not help local authorities in the preparation of their own strategies, as they are on one hand bound to improving public health via the guidance prescribed from Public Health England, and in other respects they will be looking to meet the outcomes recommended in the draft mandate of the NHS Commissioning Board, in order to maintain a good relationship with CCGs.

<sup>39</sup> Department of Health (2011) The NHS Outcomes Framework 2012–13 (Online) Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131723.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf) Department of Health: London

<sup>40</sup> Healthy Urban Development Unit (2009) Watch out for Health: a checklist for assessing the health impact of planning proposals (Online) Available at: [http://www.healthyrbandevelopment.nhs.uk/documents/integrating\\_health/HUDU\\_Watch\\_Out\\_For\\_Health.pdf](http://www.healthyrbandevelopment.nhs.uk/documents/integrating_health/HUDU_Watch_Out_For_Health.pdf) The King's Fund: London

<sup>41</sup> Ibid.

<sup>42</sup> <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1566/1566.pdf>

<sup>43</sup> Department of Health (2012) A Draft Mandate to the NHS Commissioning Board

<sup>44</sup> Department of Health (2011) The NHS Outcomes Framework 2012–13 (Online) Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131723.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf)

<sup>45</sup> Department of Health (2012) Draft Mandate to the NHS Commissioning Board



*The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level*

11. It is vital that health and wellbeing boards are truly effective in shaping the wider determinants of health, and in promoting other services that impact on public health (eg land use planning, housing, green space and transport) and are not seen as a secondary body to CCGs who are commissioning services. In the draft guidance on Joint Strategic Needs Assessments (JSNAs) and JHWSs published in the summer for consultation by the Department of Health, it is prescribed that “it would be good practice for local authorities and the NHS Commissioning Board to also involve health and wellbeing boards when developing their plans for commissioning to make sure each plan is informed by the JHWS.” However, as previously stated in this response the draft mandate of the national NHS Commissioning Board doesn’t prescribe any advice for CCGs on how to do this successfully, or examples of good practice currently being undertaken involving the work of shadow health and wellbeing boards leading up to April 2013.

*How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

12. We recommend that local regard to the provision of healthcare services needs to be viewed as shaping outcomes beyond what is seen to be traditional improvements in health.. The integration of public services into what have traditionally been seen as our retail centres would have overwhelmingly positive effects across different areas, as has been suggested throughout this response. The government has taken steps in the past year or so to support regeneration of town centres, most notably through the Portas Review<sup>46</sup> into the future of Britain’s high streets. However, this analysis was heavily based in the retail aspects of high streets, and neglected the role that sectors such as public services can play in the regeneration of our high streets. This is seen as a missed opportunity, as in some of our most deprived communities the public sector is the main investor in infrastructure—highlighting further the role that local councils’ could play in the wider regeneration of areas through healthcare services, as it is within the strategies and commissioning plans prepared by local government that healthcare services will be planned and prioritised. The review also neglects emerging good practice such as Bromsgrove-based social enterprise EPIC (Empowering People in Communities) which has already begun to revitalise a run-down shopping parade as a by-product of its work in public health.

13. Health services can act as a springboard for wider economic regeneration of an area. Encouraging health services to relocate to town and district centres within communities is a positive step as these areas are in most cases already served by good transport links. A user of health services would take the opportunity to spend money in the town centre, whilst in the area to visit the health services, helping to improve the local economy. For regeneration to flourish, experimentation will be required, and a willing on the part of local authorities to take risks—such as promoting a change in the hours which certain services will open from during the day to evening and weekends, in order to provide for a wider range of consumers who would otherwise not be able to access services, due to the hours of the working day.

14. There is wider evidence to suggest that good planning for public services with wider community involvement has positive effects on mental health and wellbeing of individuals, as well as promoting community cohesion. This will not be limited to primary healthcare services, noted by HUDU who have advised that “opportunities for the community to participate in the planning of such services [healthcare and other public services] has the potential not only for positive effects on mental health and wellbeing but also can lead to greater community cohesion.” Whilst these are outcomes which are difficult to quantify, the Department for Communities and Local Government has stated that the most positive estimate for crime reduction in the UK due to increased community cohesion stands at £530 million.<sup>47</sup>

*Barriers to integration, including issues in multi-tier areas*

15. The public health function is being assigned to principal authorities (ie county councils and unitary authorities). Whilst much guidance (eg the public health draft guidance released in May 2012 for consultation by the National Institute for Clinical Excellence on obesity<sup>48</sup>) refers to the advantages that local authority involvement in public health will confer almost invariably NICE/DoH guidance fails to distinguish between country councils and district councils, and seems to presuppose that all local authorities are unitary. This is a serious failing since in two tier areas it is district councils which provide some of the vital roles which are determinants of health such as spatial planning, environmental health and recreation, are fully brought into the public health process. We are aware that this could potentially provide quite a challenge in a county with a large number of districts. There are however parallel processes which can be used as well as membership of health and wellbeing boards.

16. Under the Localism Act, local planning authorities are required to cooperate on strategic planning matters with each other and a number of other bodies including “Primary Care Trusts (PCTs).” We would assume that PCTs’ obligations here will be transferred to either HWBs or principal authorities, although we are not clear

<sup>46</sup> Department for Business, Innovation and Skills (2011) The Portas Review: An independent review into the future of our high streets BIS: London

<sup>47</sup> Department of Communities and Local Government (2009) The Economic Case for Cohesion DCLG: London

<sup>48</sup> National Institute for Clinical Excellence (2012) Public health draft guidance—Obesity: working with local communities (Online) Available at: <http://www.nice.org.uk/nicemedia/live/12109/59116/59116.pdf> NICE: London

about this. Be that as it may, since cross boundary cooperation between district councils is expected to be occurring within county areas at least for planning purposes, it would make sense to use the same channels to foster cooperation for public health purposes, rather than reinventing the institutional wheel. This would also ensure that the strong interconnections between public health and planning were properly addressed in two-tier areas.

17. A similar issue effectively arises in unitary council areas where the unitary councils are small and what is termed “underbounded”. These are councils where the council boundary is frequently crossed by people on the way to work or recreation and the council is really part of a wider functional area. In this case we would recommend that adjoining HWBs may also need to be cooperating with each other, and using again existing channels to do this would be helpful.

*How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level*

No evidence submitted

*The accountability of Directors of Public Health*

No evidence submitted

*The financial arrangements underpinning local authorities’ responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets*

No evidence submitted

*Recommendations for Action*

The Institute would like to make two recommendations for action, arising from the memorandum:

18. Guidance prescribed by the national bodies for health needs to successfully distinguish between the different authorities at a local level. At the moment, all guidance seems to presuppose that all local authorities are unitary, a failing in two tier areas when many vital services which impact upon the wider determinants of health, such as planning and environmental health are taken at the district level.

19. Guidance needs to be given to promote how CCGs and health and wellbeing boards will work together to effectively meet the challenges of public health in their areas. Whilst recognised that there is a statutory duty upon CCGs to take into account the strategies planned by health and wellbeing boards, no advice is prescribed from the Department of Health on how to do this successfully, or examples of good practice currently being undertaken involving the work of shadow health and wellbeing boards leading up to April 2013. The draft guidance on JSNAs and JHWSs states that the NHS Commissioning Board can “take action if the [commissioning] plan doesn’t take into account the JHWS”<sup>49</sup> what action that can be taken is not laid out.

October 2012

### Written submission from Celesio UK

#### 1. SUMMARY

1.1 We welcome the opportunity to submit written evidence to this inquiry by the Communities and Local Government Committee into local authority involvement in health.

1.2 Celesio UK believes more than ever, that there is a strong economic as well as practical case for directing more services into pharmacy that, particularly in the current fiscal environment simply cannot be ignored or underestimated.

1.3 As experts in delivering successful public health initiatives and engagement through providing choice, increased access and innovative social marketing campaigns, we are keen to work in partnership with Health and Wellbeing Boards and Directors of Public Health to ensure optimisation of the readymade public health network that is community pharmacy. Ideally placed at the heart of communities we have the experience and expertise to make a significant contribution to this agenda.

1.4 To be effectively regarded as part of the infrastructure pharmacists must as a priority gain access to patient healthcare records to enhance patient care. The record should work across health and social care to support integration.

1.5 National commissioning frameworks and tariffs for core services, such as public health and minor ailments should be developed to prevent duplication at local level and provide consistency in quality and outcomes.

<sup>49</sup> Department of Health (2012) Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies—draft guidance (Online) Available at: <https://www.wp.dh.gov.uk/publications/files/2012/07/Joint-Strategic-Needs-Assessment-and-Joint-Health-and-Wellbeing-Strategy-draft-guidance-a-consultation.pdf> Department of Health: London

## 2. ABOUT CELESIO UK

2.1 Celesio UK is a leading provider of integrated healthcare services to the NHS specialising in medicines, pharmaceutical care and primary care patient services.

2.2 Our vision is a healthier world where more people can live life to the fullest and our mission is to effectively, efficiently and passionately deliver innovative healthcare services that equip and inspire more positive lives.

2.3 The Group comprises Lloydspharmacy, AAH Pharmaceuticals, Evolution Homecare, Wilkinsons Healthcare, Dr Thom and Betterlife. Whilst other companies provide some of these services to the NHS, Celesio UK is unique in our ability to offer the NHS an integrated package of medicine and patient care related services which stretch from the manufacturers of medicines through to individual patients at community pharmacies, in hospitals or at home.

## 3. IMPROVING INTEGRATED WORKING

3.1 It is clear in the current economic climate that a reduction in duplication and the utilisation of the most appropriate resources are crucial to the sustainability of public services moving forward.

3.2 Integration can go much further than across health and social care boundaries and “place” based solutions have had success in pilot areas across the country.

3.3 In working across a multi disciplined field such as health and social care it is important that contracts and incentives are aligned so that collaboration is encouraged and that the most appropriate and cost effective resource is utilised. Mutual definitions of success for providers will encourage cooperation where integration is required.

3.4 It is also important to understand that pharmaceutical care needs go beyond the dispensing of medicines: in order to achieve improved outcomes for patients and avoid costly and preventable secondary care episodes it is vital patients get the support they need to take their medicines as directed.

## 4. FUNCTIONS OF HEALTH AND WELLBEING BOARDS

4.1 To ensure that everyone is given an equal opportunity to access public health services, a robust Joint Health and Wellbeing Strategy (JHWS), Joint Strategic Needs Assessment (JSNA) associated with Pharmaceutical Needs Assessment (PNA) needs to be in place.

4.2 Health and Wellbeing Boards (HWBs) should be absolutely clear on the development of the JSNA from public involvement, to assessment of current and future needs of the community. The retention of a core data set in developing JSNAs is essential in ensuring that the needs of communities are properly assessed and comparisons can be made nationally.

4.3 The community pharmacy contract lies with the National Commissioning Board, however local enhanced services (part of the contract) and the method by which market entry and exit for community pharmacy be determined, through (PNAs) lies with Health and Wellbeing Boards (HWBs).

4.4 We recognised that HWBs may have little or no experience of community pharmacy. Therefore we encourage them to effectively engage with community pharmacy contractors through Local Pharmaceutical Committees and Local Professional Networks to better understand the importance of robust PNA development whilst also ensuring that it is an effective document in informing commissioning decisions.

4.5 It is the Department of Health’s view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process.

4.6 It is important is that the Boards publish a clear timetable which sets out when and how strategies, plans and assessments will be carried out and how JSNAs, JHWSs and Pharmaceutical Needs Assessments (PNAs) relate to and feed into each other.

4.7 Regular reviews should be in place to ensure relevance; we would suggest an annual sense check.

4.8 If the JSNAs and JHWSs work as intended, they will provide valuable tools for identifying and meeting local health and wellbeing needs. It would, however, be helpful to clarify how JSNAs and JHWSs will fit with Pharmaceutical Needs Assessments (PNAs): clearly assessing the pharmaceutical care needs of patients in local communities is a core element in any healthcare and wellbeing strategy or delivery plan.

4.9 Previous guidance relating to PNAs has stated that they should be integrated into the JSNA process. It would be helpful to make that explicit in future guidance.

4.10 It would also be helpful if the guidance for those developing JSNAs and JHWSs set out certain local health providers whom they must consult in developing the strategies and plans. That should include local community pharmacy.

4.11 It is of note and concern that when the SHAs last published their health strategies over half made no reference whatsoever to community pharmacy. A health care strategy which does not include community pharmacy is not credible.

4.12 With Clinical Commissioning Group boundaries not being constrained by geographical or local authority boundaries, health and wellbeing boards may be required to work collaboratively with neighbouring authorities—therefore it is clear that standardised data sets agreed nationally will be important.

4.13 There is potential for the Department of Health/Public Health England to highlight examples of best practice and encourage sharing of information to encourage collaboration and opportunities for delivering economies of scale where appropriate.

## 5. LOCAL LEADERSHIP FOR HEALTH IMPROVEMENT

5.1 As the squeeze on public spending becomes tighter in coming years there is a danger that money intended for public health could be diverted to other areas. We have some concerns that a lack of strategic planning for populations could lead to increased fragmentation of provision and reduced service offering.

5.2 Health inequalities pose a large threat to the health of our nation. It is widely agreed that areas of social deprivation have a higher prevalence of cancer, coronary heart disease and obesity; many of these areas are in fact under-doctored.

5.3 In its assessments of how best to stem the gaps in health provision, Local Government and commissioners need to consider how they best utilise the existing pharmacy network.

5.4 Community pharmacy is recognised as being an under-utilised resource and a highly accessible destination for healthcare. As a well established provider of services to improve public health, we are a readymade network at the heart of communities providing a range of public health services including stop smoking, NHS Health Checks, substance misuse programmes, weight management, sexual health and vaccination.

5.5 Flexible opening hours and commitment to reducing health inequalities enables pharmacy to deliver services in the heart of all communities, many of which have been recognised as under-doctored or in areas of significant health inequality.

5.6 Lloyds pharmacy's network alone has over 600 pharmacies located within under-doctored areas.<sup>50</sup> Our continued presence in such areas provides much needed access to services which help to deliver a range of targeted care to populations and we encourage local government commissioners and HWBs to make use of this valuable and cost effective resource.

## 6. CONCLUSION

6.1 We encourage Health and Wellbeing Boards to engage with community pharmacy representatives to support effective public health provision.

6.2 We also call for the development of national public health service frameworks and national tariffs to support local authorities with a suite of services which they can choose from to meet local needs and target populations.

6.3 We would welcome the opportunity to provide further information to the Committee.

*October 2012*

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### Written submission from Sue Ryder Care

#### 1. ABOUT SUE RYDER

1.1 Sue Ryder is a charitable provider of health and social care services across the UK. We provide specialist neurological and palliative care in a range of environments including community and home-based care delivery alongside our hospices and neurological care centres.

1.2 We are funded through charitable donations, contracts with health and social care commissioners and revenue from our network of more than 400 shops across the UK.

#### 2. EXECUTIVE SUMMARY

2.1 The new role in health that local authorities will take on from April 2013 is welcome. A key duty of the Health and Wellbeing Boards (HWBs) is to promote the integration of services at a local level. For people living with complex needs and those at the end of life, integration between health and social care services is vital to ensuring they have access to the right services at the right time. In some instances people can find

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<sup>50</sup> As defined by the Department as an area or PCT with fewer WTE GPs/100k weighted population than the national average

themselves falling between the gaps between these services because of the lack of coordination and planning. This means they are not accessing the services they need nor achieving their desired health and care outcomes.

2.2 The opportunity for commissioners of health and care to collaborate in HWBs and develop a Joint Health and Wellbeing Strategy (JHWS) for the local community is a key step forward to ensuring the most appropriate services that meet an individual's outcomes are designed.

2.3 We are concerned however about the different levels at which HWBs are operationally prepared to enact their new duties. Sue Ryder services span the country and from our recent engagement with local authority stakeholders it is clear that some boards are more established than others. This could potentially result in a two tier approach to strategy development with some HWBs being more innovative and driving service remodelling than others.

2.4 This submission focuses on the role of the Health and Wellbeing Boards in developing the Joint Health and Wellbeing Strategies. It sets out the case for a robust Joint Strategic Needs Assessment that will ensure the future financial and service development of services that will improve both the health and care outcomes of those living with complex neurological conditions.

### 3. *Health and Wellbeing Boards: facilitating integration between health and care*

3.1 Best practice examples of integration initiatives illustrate the importance of key relationships and individual leadership. This has meant that innovative service design has generally been specific to local context. The new HWBs provide the opportunity for integrated planning to be stimulated and a consistent approach adopted across the country. We hope they will establish the right mechanisms which will make integrated working a reality and improve the lives of people with complex needs and those at the end of life.

3.2 Last year's Demos report, *Tailor Made*, sponsored by Sue Ryder, revealed that the aspirations of individuals with the most complex needs include maintaining independence, spending time with family and remaining engaged with their community.<sup>51</sup> These aspirations are reflected in terms of broad outcomes, and can not be met by any one service. Multi service integration across health, care and other local services is required.

3.3 Many of the people Sue Ryder provides care for live with progressive neurological conditions such as Multiple Sclerosis, Huntington's disease or Parkinson's disease. These individuals will live in the care system for many years. Evidence collected for Sue Ryder indicates that these individuals benefit from services that address their specific needs resulting from their condition to help them to achieve their desired broad outcomes. The HWBs' duty to deliver a JHWS for their local area will put in place a local strategy on which integrated commissioning to plan these appropriate services can be based. To do this JHWS must make a proper assessment of the needs of their local population and identify the needs of these condition specific groups. Data collection through the JSNA must be improved.

### 4. *Joint Strategic Needs Assessment: the foundation of a robust Joint Health and Wellbeing Strategy*

4.1 The JHWS will only be as robust as the data on which they are based. The strengthened role of the JSNA should mean that a more responsive system to condition specific local need is developed.

4.2 We are concerned that the preparations for the new system and implementation aren't robust enough. Determining the needs of the local population and the tools that are needed to make this a reality will be central to developing integrated commissioning that improve health and care outcomes.

4.3 Sue Ryder recently ran a freedom of information request to local authorities in England asking about the specific design and delivery of services they offer for individuals with neurological conditions. These results have been compiled in to the report *The Forgotten Millions*. Responses were received from 131 local authorities. Only 5% of the local authorities surveyed were able to provide detailed data on the number of individuals with neurological conditions that they provided care services for. 72% of the authorities indicated that they do not collect detailed data categorising specific neurological conditions. 79% of local authorities indicated that they do not have a specific commissioning strategy for services for people with neurological conditions.<sup>52</sup>

4.4 The results, particularly the lack of data available to identify those living with neurological conditions in local communities is concerning. Because local authorities are not collecting this data they don't know the number or range of neurological conditions that people in their communities are living with and therefore are unable to plan services accordingly. As a result it is likely that many of these individuals are not receiving the best services for their needs which will impact on their health. It is telling that only 10% of local authorities have a strategy in place for people with neurological conditions. This evidence indicates that the initial needs assessment is crucial in determining the strategies and the shape of future services.

<sup>51</sup> Wood, Claudia, *Tailor Made*, Demos (2011) p.74.

<sup>52</sup> This data will be released on 1 November 2012 in Sue Ryder's research report, *The Forgotten Millions*, into commissioning services for people with neurological conditions and complex needs. For a copy of the report please contact the Sue Ryder policy team, details above.

### 5. Joint Health and Wellbeing Strategies: creating the framework for integration

5.1 The needs of those with degenerative neurological conditions like Multiple Sclerosis and Huntington's disease are complex due to the progressive and often fluctuating nature of their condition. As a result they need tailored support from multiple general and specialist services including the NHS, adult social services and voluntary sector.

5.2 In order for an individual's outcomes to be formally recognised and delivered the JHWS should include joint health and social care outcomes. This will give local authorities alongside health commissioners the opportunity to develop joint service model solutions most appropriate to the local community.<sup>53</sup>

5.3 When care is not coordinated it is likely that service users will fall between the gaps in the system. Unsupported in this way they can lack an understanding of their choices and entitlements, become isolated and unable to access the care they need. This can lead to their health deteriorating faster than necessary and potentially ending up in hospital in an emergency admission.

5.4 This was the case for one of our day service users with MS who lives in a housing association property where she moved to five years ago when her needs worsened. The progression of her condition since then has meant that she can no longer use the stairlift or wetroom upstairs and has been forced to convert her dining room into a bedroom. The only toilet is downstairs in an outhouse which is inaccessible. After an assessment from an occupational therapist it was recommended she have an extension. However neither the housing association or local authority could agree on who would pay for the adaptation. She has recently found out that neither party will pay and if she wants to live somewhere more suitable she will have to move again. This lack of coordination illustrates the tensions at a local level. Inappropriate planning between the local authority and housing association with little regard for and inclusion of health has meant that it is the service user that loses out, unsupported by a system that does not adequately meet her needs.

5.5 There is now a real opportunity through the HWBs to prevent these situations from happening. There should be provision within the JHWS to include a local strategy for the health and wellbeing of those in their area living with a neurological condition. With their role to coordinate health and social care, HWBs and their responsibility to develop JHWS, will be key to delivering a strategic commissioning framework that includes the opportunity to pool resources and plan integrated services to deliver improved user outcomes.

5.6 The HWBs' responsibility to develop the JHWS and the JSNA will provide the basis on which commissioners can collate overall figures for people living with a neurological condition in their area. This can then be used alongside data from local health services to assist in the integrated future financial and service development and improve individual outcomes through a coordinated approach to service delivery.

October 2012

### Written submission from Westminster City Council

#### EXECUTIVE SUMMARY

- We strongly support the re-introduction of a public health role for councils.
- We have concerns about the adequacy and timing of HR guidance provided by the Department of Health to local authorities and PCTs.
- We welcome the flexibility local authorities have had to determine public health objectives for themselves and hope that the public health grant conditions, and the health premium, will not undermine this localised approach.
- We welcome the introduction of Health and Wellbeing Boards and the opportunities they provide to align local partners around a common goal and to add value to the work of the council.
- Westminster City Council has made significant progress in identifying specific actions that we will undertake to deliver better health outcomes for our residents, workers and visitors. Examples of our work in relation to worklessness, oral health and fostering independence are outlined in the evidence below.
- We would welcome the Committee's consideration of how Public Health England can be supported to ensure that local diversity is fully considered in a national immunisation and screening programme.

#### INTRODUCTION

1. Westminster City Council welcomes the intention of the Communities and Local Government Select Committee to undertake an inquiry into the future role of local authorities in health issues and provides this written submission for their consideration.

2. Westminster City Council is a truly unique place which plays a pivotal role in London and the UK economically, culturally and administratively. Although we are a small city, we have a vastly diverse and, highly transient population with extreme contrasts of wealth. We also play host to a high number of visitors daily many of whom will spend more of their day in Westminster than they do in their residential home. This

<sup>53</sup> *Tailor Made*, p.184.

makes Westminster a demanding place to deliver services, and we will need to fully consider these unique characteristics when delivering against our new public health responsibilities.

3. We welcome this chance to provide our thoughts on the future role of local authorities in public health to the Communities and Local Government Select Committee and look forward to considering the conclusions you draw from all the evidence submitted.

#### *The introduction of a public health role for councils*

4. Westminster City Council strongly supports the re-introduction of a public health role for councils. Local Government has a long history of achievements in promoting and protecting public health, particularly in Victorian times. It is easy to forget that up until 1974, local government still had a large role in promoting public health. We believe that councils have a strong role to play and can put health and wellbeing outcomes at the heart of everything we do.

5. Councils are best placed to understand our local areas and how the local environment may be improving, or deteriorating, the health of our residents and visitors and we have the levers to shape this environment to deliver improved health outcomes. We also have extensive experience of building relationships with our residents and service users to work with them to solve local issues. This will be invaluable in designing innovative solutions to more entrenched public health problems. However, this will only happen if local authorities are properly supported. The inclusion of a Director of Public Health and other public health specialists will provide the expert advice that is required, but local authorities will also need stable and sufficient financial support.

#### *The adequacy of preparations for the new arrangements*

6. Westminster City Council is making good progress in most areas towards preparing for the new arrangements. We have put in place a Public Health Transition Board which is managing the process for Westminster. However, Westminster City Council has concerns about the lack of clarity over HR arrangements and the speed of change nationally.

#### **HR Arrangements**

7. We are concerned about the length of time it has taken the Department of Health to provide local authorities and PCTs with guidance on the HR arrangements for the transition of public health functions, and the lack of clarity in the final guidance received.

8. Final guidance was received by councils in August 2012. We believe that this guidance should have been made available at an earlier date to ease the transition process for both the PCT and the local authority and to ensure that they were able to finalise HR structures and transfers in a timely fashion.

9. From the guidance provided it remains unclear whether, and in what circumstances, TUPE will apply. As a result, local authorities have been forced to seek legal counsel to provide clarity over this issue. This is an additional cost to councils at a time when we are under increasing pressure to find financial savings. It also delays our ability to implement HR changes, as certainty on the guidance is required before we can begin to consider transferring staff between organisations.

10. Westminster City Council recommends that the CLG Select Committee should consider the adequacy and timing of HR guidance provided by the Department of Health to local authorities and PCTs and should consider whether organisations should be provided with additional funding to cover the cost of obtaining legal advice to clarify this guidance.

#### **National changes**

11. We believe that there could have been greater co-ordination at the national level to ensure that the setting-up of the NHS Commissioning Board and Public Health England were more aligned. The NHS Commissioning Board, possibly because it has been created using existing NHS knowledge and expertise has been set up much more quickly than Public Health England. This has made it difficult for transferring staff from the PCTs to both the NHS Commissioning Board and Public Health England. Due to the differences in readiness of the NHS Commissioning Board and Public Health England, PCTs may need to make staff transfer to these organisations on two different timetables.

12. The Public Health England process will need to speed up if it is to avoid risking the loss of expertise particularly in relation to immunisation and screening. These are very important areas of work which would have a very quick, direct and potentially large impact if slowed, or interrupted by the transfer of staff to Public Health England.

13. Westminster City Council would urge the Committee to consider the potential impact on immunisation and screening from the slow process of setting up Public Health England and what could be done to minimise this.

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*The objectives of the new arrangements and how their impact can be measured*

14. Westminster City Council does not believe that central government has put forward clear objectives for the transition of public health functions to local authorities. This has provided space for local authorities to determine local objectives which fit with their local needs. This is particularly important for Westminster City Council which has unique public health issues due to its high transient population and its large number of visitors and commuters. The Local Government Association has been helpful in providing a steer for local authorities in identifying local objectives.

15. Where the lack of national clarity may be problematic is balancing the local approaches to public health with the Department of Health's approach to measuring the impact of the new arrangements. It will be important that any grant conditions which accompany the public health grant are flexible enough to take account of locally-led public health objectives. It is also important that the health premium element of the public health funding provides a similar level of flexibility so that local authorities are not penalised on focussing public health funding on issues of local, but not necessarily national, significance.

16. An additional level of complexity for Westminster, and other inner-city boroughs, is our responsibility for a much wider population than just our resident population. We receive around 750,000 visitors a day to Westminster (three times our resident population), many of whom work in Westminster and may spend more time here than they do in their residential boroughs.

17. Westminster City Council would urge the committee to scrutinise the development of the public health grant conditions, and the health premium, to ensure that they do not undermine the local approach that councils may wish to take to public health.

*The intended role of the Health and Wellbeing in coordinating the NHS, social care and public health at the local level*

18. Westminster City Council welcomes the introduction of Health and Wellbeing Boards. They provide a real opportunity to align accountability, governance and oversight structures within the NHS, social care, public health and councils behind one cohesive strategy. In Westminster, our board is already playing an invaluable role in joining together these individual organisations to focus on delivering Health and Wellbeing outcomes for the people of Westminster at the same time as focusing particularly on the needs of our most vulnerable residents and service users.

19. We believe that Health and Wellbeing Boards have the potential to add value to the work and responsibility of councils across a wide range of areas including housing, planning, licensing, environmental health, public health, skills and employment. We would urge the Government to recognise that this added value will not appear overnight, the Health and Wellbeing Boards will need time to mature. While Westminster recognises and welcomes that a sizeable amount of funding has been invested in the development of Health and Wellbeing Boards, we do question whether the Government could have taken a more staged approach to their funding, with a slower but well spaced flow of money.

*How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education*

20. Westminster City Council has had a good working relationship with the Inner North West London Primary Care Trust which has allowed us to make links between health prevention and these areas already. For example Westminster City Council has been working for a number of years with the Inner North West London PCT to build better links between health prevention and housing policy. This is a particularly difficult area for us a council because we have a lack of space in which to build new social housing.

21. We relish the opportunity to build on these relationships to maximise the opportunities arising from the transfer of public health functions to the local authority. We have been actively developing implementation plans to sit underneath the Health & Wellbeing Strategy which set out the actions we will take as a council to improve the health outcomes of our residents, workers and visitors. We have outlined examples of this below:

**Worklessness**

22. Employment is one of the most evidence based determinants to a person's health and well-being. Worklessness is associated with poorer physical and mental wellbeing and impacts on other determinants of health including income, secure housing and the overall wellbeing of families and communities.

23. Our Health and Wellbeing Strategy will help people to successfully return to work and retain work by supporting people with health conditions/disabilities and promoting quality work and health and well-being in the workplace. The Health and Wellbeing Board will use their leverage with contractors to generate employment opportunities for local residents, focussing on intermediate employment for long term unemployed residents with health conditions and disabilities. Intermediate employment provides a stepping stone to more mainstream work and connecting to pathways for residents leaving hospital or with long term periods without work.



## Oral Health

24. There are high levels of poor oral health and oral health inequalities in Westminster particularly among children and specific vulnerable groups among adults. Oral health is widely linked to poorer overall health but is an area that can often be overlooked. We will work to raise awareness of the risks to oral health and support individuals and families to make healthy choices through a combination of universal approaches and approaches targeting those in most need. For example, in relation to children we are developing a paediatric care pathway for dentistry and work is also underway to develop and share consistent messages across health professionals working with children around diet and oral health.

## Fostering recovery and independence following hospitalisation

25. Many people, with the right support early after discharge from hospital, are able to regain their independence. For some however, often due to a lack of access to the right care at the right time, the extent of the damage can lead to long term dependence on a number of services and social isolation, increasing the cost to health and care services. This is a particular priority for Westminster as we have twice the national average of older people who live on their own. We are working to integrate social care re-ablement services with NHS community rehabilitation and rapid response services. This will provide a single point of access for residents using the service. It will also enable us to provide an integrated, co-ordinated and personalised level of service and care with each individual using the service having a personalised rehabilitation plan. This will help us support people to stay independent for longer.

26. We hope that the examples of practical action we have offered will be of help to the Committee in understanding the important role local authorities will be able to play in delivering better health outcomes.

## *Barriers to integration, including issues in multi-tier areas*

27. It is important that the Government recognise that although there will be some quick wins, it will take time for local authorities to fully realise the opportunities that this move could bring. For example, while there is evidence to show the improved health outcomes that can be delivered through “quality work”, we do not have strong enough links between health and businesses locally to deliver these outcomes quickly. It will take time to develop these relationships and “sell” the advantages of these health benefits to businesses. This will be the same for other areas as well, including education and health in schools.

28. Due to the diverse nature of London boroughs, we believe that a large proportion of public health work would benefit from happening at a relatively local level. Westminster City Council is part of a tri-borough arrangement with Hammersmith & Fulham and Kensington & Chelsea, and in some cases, particularly when contracting services we may wish to co-ordinate our provision across the three boroughs. We are fortunate, as tri-borough arrangements are already working across services, particularly adult social care and children’s services. This provides experience that we can draw on to approach tri-borough arrangements in relation to public health.

29. We can see the benefit to undertaking some specific projects at a London-wide level, especially on issues where the Mayor of London has a greater influence such as embedding better health outcomes within a London wide transport strategy.

30. We have some concern that local authorities could become too overly focussed on their commissioning role in relation to public health and on health & wellbeing and less focussed on front-line health protection. They may also have not properly considered their important role in providing policy and research support to help shape their Clinical Commissioning Group(s) commissioning strategy.

## *How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level*

31. The creation of Public Health England has dragged behind other changes including the creation of the NHS Commissioning Board. The Public Health England process needs to speed up to avoid the loss of talent, particularly from people involved in immunisation and screening. Westminster has had to do a lot in previous years to improve the uptake of immunisation and screening services, mainly due to the diverse nature of its residents and service users. Much of this work will be transferred to Public Health England. It is imperative that immunisation and screening do not lose momentum as this could have a big impact very quickly. We also urge Public Health England to think carefully about how they will take account of local diversity and issues to ensure that uptake of immunisation and screening services continues to grow in marginal communities.

32. Westminster City Council would welcome the Committee’s consideration of how Public Health England can be supported to ensure that local diversity is fully considered in a national immunisation and screening programme.

## *The accountability of Directors of Public Health*

33. With the transfer of public health responsibilities to the local authority, there will need to be a period of adjustment in which public health officials acclimatise the different governance structures of local authorities

and the new dynamic of clear political leadership within an organisation. A balance will need to be struck between maintaining the independence of public health officials, whilst ensuring that the political leadership of the council is not constricted.

34. It is also important that local authorities take time to consider and understand the role of the Director of Public Health. Supporting the Clinical Commissioning Groups will be a significant part of the Director of Public Health's role, around 40% of their total time. This role will include providing technical advice to the CCG but will also include a role in shaping the public health focus within the decision-making processes of the CCG.

35. Local authorities must position public health carefully within their organisation. At Westminster City Council, we are likely to create a separate public health department rather than subsuming it within an existing department such as Adult Social Care, with the Director of Public Health having a clear and direct line of accountability straight to the Chief Executive of the council. This governance structure is replicated in the political leadership of the council, where we have a Cabinet Member responsible for public health separate to adult social care.

36. We very much welcome the move by the Government to accept recommendations on the registration of public health professionals. This will ensure that when local authorities employ public health specialists they can be assured that the specialists are qualified and are maintaining their competency.

37. *The Committee may wish to consider the differing approaches that local authorities may take in relation to positioning public health within their organisation and the potential benefits and risks of these approaches.*

*The financial arrangements underpinning local authorities' responsibilities, including the ring fencing of budgets and how the regime can link with the operation of Community Budgets*

38. We have concerns about the financial arrangements that will underpin our new responsibilities. The interim allocation formula constructed by the Advisory Committee on Resource Allocation (ACRA), which went out to consultation over the summer, is based upon a Standardised Mortality Ratio for those aged under 75 years. This fails to recognise other key drivers of public health need, particularly the unique characteristics of urban areas like Central London including the high demand for sexual health services, drug and alcohol services and our large non-resident populations.

39. Indicative modelling from London Councils indicates that the current formula would see a reduction in funding within the Westminster area of around 57%. This would have a severe impact on our ability to deliver good public health outcomes including restricting our ability to undertake preventative policies and projects which could reduce future NHS and local authority costs.

40. We welcome the Government's recent move to provide a limited amount of transition funding to local area. It should be recognised however, that the amount offered does not genuinely reflect the cost of transition for the PCT or the local authority.

41. As a council, we are excited about the opportunities that the Community Budgets pilot offers us across a range of areas, not least in integrating health and adult social care. However, it has been challenging to set up community budgets pilots before being given detail of the grant conditions.

42. *Westminster City Council would urge the Committee to consider the potential impact of the interim public health funding formula on the resources available to inner-city areas to deliver their public health responsibilities.*

October 2012

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### Written submission from Newcastle City Council

This submission provides further evidence by Newcastle City Council, in addition to that submitted collaboratively through evidence provided by the Core Cities and the UK Health Cities Network.

### THE INTRODUCTION OF A PUBLIC HEALTH ROLE FOR COUNCILS

This is the re-introduction of a public health position that councils held previously. We should acknowledge that councils have always had a key role in tackling public health issues such as health inequalities and the wider determinants of health. Taking on this role once more confirms our leadership role and ability to work with communities and partners to find innovative solutions that can have the greatest impact on the wider determinants of health and can encourage the adoption of healthier lifestyles. We acknowledge that the task is significant at a time when resources are scarce, but there is willingness from the sector to take responsibility and to drive change.

## THE ADEQUACY OF PREPARATIONS FOR THE NEW ARRANGEMENTS

It is all too easy to spend the preparation time on the technical aspects of transfer—such as transfer of HR, contractual responsibilities and the management of risk. Whilst these are important, they can also distract from the wider aspects of transforming our approaches to the way we work so that we are better placed to improve wellbeing and health throughout everything we do. For Local Authorities, there is a large workforce development agenda—not only do we need every contact to be a health improving contact, we also need every decision to be a health improving decision. In addition, the more specialist public health workforce need to be supported to use their expertise in a different kind of setting—one that supports political activity and social change, not just the commissioning of services

## THE OBJECTIVES OF THE NEW ARRANGEMENTS AND HOW THEIR IMPACT CAN BE MEASURED

Measuring wellbeing and health, changes to wellbeing and health over time, and inequalities in wellbeing and health are important aspects of learning about and understanding the situation we need to improve. However, there is a risk that such measurement becomes an end in itself, rather than a means to understanding. Measuring impact in the short-term can lead us to focus on individual interventions where there is a greater evidence base, rather than enable us to use our energy and resources to drive social change that will lead to sustained improvements for wellbeing and health for this and future generations. The impact of the new arrangements needs to be evaluated in terms of how it builds the use of health and health equity into all our thinking and actions—this is a shift in approach that does not necessarily lend itself to measurement.

## THE INTENDED ROLE OF HEALTH & WELLBEING BOARDS IN COORDINATING THE NHS, SOCIAL CARE AND PUBLIC HEALTH AT A LOCAL LEVEL

We welcome the role of Health and Wellbeing Boards in joining up both commissioning and provision of services. However, we are concerned that in describing the role of the Board, other possible ways of intervening to improve wellbeing and health are often overlooked. Local Authorities do more than commission and provide services to individuals—we also need to bring to bear the mechanisms we have at our disposal to improve the wellbeing and health of whole populations, such as spatial planning, regulation and crucially supporting communities to mobilise and use their own assets and resources to improve their own and others wellbeing and health. These functions need to be seen as part and parcel of our integrated approach to improving wellbeing and health—and is the reason why we in Newcastle have extended the role and membership of our Health and Wellbeing Board

## HOW ALL LOCAL AUTHORITIES CAN PROMOTE BETTER PUBLIC HEALTH AND ENSURE BETTER HEALTH PREVENTION WITH THE LINK TO SPORT AND FITNESS, WELL-BEING, SOCIAL CARE, HOUSING AND EDUCATION

See Q1 and Q2.

## BARRIERS TO INTEGRATION INCLUDING ISSUES IN MULTI-TIER AREAS

Partners in Newcastle are all committed to improving wellbeing and health of local people and working together in a cohesive way—both strategically and operationally. Often barriers are created by performance regimes and planning requirements established nationally that distract partners from working well in partnership. Currently, for example, our two CCGs are so engaged in authorisation activity that it is difficult for them to also take part in all the conversations we'd like to be having. The multitude of different funding streams with different requirements do not help either—especially when investment made in one place can result in savings elsewhere and or there are perverse incentives. That is why we like the idea of a health and social care “city deal”—to give us more flexibility around both investment and re-investment. We are setting up a Social Care Commission to investigate this idea further.

## HOW THE TRANSFER TO LOCAL AUTHORITIES OF THE FRONT-LINE HEALTH PROTECTION ROLE AND THE CREATION OF PUBLIC HEALTH ENGLAND WILL AFFECT RESILIENCE ARRANGEMENTS AT THE LOCAL LEVEL

We already have strong local arrangements for responding to public health emergencies and the local authority has been an active player in leading resilience arrangements. The transfer of public health staff to the local authority will only strengthen this relationship and we are confident that we will build an effective relationship with Public Health England.

## THE ACCOUNTABILITY OF DIRECTORS OF PUBLIC HEALTH

The structural accountability and functions of Directors of Public health have been defined. However, accountability for improving wellbeing and health lies with the council, not just with the individual post-holder. Accountability is more than just a “vertical” relationship—it is about working collaboratively, persuading, negotiating, championing and advocating.

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THE FINANCIAL ARRANGEMENTS UNDERPINNING LOCAL AUTHORITIES' RESPONSIBILITIES, INCLUDING THE RING FENCING OF BUDGETS AND HOW THE NEW REGIME CAN LINK WITH THE OPERATION OF COMMUNITY BUDGETS.

The links between poor health and income and the importance of the wider determinants of health were highlighted in the Marmot Review. The overall funding levels for public health are comparatively low compared to the overall spend on healthcare services in England. There is a clear case for investment in health improvement/prevention if we are to reduce the net costs to the public sector in future years. With this in mind we are therefore greatly concerned at what appears to be a potential reduction in future funding shares of 21% resulting from the initial funding formula. We are also concerned that the health premium appears to be delayed until 2015–16.

November 2012

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**Written submission by Liam Hughes, LGA and NetworkIdea Associate and Independent Chair of Oldham's Shadow Health and Wellbeing Board**

INTRODUCTION

- The establishment of Health and Wellbeing Boards and the transfer of key local public health functions to local councils provide a huge opportunity to rebalance national effort and strengthen the upstream building blocks for health. The big risk is that issues related to health and social care provision will “crowd out” attention to the wider determinants of health and the urgent need for changes in lifestyle and behaviour. We have a unique opportunity to build more sustainable, healthier and more resilient communities, and the new Boards will need to be courageous about maintaining this ambition in the face of more immediate pressures.

HEALTH AND WELLBEING BOARDS

- The rapid development of the Boards is a significant achievement. They are charged with working to improve health, reduce health inequalities, integrate health and social care (and housing?) services, and produce better outcomes for local people through improved commissioning. Their key functions are to promote systems coherence/alignment and mobilise support for improvement.
- There are positive signs about these challenges. Shadow Boards are developing quickly, they have used their preparatory time to build relationships, engage with stakeholders, come to grips with their leadership responsibilities, develop a shared understanding of the local story for health improvement, and develop draft strategies.
- The Boards can learn from previous improvement initiatives. “Communities for Health”, “Healthy Places, Healthy Lives” and the “Academy for Large Scale Change” brought people together in the common effort to generate significant health improvement across complex systems. The LGAs National Programme for Tobacco Control, “Ageing Well” and “Healthy Communities” programmes also provided valuable learning about improvement methods, and helped prepare the ground for Health and Wellbeing Boards.
- Despite these positive examples, the evidence about partnership working has often been disappointing. There is limited evidence about partnerships producing sustained health improvement, nor have they been able to move much investment upstream. It is, therefore, an act of faith that Health and Wellbeing Boards will be able to generate better outcomes for population health and service integration.
- One of the key indicators for the success of Health and Wellbeing Boards, therefore, should be the scale of the redirection of commissioning investment upstream into prevention. There is good evidence about the value of such investment, eg, for stopping smoking, increasing physical activity, preventing excess seasonal deaths and loneliness, and improving mental health. It would be helpful to have indicative targets for the pace of change, and better advice about the “best buys”.
- Boards are developing a common language and are beginning to provide a common strategic framework and a shared culture for local stakeholders. Lead GPs and councillors, in particular, are learning about each other, and discovering that they have common experiences and aspirations—they work for long periods at the sharp end of things in particular neighbourhoods, they have local information about needs and assets, and they see at first hand the effects of social and economic change and the impact of national policies.
- Some CCGs are already making upstream investments alongside their Health and Wellbeing Boards, eg by tackling fuel poverty and loneliness, promoting walking and prescribing book therapy.

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- Board membership is settling down. Most now include the Voluntary, Community and Faith Sector, many have a member with experience of health provision, and at least one is chaired by a senior police officer. Very few, however, have enlisted Board expertise from people with a background in spatial planning, regeneration and housing; sports, culture and leisure; or economic development, commerce and industry. A small number of councils have merged their work on crime reduction with health and wellbeing.
  - Boards have the potential to influence patterns of commissioning and expenditure. They are concentrating on a small number of key themes and priorities where they can add value, and learning how to balance the tensions between being strategic, being executive and being inclusive. They have come late to the party, and are dealing with a pre-existing and complex world of interacting partnerships and initiatives. Handling these interdependencies is challenging.
  - They are considering how they can gain traction to generate change (by informing, influencing and directing the activity of others in their area). They are determined not to “sit like clouds” above the action, nor attempt to “micro-manage” it. They are seeking to position themselves as local leaders—promoting more integrated systems of work, mobilising action for improvement, and holding each other to account.
  - The national programme of Board support has helped, and most Boards are making use of facilitated development from the LGA and NHS Leadership Programme or elsewhere. Common development strands include leadership and board behaviour, engagement with partners and other stakeholders, communications and community engagement, developing priorities and strategies from the JSNA, and integrating health and social care commissioning. The Scenarios developed by Birmingham University have helped. Continuing support to promote effective and productive Boards will be needed in some form post-April 2013, and one key area for further work is helping Boards to handle the investment costs and dividends which arise from improvement effort across the partnerships.

#### PUBLIC HEALTH TEAMS AND BUDGETS

- The public health transition is going well in most places, and teams have been made welcome by local government colleagues. There is still anxiety about the amount of funding to be transferred from the NHS for the designated functions, the duration of the ring fence, financial substitution for council services, the organisational position of the Directors of Public Health, and the future prospects for individual staff.
- Public health approaches to population health and the evaluation of good investments have much to offer local government, not least in terms of demonstrating that good health, like good education and reduced crime, is a local asset which contributes to the long-term sustainability of a place.
- So far, Public Health England is winning the confidence of both public health specialists and the local government sector. They are conscious that the switch from top-down direction to sector-led improvement requires first-rate data and intelligence, the identification of blind-spots, and the will to take action about them. Public Health England, therefore, should be more of an ally and “critical friend” than a regulator.
- We will need to raise the “health literacy” of Board Members. NICE guidance, eg is important when Boards consider their priorities. However, there are gaps in the evidence base, eg there is a shortage of useful material about the social return on investment from social care. (One example of some interesting recent research is the Bristol/University of the West of England work on the social return from efforts to reduce loneliness, which is due to report soon).
- There is concern that arrangements for health protection and resilience need more attention. The key role for organising the local response to public health emergencies is to rest with Directors of Public Health, and through them with both their councils and Public Health England. DPHs will need reassurance that they can still mobilise the support of other health professionals as necessary. Councils, of course, have had considerable experience of handling major emergencies, and the new location of DPHs inside the council should help to strengthen resilience planning.
- There is likely to be a shortage of experienced senior public health staff, and whilst a start has been made in preparing the next generation of leaders, more needs to be done—not least because their new home in local government requires even greater skills in working in a political environment, and brokering inter-sectorial alliances. The Local Government Association and the Faculty for Public Health have worked together to find solutions to some (but not all) of the dilemmas associated with the transfer of staff, and the LGA has run an extensive orientation programme for public health teams.

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- We should not underestimate the importance of the statutory offer of public health support to the CCGs. Public health specialists see their work on clinical commissioning priorities and evidence-based interventions as an integral part of their professional activity. The fear is that this will quickly become a distraction from work on the wider determinants of health and lifestyle issues—the Marmot agenda.
  - Budgets are a matter of concern. The three key risks are that:
    - (a) insufficient funds will be transferred to cover existing commitments
    - (b) local councils will raid the funds
    - (c) too much energy will go on arguments about the relatively small sums transferred with public health teams rather than the potential of the whole public services budget.

In relation to b), my personal view is that the public health budgets cannot be entirely protected from cuts when local government funds are falling steeply, but substitution of funding should only be acceptable when it involves services related directly to the transferred public health functions rather than other local government functions.

#### INVOLVING DISTRICTS, FORMAL PARTNERSHIPS AND OTHER STAKEHOLDERS

- Counties and Districts are working together thoughtfully to make sure that the Districts are fully involved in what can and should have a very local focus, and what can best be done at county level. It is generally recognised that much successful health improvement will have strong local roots. Inevitably, there will be some tensions, and Districts have sometimes thought that they have become invisible from the centre.
- Some County Boards, in the effort to become inclusive, have offered places to all their Districts and become quite large. They often tackle their executive functions through subgroups. Others have federated arrangements for Board Membership, are smaller and therefore more focused in their approach, but have to work harder at inclusion.
- One consequence of the difference in scale between Unitary Authorities and Counties is that the strategies of the former are often likely to be accompanied by delivery plans, whilst County strategies are more likely to provide a high-level framework rather than a detailed blueprint for action. This framework can then be used by District Councils and local CCGs to develop detailed local plans. This difference will make any comparative evaluation of the new strategies more complex.
- Most Boards are making a strong effort to reach out to local communities and stakeholders as they prepare their strategies. There is far more to be done to reach the “Inclusion Health” groups, and Healthwatch will be a major strength in this respect. There are already many practical examples of effective engagement activity, often building on pre-existing arrangements. In addition to making use of these mechanisms for neighbourhood and community engagement, most Boards have also set up forums for partners, providers and other stakeholders.
- Far less attention has been given to mobilising effort for change in communities and neighbourhoods. Boards will need to explore how best they can support community health development and social marketing as well as approaches to individual change such as motivational interviewing. The recent national emphasis on public mental health is important for health as a whole.
- Boards have given considerable thought to how best to link up with providers (large and small). Some have Board Members with experience of health provision (chosen not as sector representatives but for their contribution to the work of the Board). A very small number have recruited people with housing and regeneration experience, which is a matter of concern given the need to focus effort on the wider determinants of health. Even fewer have direct connections with business and commerce, although most Boards are building productive relationships with their LEPs.

#### THE WIDER CONTEXT

- Many Boards are concerned about the impact of major policy changes on health, especially the welfare reforms, the availability of housing, the funding of care and the impact of reductions in council resources on the voluntary sector. It is important to promote economic recovery, secure sound finances and reduce welfare dependency. However, for some of the most vulnerable people in our society, the combination of reduced income, more insecure housing and reduced support will work against the grain of health improvement.

## Written submission from Sheffield City Council

### EXECUTIVE SUMMARY

The sections below provide detail and evidence about the role of local authorities in health issues from Sheffield's perspective but there are three clear themes to note:

1. The transfer of public health to local government is a historic opportunity to bring together the skills and expertise of public health specialists with the skills and expertise, resources, knowledge and place-shaping capacity of councils. Government must maximise this opportunity to take a comprehensive approach to improving wellbeing and we urge Government to empower Sheffield with the necessary tools to tackle the wider determinants of health which cause health and wellbeing problems and enable the city to deliver a truly integrated approach to health and wellbeing.

2. Whilst there has been rapid progress on the transition locally, the adequacy of preparation at a national level has been and is mixed. There have been unhelpful delays in deciding how certain functions will operate, in agreeing budget allocations and in the human resource arrangements. Further, there has been a lack of clarity about where accountability will lie, unnecessarily risky and complicated responsibility arrangements for specific areas of public health (for example, health protection) and an overly "NHS-led" focus to the transition with limited involvement from individual local authorities.

3. It is crucial that the opportunities presented by the public health reforms are considered with recognition of the economic environment in which they are taking place. Whilst this is an opportunity for local authorities to ensure better health and wellbeing outcomes are the focus of all council services, the new approach is likely to be undermined by unintended consequences resulting from the Government's funding reductions for councils and reforms to the welfare system, council tax support, housing benefit support and the Social Fund which will all have a detrimental impact on the well-being of some of the most vulnerable people. The proposed public health funding formula which redistributes funds *away* from some of the most deprived areas of the country only add

### A HEALTHY AND SUCCESSFUL CITY: SHEFFIELD'S OFFER TO GOVERNMENT

4. We know that better well-being is the key to being a successful city. Poor health and inequality undermines Sheffield's ability to fulfil its social, economic and cultural potential at an individual, community and city level. Our ambition is to be a leading city for health and wellbeing with a committed City Council that is a high achieving, public health organisation.

5. Despite reducing resources, we aim to transform well-being in Sheffield and ensure that the resources we do have available are targeted at the most effective interventions to address and prevent the real underlying causes of poor health. Our health offer to Government is to deliver a transformational, sustainable health and well-being system which puts health at the forefront of everything the city does to make Sheffield a healthy successful city.

6. We want to deliver critical changes to the delivery of health and wellbeing in Sheffield by:

- Focusing on root causes to make Sheffield a healthier living environment.
- Prioritising problems on which we need to make a significant impact.
- Using resources available to focus on interventions which are proven to make the biggest impact on well-being; this may require changes of emphasis and priority to what the NHS has spent its public health funding on.
- Using local accountability and expertise to influence Governments and partner organisations for example on issues such major food and consumer issues, alcohol pricing, spatial planning, which have a direct impact on public health.
- Developing a genuinely people-led approach with ambitions and impacts designed by and with communities.

7. To deliver a successful approach to health and wellbeing, we urge Government to decentralise powers and associated resources to the City Council and where appropriate, the developing Sheffield City Region Combined Authority, to give the local area the critical tools to deliver better outcomes on the major drivers of wellbeing. If we are to deliver an integrated local approach to transforming health and wellbeing, it is crucial that local areas have greater control over the spectrum of wider determinants which impact on the wellbeing of individuals.

8. For example, the Marmot Review and other studies show that tackling the wider determinants is key to improving wellbeing and health is intrinsically linked to the success of cities. Poor health and wellbeing undermines people's life chances, mutually reinforces poverty, low pay, unemployment, and creates a drag on the socioeconomic success of the city. For example, Sheffield's GVA is currently around £9.5 billion but its "potential prosperity" is £11.2 billion. This "prosperity gap" of over £1.6 billion is significantly affected by long term unemployment (with ill-health a significant part of this) and lower productivity.<sup>54</sup> This is untapped

<sup>54</sup> Sheffield City Council (2012). *Bigger economy, better businesses, faster growth: draft economic growth strategy for Sheffield*, [http://www.welcometosheffield.co.uk/content/images/fromassets/100\\_1591\\_190912112019.pdf](http://www.welcometosheffield.co.uk/content/images/fromassets/100_1591_190912112019.pdf)

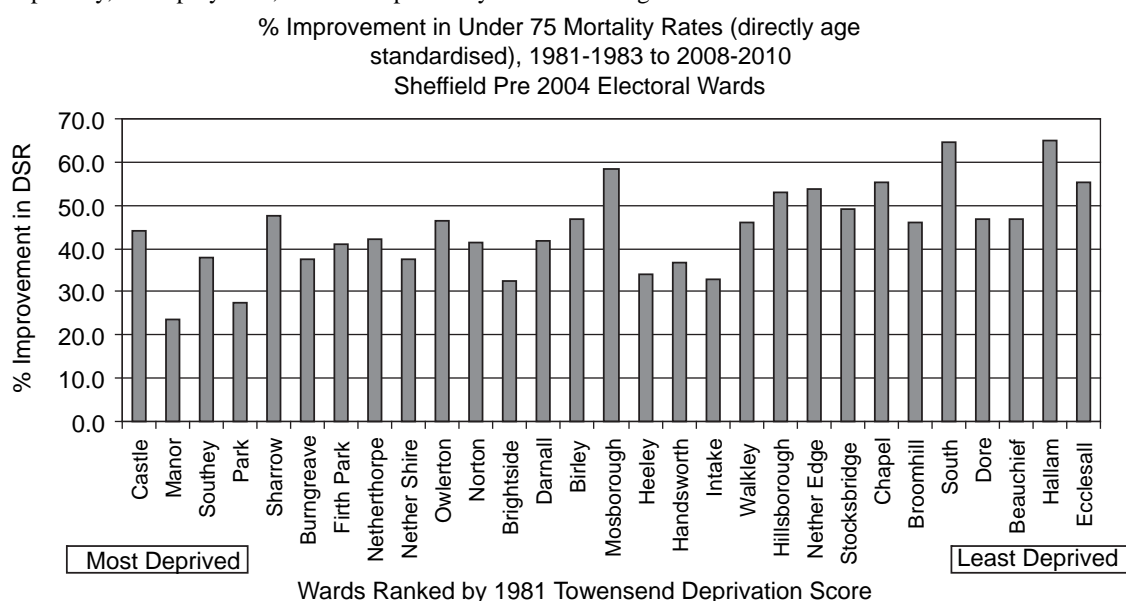
capacity and we want to support communities so that they are healthy and well to fulfil their potential and contribute to the economic success of the city.

9. Local areas need control over the necessary levers to make a step change in wellbeing. Government should adhere to its localist principles and devolve greater responsibility over skills, welfare, education, and housing to Sheffield to ensure that our local leaders have the right tools to drive the socioeconomic success of the city and enable local people to fulfil their potential. This could include:

- Building on Sheffield City Region’s (SCR) deal—devolve the full responsibility for skills to SCR so that people can access the training which our economy needs
- Devolve responsibility for the Work Programme to local areas to enable local partners to manage the delivery of the programme, provide a holistic approach which looks at health, wellbeing and employment issues together, ensure fairer outcomes for local people and hold providers to account.
- Enable local areas to retain a proportion of the welfare savings as a localised approach supports people back into work. Retained savings would then be reinvested in tackling the wider determinants of health.

## INTRODUCTION

10. The health and wellbeing of a city’s population is fundamental for the success of that city. In Sheffield, we have made significant steps forward with life expectancy increasing and deaths from cancer and cardiovascular diseases falling, ensuring that Sheffield is healthier than ever before. Between 2000 and 2010, life expectancy increased by 2.7 years for men and 1.5 years for women; a 37% reduction in deaths from cardiovascular disease and a 17% reduction in deaths from cancer.<sup>55</sup> Whilst we have had success in improving wellbeing, the city still faces significant challenges and some communities are blighted by the health and socioeconomic inequalities which remain the main causes of ill health and which perpetuate the higher levels of poverty, unemployment, welfare dependency and lower wages in those communities.



Source: ONS Mortality files, ONS 1981 population, PHR populations 2008-2010

11. The transfer of public health (PH) back to local government represents an historic opportunity to bring together the skills and expertise of PH specialists with the skills and expertise, resources, knowledge and place-shaping capacity of councils. Sheffield’s approach to the public health transition builds on this opportunity—designing a PH model for the future that is focused around achieving city and council outcomes.

12. With our partners on Sheffield’s (Shadow) *Health and Wellbeing Board* (HWB), we have agreed an ambitious *Joint Health and Wellbeing Strategy* (JHWS) which makes tackling the wider determinants of health central to the city’s new approach to commissioning and delivering health and wellbeing services, ensuring that we can make full use of the resources available to address the causes of poor health.

13. It is indeed “a major misconception...that anything to do with health and ill-health is surely the business of the health sector and primarily the NHS”<sup>56</sup> and we agree with the analysis of Sir Michael Marmot that “action is required across all these social determinants of health and needs to involve all central and local

<sup>55</sup> NHS Sheffield (2012)

<sup>56</sup> Hunter, D J (2010). “What makes people healthy and what makes them ill?”, in *The social determinants of health and the role of local government*, [http://www.local.gov.uk/c/document\\_library/get\\_file?uuid=e04ec7cd-5721-4832-9df0-e456b898f572&groupId=10171](http://www.local.gov.uk/c/document_library/get_file?uuid=e04ec7cd-5721-4832-9df0-e456b898f572&groupId=10171)



government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities”.<sup>57</sup>

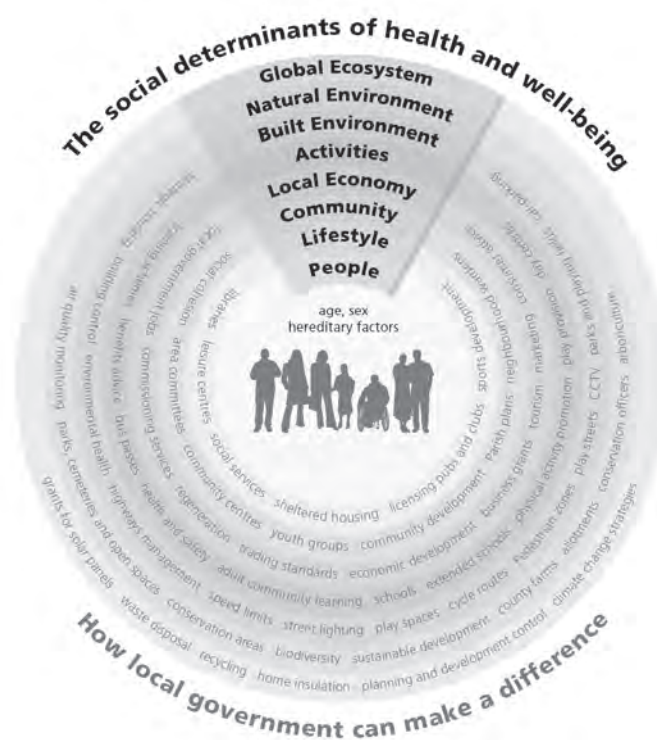
14. Therefore, we are committed to make Sheffield City Council a “public health organisation” with a strong public health ethos impacting across the Council’s and the city’s strategic outcomes, commissioning and service delivery. Our key design principle is that the success of the transfer will be very much about integrating PH expertise within the everyday work of the Council so as to achieve better outcomes for the people of Sheffield.

#### THE INTRODUCTION OF A PUBLIC HEALTH ROLE FOR COUNCILS

15. It is misleading to suggest that the Government’s decision to transfer public health responsibilities to local authorities marks an “introduction” of the public health role into councils. Local authorities have always had a key role in addressing the health and wellbeing needs of the population, whether that be through housing, environmental health, education, CYP services, adult social care or services which improve and maintain street and community environments. This added value is sometimes under-estimated and under-valued in the current debate about the transfer of NHS Public Health services.

16. Numerous studies have demonstrated that wellbeing across the life course is influenced and affected by a wide range of factors, many of which can be positively influenced by a well-resourced, outcome focused local authority. As Sir Michael Marmot argued in his review of health inequalities:

Councils are therefore well placed to bring all agencies—public, private, third sector—to tackle crosscutting issues which affect their residents and their community...Local councils have the power to secure the economic, environmental and social well-being of the local population. They are therefore in a key position to mobilise action to tackle health inequalities and improve well-being.<sup>58</sup>



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17. The place-shaping role of local authorities ensures that the changes to the health system in England represent an opportunity to combine the expertise in the NHS in Sheffield with those in the council to put health and wellbeing at forefront of services.

18. Whilst Marmot also suggested that councils have sometimes been “reticent” of taking a lead on health because the NHS was traditionally seen as the lead agency, Sheffield City Council and the NHS in Sheffield have developed a strong, collaborative relationship including a number of joint appointments and service-level working between organisations for a number of years. The two organisations co-ordinated working between

<sup>57</sup> Marmot, M (2010). *Fair Society, Healthy Lives*, <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> p18.

<sup>58</sup> Ibid, p158

<sup>59</sup> LGA (2010). *The social determinants of health and the role of local government*, [http://www.local.gov.uk/c/document\\_library/get\\_file?uuid=e04ec7cd-5721-4832-9df0-e456b898f572&groupId=10171](http://www.local.gov.uk/c/document_library/get_file?uuid=e04ec7cd-5721-4832-9df0-e456b898f572&groupId=10171)

their respective strategic leadership before the HSC Act was introduced. We've continued and built on this with Sheffield's Clinical Commissioning Group.

19. The Public Health Directorate in Sheffield PCT, and its predecessors, the former 4 PCTs in the City and the former Sheffield Health Authority, has been working for over two decades with the City Council to address the root causes of ill health and health inequalities, leading, for example, to "Beacon Status" being granted to the City for addressing health inequalities.

20. SCC has had a Health Improvement Team with a Director jointly appointed by SCC and NHSS for some time. This team has been successful in developing a joint health inequalities action plan to address wider determinants of ill health in the city.<sup>60</sup>

21. We have established a clear vision for what we want to achieve through the new arrangements for health and wellbeing. In Sheffield's JHWS, we have identified that our mission is to:

- *Tackle the main reasons why people become ill or unwell* and in doing so reduce health inequalities in the city.
- *Focus on people*—the people of Sheffield are the city's biggest asset. We want people to take greater responsibility for their own wellbeing by making good choices. Services will work together with Sheffielders to design and deliver services which best meet the needs of an individual.
- *Value independence*—stronger primary care, community-based services and community health interventions will help people remain independent and stay at or close to home
- Ensure that all services are *high quality and value for money*.

22. We've identified 5 outcomes which demonstrate our ambition and commitment to delivering holistic change to the health and wellbeing system in Sheffield which is necessary to deliver the improvements to health which the city needs.

- *Outcome 1*: Sheffield is a healthy and successful city (wider determinants).
- *Outcome 2*: The health and wellbeing of people in Sheffield is improving all the time.
- *Outcome 3*: Health inequalities are reducing.
- *Outcome 4*: People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and feel is right for them
- *Outcome 5*: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money.

23. We have set out our aspirations to deliver a significant change in this area by ensuring people get the right services they want first time and we will prioritise helping people to be independent able to access the services at home or as close to home as possible.

#### THE ADEQUACY OF PREPARATIONS FOR THE NEW ARRANGEMENTS

24. At a local level, Sheffield City Council and the CCG have used the joint working which has developed over the years to make rapid, early progress on the transition. There has been close Member engagement and while the transfer of staff is not required until April 2013, in many areas public health staff are already integrating successfully with services and Sheffield City Council management arrangements.

25. We have established a programme to manage the transition in Sheffield led by the Executive Director for Resources. Our PH model will ensure that the DPH, (who will report directly to the SCC Chief Executive) leads a core DPH Office; works with other directors to ensure strong public health expertise and leadership across the council and the city; and is seen as city's chief advisor on public health. The DPH Office will provide professional leadership to other senior PH staff, take lead responsibility for their continuing professional development and work with portfolio Executive Directors to deploy public health skills, capacity and resources into their teams. The DPH Office will provide advice and support to ensure that public health expertise continues to be of high quality and consistency across the Council and provides a "core offer" to the CCG. We also recognise that the DPH has an important outward facing role, across the City.

26. We feel that the adequacy of preparation at a national level is mixed. There have been unhelpful delays in deciding how certain functions will operate and where accountability will lie. For example, it is not known whether the responsibility and resource for infection control in hospitals and community settings will come with PH to councils, pass to CCGs, or go to the NHS CB LAT—or something else altogether.

27. The arrangements for screening, vaccination and immunisation are only now just becoming clear and it remains unclear how the vital health protection on-call arrangements are going to work. At the moment these are staffed in most areas by PCT Public Health Consultants, but it is not known whether they will continue to have this responsibility in future.

28. The precise way in which the DPH is expected to hold other public health agencies to account without either the commissioning budget or formal managerial authority, is not clear. For example, the DPH will have

<sup>60</sup> SCC and NHSS (2010). *Fairer Sheffield, healthy lives: health inequalities action plan 2010–13*, <http://www.sheffield.nhs.uk/healthdata/resources/hiap2010.pdf>

to be assured that screening programmes are working well locally, but they will be commissioned by another organisation (PHE), working in a second one (NHS CB LAT) and from a variety of other organisations (local Foundations Trusts, GPs etc).

29. Further, under the new system, the DPH will be accountable to councils and the Secretary of State via Public Health England. It is understandable why Government wants to have this accountability in place but the operating rules for this arrangement need further focus and development.

30. There remains a lack of information about some important details, for example on the ability (or not) of ex-NHS staff to continue to be members of the NHS pension scheme if they change jobs post transfer. This is very unsettling for staff transferring, and is militating against smooth transition and the continuation of essential public health functions during the process.

31. The delay in the announcement about the PH budget has caused difficulties with existing contracts and providers meaning that arrangements with current providers are having to “roll over”.

32. The Department of Health’s transition programme is perceived as taking a very NHS-led approach to the PH changes. It could have secured more active involvement of individual local authorities in the “design” of the new system. Moreover, there is a perception that the national focus has been on “protecting” NHS Public Health specialists and programmes rather than actively engaging and supporting local government—clearly, there does need to be support for NHS staff who are moving across to councils but this needs to be balanced alongside the potential opportunities for the future in terms of public health impact. The Local Government Association has tried to re-balance this perception and Public Health England has started to open up a dialogue with local government on these issues.

33. As a consequence, not enough recognition has been given to the fact that LAs already have well established health functions, and the transfer in of Public Health is not so much the addition of a wholly new set of functions, responsibilities and staff, so much as the need to integrate a team and resources with already existing skills and structures. This has implications for the leadership of health within local authorities: one of the big opportunities from the changes is to harness the combined expertise of NHS Public Health specialists and the significant number of council staff who deliver public health improvement day in day out but who may not be recognised by the Faculty of Public Health or the NHS as doing so.

34. The prolonged transition period has inevitably led to some “planning blight”, with key decisions, (eg about the appointment of senior posts at a national level), not being taken.

#### THE OBJECTIVES OF THE NEW ARRANGEMENTS AND HOW THEIR IMPACT CAN BE MEASURED

35. The new Health and Wellbeing Board in Sheffield has made an explicit commitment to address the wider determinants of health and the local performance arrangements will be structured to best measure our impact on this.

36. Measurement of the impact of specific public health programmes on a population level has always been, and remains, a challenge. This is because public health initiatives take place in the context of continuing change within society, which in turn impacts on health. In many cases, these “external” (ie non- “public health”) forces are significantly more powerful. Thus, for example, the current economic recession is likely to have far more extensive impact (negatively) on the health of the population than locally managed, relatively poorly resourced, public health programmes.

37. This is one reason why the proposed “Health Premium” (the allocation of a proportion of the Public Health Grant on the basis of progress against certain PH outcomes) is flawed both in theory and practice. Local Authorities are already motivated to address poor health, and the addition of a small amount of funding will not enhance that. Improvement of particular PH outcome measures is not a reliable indicator of successful Public Health activity (since there are so many other external factors), and PH outcomes change over a longer time frame than allows this mechanism to work. Finally, it will inappropriately and unfairly reward those areas where health is improving anyway, where arguably less Public Health resource is needed.

#### THE INTENDED ROLE OF HEALTH AND WELLBEING BOARDS IN COORDINATING THE NHS, SOCIAL CARE AND PUBLIC HEALTH AT THE LOCAL LEVEL

38. Sheffield benefits from having one Clinical Commissioning Group (CCG) at the city level and an equal number of GPs and Elected Members on the HWB who are committed to achieving shared outcomes. The HWB have agreed that it will discuss commissioning plans from both CCG and SCC at an early stage to add challenge where investment is targeted and ensure that commissioning is focused on Sheffield’s JHWS outcomes and the health and wellbeing needs of local people.

39. We recognise there is a danger in HWBs being dominated by process. HWBs comprise the lead GPs, Cabinet Portfolio holders and offers in local authority areas. The challenge for the HWBs is to use their joint and individual status and influence to advocate better health and wellbeing; challenge each other, partner organisations, local people and national bodies (DH, PHE, NHSCB etc) to deliver better health outcomes.

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HOW ALL LOCAL AUTHORITIES CAN PROMOTE BETTER PUBLIC HEALTH AND ENSURE BETTER HEALTH PREVENTION WITH THE LINK TO SPORT AND FITNESS, WELLBEING, SOCIAL CARE, HOUSING AND EDUCATION

40. The evidence presented in Sir Michael Marmot's review into health inequalities is very strong. The Government's policy position regarding public health of "personal responsibility" is somewhat at odds with the evidence presented by Marmot. We believe that, in some instances, the public health budget can legitimately be used to target access and opportunities in these social determinants, not merely using the arenas to promote personal lifestyle changes.

41. Therefore, to use these "services" to provide public health "solutions", the health and local authority data and intelligence must be combined, so that together, we can ensure we provide the services (eg home insulation, extra care for older people, support for vulnerable adults, improved opportunities or physical activity etc) to people and families who the health sector already know are likely to have poor health outcomes. We can do this by geography but with shrinking resources and increased "mobility" (be it optional or forced), the grain needs to be finer. We still seem to be unable to exchange data for these important issues due to data protection or organisational "security".

42. It is important to recognise that local authorities can only better promote public health under the new arrangements *either* by using the money transferred from the NHS differently and more effectively than they were being used previously, or by using the public health expertise that is being transferred to alter the way they have previously been discharging their responsibilities in the areas of sport and fitness, social care, housing etc. The likely benefits from the former approach are very modest, partly because the Public Health grant itself is a ringfenced, finite allocation, and within that a very large proportion is to be spent on mandated (eg sexual health) or otherwise unavoidable (eg substance misuse) services, and partly because, within the NHS, Public Health teams have been very careful to use the money on effective, evidence based, interventions. If there were better ways (in the sense of delivering more health gain) of using the money, it is likely that this would already have been considered. This means that the only real way in which the changes can lead to LAs making a step change in public health is through the second route—ie using public health expertise to influence activity across the whole Council, thus addressing the root causes of poor health in the area. This is the thinking that underpins the "distributed" model of public health which we are pursuing in Sheffield.

BARRIERS TO INTEGRATION, INCLUDING ISSUES IN MULTI-TIER AREAS

43. Despite the opportunities the transition creates, there are some clear barriers which may impact the effective delivery of public health in local areas. The dividing up of responsibility for commissioning some programmes is a major barrier to integration. For example, responsibility for addressing overweight and obesity now falls between *three* organisations—local authorities (public health initiatives, prevention, weight management programmes), CCGs (treatment of overweight and obesity), the NHS CB LAT (specialised commissioning of bariatric surgery, and primary care commissioning). This militates strongly against a joined up approach.

HOW THE TRANSFER TO LOCAL AUTHORITIES OF THE FRONT-LINE HEALTH PROTECTION ROLE AND THE CREATION OF PUBLIC HEALTH ENGLAND WILL AFFECT RESILIENCE ARRANGEMENTS AT THE LOCAL LEVEL

44. There is a real danger in the separation of the responsibility for health protection in a local area being vested in the DPH within the Local Authority, whilst the resource and professional expertise to address it rests within the Health Protection Agency, which is in turn to become part of Public Health England. This gives the DPH and LA responsibility without any authority.

45. There is still no clarity about how the on call, out of hours, cover for health protection will operate, and in particular whether the PH specialist staff transferring from PCTs to LAs will be expected to continue to provide this when based in local authorities.

46. As stated previously, the division of responsibility in some important areas militates against effective health protection arrangements. For example, the detection and treatment of tuberculosis, whilst clearly a public health issue of great importance, falls between CCGs, Public Health England and NHS CB LATs (specialised commissioning for treatment of multi-drug resistant TB).

THE ACCOUNTABILITY OF DIRECTORS OF PUBLIC HEALTH

47. There are naturally questions about the ability of DPHs to remain neutral commentators on public health whilst employed within a political environment. This will undoubtedly be a challenge for all DPHs, especially when faced with current financial climate and Elected Members potentially favouring "non-traditional" or "non-medical" public health interventions which address the wider determinants of health. However, other local government roles have been successful in maintaining this neutrality (eg monitoring officer, Section 151 officer).

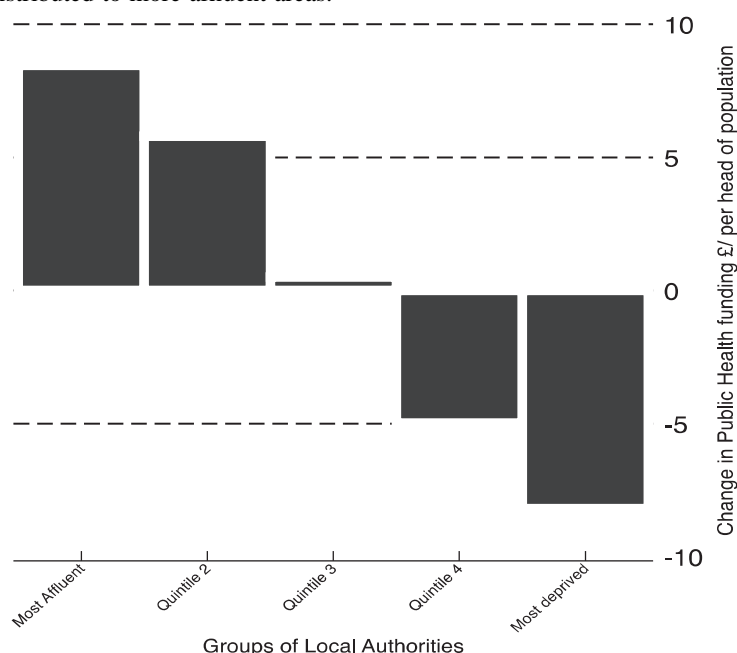
48. If Directors of Public Health are to be, and are to be seen to be, effective champions for the health of the population, they must be senior positions of authority both within the Local Authority management structures, as well as more widely across the local area. The former indicates that they should be accountable to the Chief Executive, and the latter requires that they should be seen to have both a high status and respect

within the employing authority, as well as an ability to speak independently on matters of public health importance.

#### THE FINANCIAL ARRANGEMENTS UNDERPINNING LOCAL AUTHORITIES' RESPONSIBILITIES, INCLUDING THE RING-FENCING OF BUDGETS AND HOW THE NEW REGIME CAN LINK WITH THE OPERATION OF COMMUNITY BUDGETS

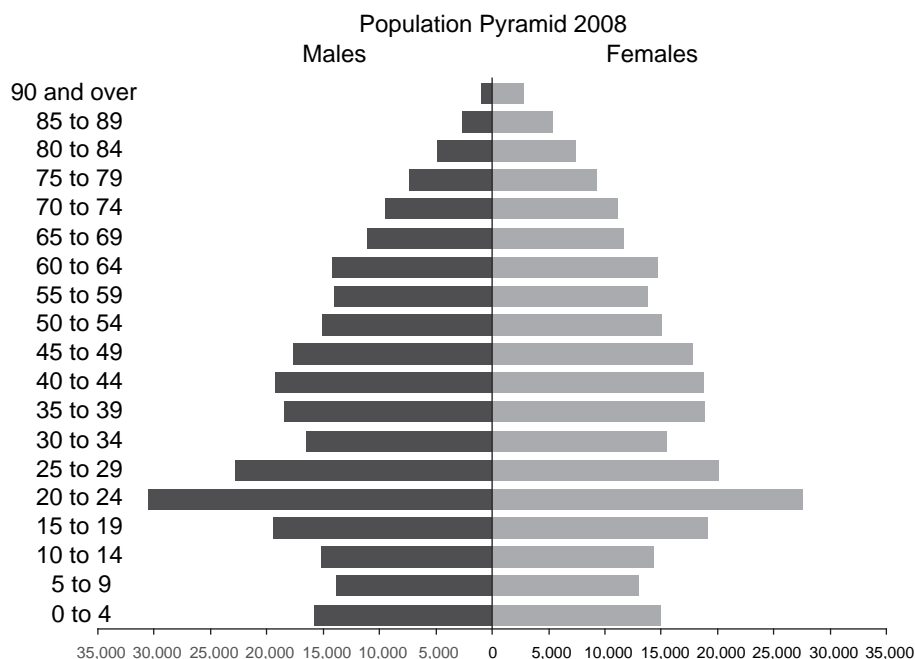
49. The shift to HWBs and a joint strategy for areas does mean that there is an opportunity to utilise the totality of council and NHS spend in an area to improve wellbeing outcomes and make better, health-focused decisions.

50. There has been much debate about how the proposed formula redistributes funds away from some of the most deprived areas of the country and does not reflect some historical funding in some more deprived areas that have been invested because of the higher levels of need. The formula doesn't adequately justify why this should now be redistributed to more affluent areas.



51. The appropriateness of using Standard Mortality Rates (aged under 75) as the only deprivation measure and the way it has been applied to the formula (ie the way in which the indicator of need has been used to arrive at a weighted population figure with the figures for each area grouped into deciles and a ranking applied and a score attached to each decile that ranges from 1 for the lowest decile to 3 for the highest decile).

52. The proposed formula does not include any age-weighting. There is a strong case for applying an age weighting in the formula because of the nature of the services that are being transferred to the Local Authority. The two largest areas of spend, sexual health services and the drugs service, account for over 50% of the overall public health grant and users of these services are predominantly younger. Therefore, applying an age weighting element to the population in the formula would potentially increase the allocation to areas where there is a higher demand for these services. Other services such as school nursing are clearly age defined.



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53. It is welcomed that there will be some initial protection of current funding levels. However, as shown in *Appendix 1*, there are significant changes proposed to funding levels as a result of the proposed formula change. Similarly, *Appendix 2* sets out the impact on the Core Cities in England. Sheffield City Council has seen its own resources reduce significantly over the last few years and faces a further challenging savings target in 2013–14 with more savings projected for future years. It will not be able compensate for any loss of funding in public health.

54. We would therefore suggest a longer timeframe for change with no real term cuts. Additional investment should be prioritised to level up those areas of lower funding rather than penalise areas that have invested in the service to address its population need and reduce health inequalities.

55. In 2008 the WHO said if health inequalities are to be reduced, inequities in how society is organised have to be addressed “this requires a strong public sector that is committed, capable and adequately financed”: the austerity impacts on local government presents a difficulty here.

56. Despite the fact that the Public Health Grant is notionally “ring fenced”, it will be under enormous pressure. Local authorities are managing significant reductions in resource at a time of significantly increasing demand for some statutory services. There is a critical need for local authorities to shift the focus for investment to tackling the real causes of ill health and making targeted, evidence-driven interventions in the key things which will improve the health and wellbeing of local people. In the challenging financial climate, it is fundamental that we make best use of our reducing resources and this might mean prioritising a smaller number of interventions which are proven to have the greatest impact on public health and wellbeing in Sheffield rather than trying to maintain a wide-range of potentially less successful interventions.

57. Recognising the relevance of “place” within the social determinants of health mean, with an adequate Joint Strategic Needs Assessment process, the resources of health system and local authority can be applied jointly to address these social factors within the context of community budgets. However the big challenge will still be to find a way to develop a more preventative approach to health, whilst still having to fund treatment within the system, as successful prevention measures are developed.

58. Our ambition is to tackle inequality and the wider determinants but there may be unintended consequences which result from the Government’s reforms to the welfare system, council tax benefits, housing benefits, the Social Fund which will take an estimated £180 million out of the pockets of some of the most vulnerable people in Sheffield and out of the city’s economy. We want to deliver a more sustainable health and wellbeing system which prioritises prevention, independence and early intervention while reducing the high cost demand on acute care. However, without the resource capacity to tackle the causes of ill health and invest in upstream services and interventions, the cost will continue to accumulate on hospital and social care services. The “Graph of Doom” scenarios are a real threat to the wellbeing of people and the affordability of the health system.

59. Cities like Sheffield need the necessary powers to not only promote and create opportunities for economic growth (ie. as in our successful City Deal recently agreed with Government) but also to address the health and wellbeing problems which exacerbate benefit dependency, poverty, low incomes and productivity lags in our economies.

November 2012

## APPENDIX 1

### COMPARISON OF PUBLIC HEALTH FUNDING—YORKSHIRE AND THE HUMBER

#### COMPARISON OF PUBLIC HEALTH FUNDING

<i>Council</i>	<i>Baseline Spending Estimates £000 (1)</i>	<i>Share implied by ACRA</i>	<i>ACRA interim Allocations £000 (2)</i>	<i>Increase (+)/ Decrease (-)</i>	<i>% Change</i>
Kingston upon Hull	20,164	0.68	15,120	-5,043.60	-25.01%
East Riding of Yorkshire	7,430	0.51	11,340	3,910.30	52.63%
North East Lincolnshire	8,762	0.36	8,005	-757.08	-8.64%
North Lincolnshire	7,364	0.34	7,560	196.20	2.66%
York	5,620	0.33	7,338	1,717.84	30.57%
Barnsley	12,181	0.53	11,785	-395.98	-3.25%
Doncaster	16,707	0.67	14,898	-1,808.96	-10.83%
Rotherham	12,990	0.55	12,230	-760.27	-5.85%
<b>Sheffield</b>	<b>25,730</b>	<b>1.10</b>	<b>24,459</b>	<b>-1,270.53</b>	<b>-4.94%</b>
Bradford	25,225	1.20	26,683	1,458.06	5.78%
Calderdale	7,013	0.41	9,117	2,103.71	30.00%
Kirklees	19,487	0.85	18,900	-586.50	-3.01%
Leeds	30,255	1.50	33,354	3,098.82	10.24%
Wakefield	18,736	0.74	16,455	-2,281.45	-12.18%
North Yorkshire	16,382	0.91	20,235	3,852.65	23.52%
<b>Yorkshire and the Humber</b>	<b>234,046</b>	<b>10.68</b>	<b>237,479</b>	<b>3,433.20</b>	<b>1.47%</b>
<b>Other Regions</b>					
<b>North East</b>	<b>177,598</b>	<b>5.53</b>	<b>122,964</b>	<b>-54,633.58</b>	<b>-30.76%</b>
<b>North West</b>	<b>358,019</b>	<b>15.00</b>	<b>333,538</b>	<b>-24,480.80</b>	<b>-6.84%</b>
<b>East Midlands</b>	<b>178,820</b>	<b>8.30</b>	<b>184,558</b>	<b>5,737.80</b>	<b>3.21%</b>
<b>West Midlands</b>	<b>244,538</b>	<b>11.00</b>	<b>244,595</b>	<b>56.68</b>	<b>0.02%</b>
<b>East of England</b>	<b>167,051</b>	<b>9.30</b>	<b>206,794</b>	<b>39,742.68</b>	<b>23.79%</b>
<b>London</b>	<b>471,360</b>	<b>18.00</b>	<b>400,246</b>	<b>-71,114.16</b>	<b>-15.09%</b>
<b>South East</b>	<b>240,677</b>	<b>14.00</b>	<b>311,302</b>	<b>70,625.32</b>	<b>29.34%</b>
<b>South West</b>	<b>151,478</b>	<b>8.60</b>	<b>191,229</b>	<b>39,750.57</b>	<b>26.24%</b>
<b>National Total</b>	<b>2,223,587</b>	<b>100.41</b>	<b>2,232,705</b>	<b>9,117.71</b>	<b>0.41%</b>

## APPENDIX 2

### COMPARISON OF PUBLIC HEALTH FUNDING—CORE CITIES

<i>Local Authority</i>	<i>2012–13 Baseline</i>		<i>Indicative Formula</i>		<i>Gain/(Loss)</i>	
	<i>Spend</i>	<i>% Share of Total</i>	<i>% Share of Total</i>	<i>Allocation of £2.2m</i>	<i>Change</i>	<i>% of Total</i>
	<b>£000s</b>			<b>£000s</b>	<b>£000s</b>	
<b>ENGLAND</b>	<b>£2,223,588</b>			<b>£2,223,588</b>		
Birmingham	48,348	2.174%	2.497%	55,523	7,175	14.8%
Bristol, City of	17,465	0.785%	1.026%	22,816	5,351	30.6%
Leeds	30,255	1.361%	1.550%	34,463	4,208	13.9%
Liverpool	34,159	1.536%	1.216%	27,038	-7,121	-20.8%
Manchester	29,904	1.345%	1.317%	29,289	-615	-2.1%
Newcastle upon Tyne	18,213	0.819%	0.647%	14,393	-3,820	-21.0%
Nottingham	23,422	1.053%	0.758%	16,851	-6,571	-28.1%
Sheffield	25,730	1.157%	1.107%	24,612	-1,118	-4.3%
<b>Core Cities</b>	<b>227,496</b>	<b>10.231%</b>	<b>10.118%</b>	<b>224,985</b>	<b>-2,511</b>	<b>-1.1%</b>

### **Supplementary written submission from Sheffield City Council**

#### **RE: CLG SELECT COMMITTEE INQUIRY — PENSION FUND INVESTMENTS IN TOBACCO BUSINESSES (Q222–224)**

Thank you for giving me the opportunity to give evidence to the CLG Select Committee Inquiry into the role local authorities play in health issues. I hope you found both our written and oral evidence useful for the Inquiry. I feel that it gave me the opportunity to demonstrate the progress and commitment we have in Sheffield, both as a City Council and as a partner of the Health and Wellbeing Board, to transform wellbeing in the city and tackle the root causes of ill health and health inequality. I also feel it was crucial that we were able to raise our concerns about some specific elements of the changes to the health system and that our concerns were shared by the fellow local authorities who gave evidence in the same session.

With regards to your final question (Q222–224) about the investments made by local authority pension funds in tobacco-related businesses. I am aware that the December 1 British Medical Journal (BMJ) (Volume 345) has recently published an article using information obtained under the Freedom of Information Act which suggested that the South Yorkshire Pensions Authority (SYPA) has investments worth £62.8 million in tobacco-related businesses.

Following the Select Committee, I asked SYPA to provide me with an updated figure (the FoIA value is thought to be as at end June 2012) and as of the end of November 2012, the value of shares held in tobacco-related companies had risen to £64.5 million.

As you know, share prices fluctuate and the whole Fund value has also risen over this period from £4.57 billion to £4.82 billion. This means that roughly 1.2%/1.3% of the total value of the Fund is represented by tobacco shares.

Whilst investments are undertaken to ensure the long-term financial sustainability of the pension fund for its members, SYPA recognise the potential conflicts some investments may cause with the commitments of South Yorkshire's public sector organisations to improve the health and wellbeing of local people.

From March 2013, SYPA will carry out an investment review to ensure that the fund is sustained by responsible investments. The results of the review will be then put to the SYPA Board to decide how to proceed.

*December 2012*

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### **Written submission from Cornwall Council**

#### **EXECUTIVE SUMMARY**

Our response focuses on the adequacy of preparations for the new arrangements and the intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health in Cornwall.

Cornwall Council welcomes the reforms which present an opportunity for increasing democratic influence in future health and care commissioning. From the start, the council, NHS and voluntary sector colleagues including LINK volunteers have taken a positive and proactive approach to the reforms seeing the opportunities for beneficial change and the realities of managing those changes in the light of reducing public sector resources and the wider economic context.

Cornwall was one of the first councils to engage with the reforms as an Early Implementer for Health and Wellbeing Boards and Health Watch pathfinder. John Wilderspin, Director for Health and Wellbeing Boards, spoke at the Shadow Board's first joint conference in October 2011 which resulted in the Chair of the Health and Wellbeing Board being invited to contribute to discussions at a national level both for health and wellbeing development and public health engagement as a member of the NICE steering group. The Shadow Board has also engaged in the national pilot for health commissioning which has been sponsored by the Department of Health and facilitated by Institute for Voluntary Action Research (IVAR) and Social Enterprise UK.

As a result of involvement in the National Learning Sets, Cornwall has been invited to national conferences to present the approach being taken in Cornwall:

- The Commissioning Show 2012—June (London Olympia) (Corporate Director, Adult Care and Support).
- LGA Healthy workforce, healthy communities conference—October (London) (Chair Shadow Health and Wellbeing Board).
- Capita's 3rd National Conference, Implementing Health and Wellbeing Boards—October (London) (Managing Director Designate, Kernow Clinical Commissioning Group and Corporate Director, Adult Care and Support).



Cornwall is in a position to launch its health and wellbeing board, health and wellbeing strategy, HealthWatch Cornwall, NHS Complaints Advocacy and transfer of public health functions in April 2013 (subject to regulations being in place).

*Cornwall Council requests that the Committee acknowledges the positive progress made to date by Cornwall regarding the establishment of its health and wellbeing board and considers the following*

1. Unlike LEP and LNP Boards, there has been no additional funding towards development costs and the Council has mainly picked up these costs in relation to establishing the HWB, producing the joint strategic needs assessment and strategy and establishing Local HealthWatch. On-going development, administration and integration will need to be covered from existing resources at a time when public funds are under significant pressure.

2. Delays to secondary legislation have exposed the council and partners to risk which has at times been difficult to manage within existing democratic processes and at a time when there are concerns over limited finances. It has been challenging to manage preparedness without knowing the full extent and impact on resources.

3. The addition of the Health and Wellbeing Board to the governance structure of the Council may require revisions to the Constitution. Delay to the publication of the secondary legislation will mean the statutory deadline of April 2013 may not be met, although Shadow arrangements will continue as necessary.

4. Strategic commissioning arrangements will need to be reviewed to enable an integrated approach to commissioning and facilitate the provider market; to adjust services to needs, including prevention and develop integrated health and care pathways.

5. Strategic commissioning arrangements will need to be reviewed to enable an integrated approach to commissioning and facilitate the provider market; to adjust services to needs, including prevention and develop integrated health and care pathways.

6. It is unknown at this stage how the role and relationship with Local HealthWatch will unfold. This will need to be developed in terms of its role on the Health and Wellbeing Board and how we deal with issues that the public and patients experience and the interface with the Council's health scrutiny function.

7. Council and NHS partners' ability to maintain effective services in the present system and manage current pressures on resources across the system are exacerbated with the level of structural change in the system. Our collective ability to secure cashable savings to invest in alternative service provision and innovation with no extra funding and managing existing deficits as a result of historic under-funding is regularly challenged.

8. There is potential for a contradiction of policies being developed by other Departments, for example, welfare reform which will pay "head of household" and Department of Health encouragement of personal budgets.

## INTRODUCTION

Cornwall is a maritime area, set on the most south westerly tip of the South West peninsula, covering an area of 3,559 sq km. It is the second largest local authority area in the South West region with a population of approx 550,000, and has the longest coastline of all English counties at 697 km. Cornwall itself has a distinctive peninsular form with a long indented coastline. The sea forms the northern, southern and western boundaries, with the River Tamar forming the eastern border with Devon.

Cornwall is an area of many contrasts; with varied landscapes encompassing remote rural, coastal and environmentally sensitive areas, interspersed with villages and historic market towns and where affluence sits alongside some of the most disadvantaged areas in England. This shapes how we plan for and deliver growth and influences the cost and shape of our services and presents particular challenges for the future of health and care in Cornwall.

In April 2009, Cornwall became a unitary authority. The Council has 123 Councillors, working with and supported by 213 Parish Councils. There are also currently five parliamentary constituencies in Cornwall, this will rise to six from the next General election in 2015.

Cornwall falls within the southern region of the NHS Commissioning Board and Public Health England boundaries and has one clinical commissioning group which covers the county and the Isles of Scilly.

## THE SHADOW HEALTH AND WELLBEING BOARD

The Shadow Board has met regularly since July 2011. It has held meetings in public and informal meetings that have been used to build relationships between partner organisations and develop its approach. Board membership reflects the requirements of the Act but also includes a place for a strategic representative of the voluntary and community sector and the police.

The Shadow Board is keen to promote the use of all resources such as Cornwall's unique environment, community and voluntary sector resources and facilities and culture and heritage so we are working to

understand and map what this looks like to find creative ways of improving wellbeing. The Shadow Board is applying the following principles to achieve success:

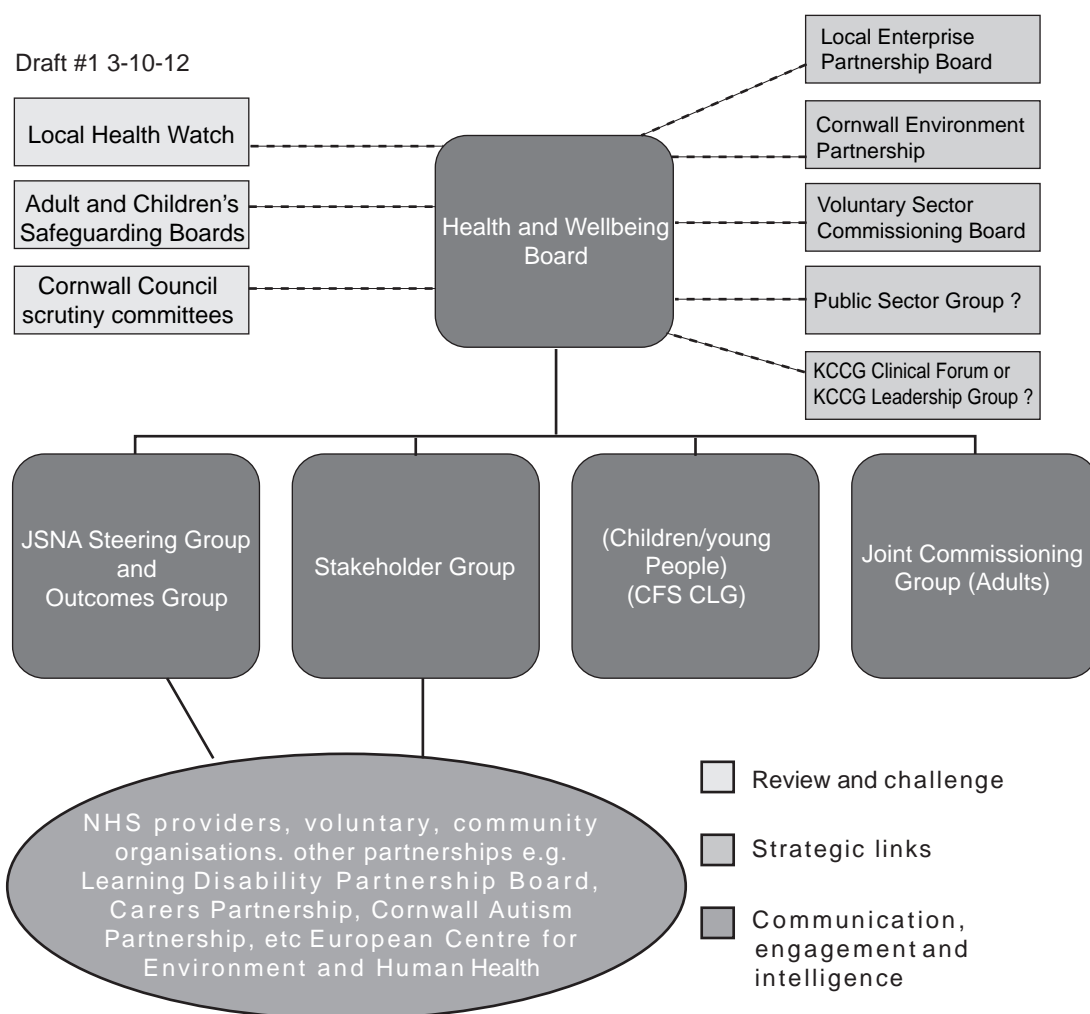
- Leadership and shared vision.
- Shared values, assessment and agreed multiple outcomes.
- Integrated delivery and mainstreaming prevention.
- Encouraging Self care and self management.
- Increasing capacity for expertise and shared learning.

A fundamental aspect of the Board's philosophy is effective and regular communication and engagement with all stakeholders. A stakeholder group has been established to provide a mechanism that will reach organisations and user groups across the spectrum of health and wellbeing including NHS Trusts, service user groups, other partnerships including safeguarding boards and community safety. The Kernow Clinical Commissioning Group has established its clinical forum and the Board will be exploring links to this as well as the patient participation groups attached to each GP practice.

The Health and Wellbeing annual conference will take place in February 2013 in partnership with the European Centre for Environment and Human Health and the new Health and Wellbeing Innovation Centre which will also provide the venue. The Board is pursuing these relationships recognising the potential for research, innovation and economic development opportunities in the reform agenda. Our keynote speaker is Sir David Nicholson.

#### GOVERNANCE ARRANGEMENTS

Discussions have been held with a number of stakeholders to establish views and "fit" with other structures. A draft structure has been produced for consultation in November with the Joint Commissioning Group (council and clinical commissioning group commissioners leading on priorities for commissioning that will support delivery of the health and wellbeing strategy and health priorities) and Stakeholder Group as well as Health and Wellbeing Board member senior teams. Final detail will be confirmed when the outcome of the secondary legislation is agreed which is unlikely to go to Parliament until January and presents a potential issue for Cornwall which has all out elections in May.



*NHS providers, voluntary, community organisations. other partnerships eg Learning Disability Partnership Board, Carers Partnership, Cornwall Autism Partnership, etc European Centre for Environment and Human*

*Review and challenge*

*Strategic links*

*Communication, engagement and intelligence*

#### DEVELOPMENT PROGRAMME

The scale of change is considerable as a result of the reforms and the council and its NHS partners will need to understand each others cultures and practices better to ensure that the changes can deliver maximum benefit. The shadow health and wellbeing board commissioned a development programme that will enable an exchange of experience and expertise across GPs and councillors and a pilot will be implemented in the New Year.

#### KERNOW CLINICAL COMMISSIONING GROUP

Kernow Clinical Commissioning Group (KCCG) has been a proactive member of the Shadow Health and Wellbeing Board, together with the NHS Cornwall and Isles of Scilly, the Primary Care Trust Cluster. Kernow Clinical Commissioning Group is set up as a networked organisation built on 69 GP practices, grouped in 10 localities. The developing organisation is building strong links with the Council and organisations in Devon to align commissioning processes and plans and is working to five overarching guiding principles patient, staff and providers; clinical excellence; delivering excellence; leadership; financial balance. The organisation will be retaining the majority of the commissioning functions of the outgoing PCT Cluster.

KCCG co-ordinates a regular leadership summit involving local authority and NHS commissioners and NHS Trust providers at chief executive level together with its clinical forum. Many GP practices have Patient Participation Groups and these groups will be pivotal to the development of KCCG's People's Commissioning Board which will have a central role in influencing commissioning. The GP locality areas will work with the Council's community network areas and these relationships are currently being explored for future engagement purposes.

#### THE JOINT HEALTH AND WELLBEING STRATEGY

The strategy has been informed by the Joint Strategic Needs Assessment (JSNA) and an initial mapping of community assets. The Strategy (working draft) has been co-produced in partnership alongside a range of interests and stakeholders in the community to ensure it reflects the needs of the community based on evidence and public and patient experience of existing services. Over 250 organisations, user groups and stakeholders participated in the engagement programme together with 100 (including 10 Easy read) online responses. Draft outcomes and priorities were presented to all NHS commissioner and provider boards and the local authority's scrutiny committees, Cabinet and Council for comment and endorsement.

The Health and Wellbeing Strategy will inform and influence commissioning decisions across local services to be focussed on the local needs and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. It will also influence the commissioning of local services beyond health and care to make a real impact upon the wider determinants of health. Public health expertise has been integral to the development of the strategy and the process has provided an opportunity for council and public health staff to work together in advance of the public health function moving to the Council in April 2013.

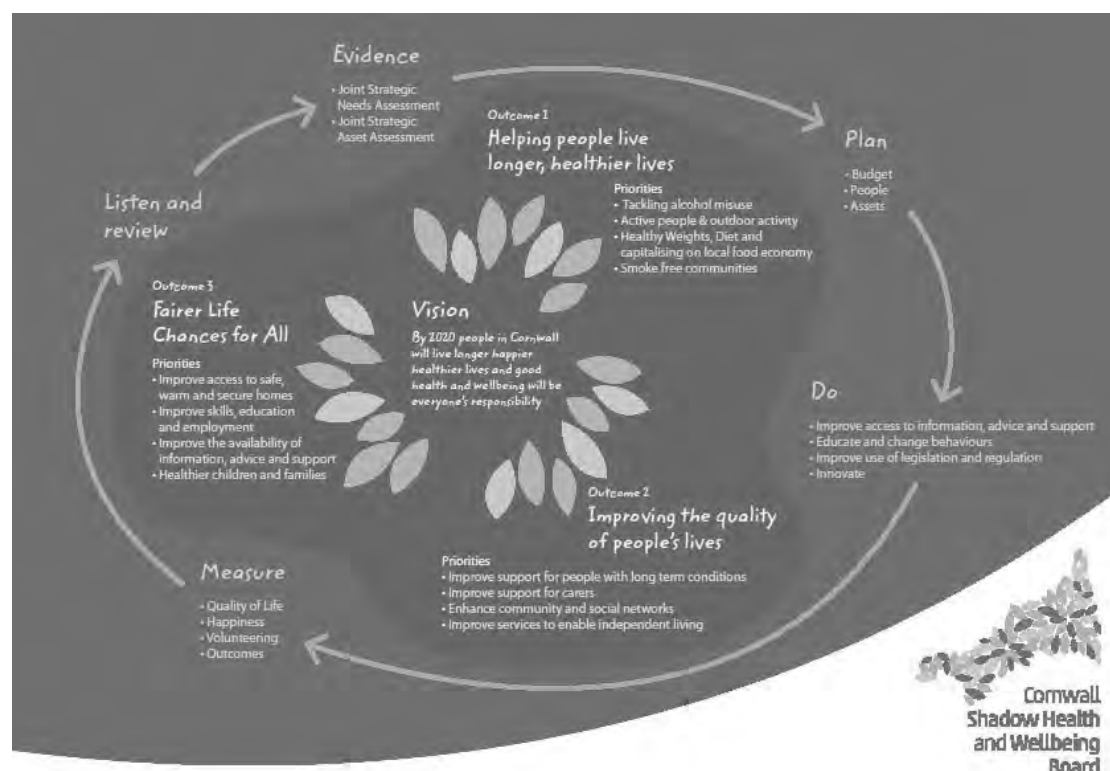
In assessing needs and priorities, the Health and Wellbeing Board will need to adopt an "outcomes-based approach", to improve the outcomes that matter most to Cornwall. Through the Health and Wellbeing Strategy, it will set the local priorities for joint action and use information and indicators from the national outcomes frameworks for the NHS, adult social care, public health, children, and the wider determinants of health to assess current priority outcomes and identify priorities for action. There is a significant opportunity to bring together strategic objectives for the economy, environment and community, building on the many assets in Cornwall, including the education and research establishments and innovation centres.

General support has been secured for the approach and style of the strategy and adjustments made to outcomes based on comments received which were then reviewed against the joint strategic needs assessment. During the process there was a regular cross referencing with the Kernow Clinical Commissioning Group's commissioning intentions. These included:

- people with long term conditions;
- planned care in hospital;
- medicines management;
- healthy lifestyles;
- mental health;
- access for people with learning disability;
- urgent care; and
- children and young people.

Work is currently underway to prepare the delivery plan and strategic indicators/measures and the strategy is on schedule for formal adoption by the Health and Wellbeing Board in April 2013.

## STRATEGY AT A GLANCE



The strategy process has begun to identify more clearly some of the challenges and there is still a lot to do to work out what the Board can do differently to make the step change needed not least how we will manage current pressures in the system, deliver savings for investment in prevention and encourage people to live healthier lifestyles. There will be continuous dialogue via the Board, with stakeholders, to ensure the Strategy provides a relevant framework for future commissioning and reflects needs in Cornwall; the role of HealthWatch Cornwall will be an integral part of this process.

## VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISES IN HEALTH COMMISSIONING PILOT

Cornwall has been selected as one of four national pilots across England to establish the readiness of the voluntary community and social enterprise sectors for health commissioning. The final report is due by the end of November and it is likely that Cornwall will be featured as a case study. The pilot has provided an opportunity for voluntary, community and social enterprise organisations to begin a dialogue with the Kernow Clinical Commissioning Group and Council commissioners. Cornwall Council had already established its Voluntary Sector Commissioning Board as a strategic mechanism for engagement with the sector and proposes to develop a relationship with the Health and Wellbeing Board to deliver the outcomes in the health and wellbeing strategy.

## HEALTHWATCH CORNWALL AND HEALTH ADVOCACY

The establishment of HealthWatch Cornwall is on schedule for its operational deadline of April 2013. Managing the change from LINK to HealthWatch Cornwall has presented a number of challenges including maintaining relationships with LINK and volunteers and designing a specification that fulfils the requirements of the legislation (as it is still developing) without exposing the Council to financial risk. A decision to co-produce HealthWatch was taken which provided an opportunity for building on existing strengths across the public and voluntary sector networks and consulting on the draft health and wellbeing strategy.

The proposed model comprises a Community Interest Company which will work through a small number of networked voluntary sector organisations to provide signposting and joined up service and a network of "listening" and collation of data. The specification has been co-designed with voluntary sector organisations; the contract is currently being negotiated.

The contract for NHS complaints advocacy, formerly a national contract, will be tendered and managed by the Council in readiness for 1 April 2013.

## LOCAL INFLUENCE AND INVOLVEMENT

Strategic links are being formed with the chairs of the Local Enterprise Partnership and Local Nature Partnership. The objective is to explore mutual priorities using the environment as a driver for health and wellbeing and the economy and potential activity relating to skills, workforce development and business development particularly exploiting technology and superfast infrastructure. Good links have already been formed with the European Centre for Environment and Human Health and the Health and Wellbeing Innovation Centre which are managed by Exeter and Plymouth Universities. The Cornwall Works Strategy will continue to play a major role in the health and wellbeing and skills agenda working closely with Jobcentre Plus, and in particular, to understand the implications arising from welfare reforms.

## CONCLUSION

The NHS reforms give rise to new commissioning arrangements in Cornwall which is probably one of the least complex areas in the country in terms of local authority and clinical commissioning group boundaries, but complex given its rural and coastal geography and demographics.

It is early days and positive relationships are being built but partners are not complacent about the challenges ahead that the financial climate is driving.

There are opportunities in sharing similar boundaries with the Local Enterprise Partnership and Local Nature Partnership and close proximity to the Isles of Scilly and Devon where the respective populations are dependent on the same services such as, health care, social care, employment and transport. This prompts the need to ensure that effective dialogue is maintained during the commissioning cycle and planning process and to ensure that a truly joined up understanding of the collective resources and need are more effectively matched in future.

The Health and Wellbeing Board has an important role to play in maintaining and building relationships across the health and care system and brokering others to improve people's wellbeing. The Board will be responsible for steering a difficult but necessary set of changes to ensure future health and care services are sustainable in Cornwall in the future.

November 2012

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## Written submission from Kent County Council

### 1. EXECUTIVE SUMMARY

1.1 Kent County Council has a well developed role in health issues, whether focussed on delivering public health outcomes to prevent ill health or narrow health inequalities, or delivering integrated health and social care services. We have embraced the challenges presented to us in the Health and Social Care Act and are taking a radical approach to Clinical engagement in our Health and Wellbeing Boards, by establishing Health and Wellbeing Board sub committees based on Clinical Commissioning Group (CCG) boundaries. But we believe more can be done, including developing an integrated commissioning approach that encompasses both tiers of local government and that more can be done to shift resources from the acute sector to the community and that local government has a key role to play in this.

### 2. BACKGROUND INFORMATION

2.1 Kent has the largest population of all of the English counties, with just over 1.46 million people. There is a wide range of health needs across the county reflecting its large and diverse population. Life expectancy is higher than the England average, with men living for 79.1 years and women living for 82.7 years. However, life expectancy is significantly lower in deprived areas; life expectancy for a man in a deprived area is 70.9 years and for a woman 78.2 years.

2.2 Over the past 10 years Kent's population has grown faster than the national average, increasing by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

2.3 Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 5–19 years and of people aged 45+ years than the England average. Kent has an ageing population. Forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026. 16.5% of Kent's population live with a limiting long term illness; this will increase as the population ages, placing significant pressures on housing, health and social care services.

2.4 Kent is the largest two tier authority area to have to implement the Health and Social Care Act 2012; some of the provisions within the Act are not designed for this scale and Kent County Council faces unique challenges to engaging successfully in the health agenda. Within Kent there are 12 District Councils, seven emerging Clinical Commissioning Groups (CCGs); four acute hospital trusts and complicated patient flows across some of its borders. One of the key issues is the lack of co-terminosity within Kent (only one CCG is coterminous with a District Authority boundary). In addition, the health economy also encompasses the neighbouring authority of Medway, adding an additional level of complexity. Kent has worked proactively with

its partners in health, to ensure that the opportunities afforded through the Health and Social Care Act 2012 are maximised in order that the health of the population improves.

### *3. The adequacy of preparations for the new arrangements*

3.1 The new arrangements suit unitary councils very well. In upper tier local authorities there are a number of difficulties to overcome in order for the arrangements to be effective. Constructing a robust framework to ensure all the new relationships that will be necessary between county and districts and CCGs is a detailed, involved and time-consuming process.

3.2 In the earlier stages of the transition, local politicians in Dover and Kent, alongside Charlie Elphicke MP, established the Kent Health Commission to ensure Kent, and in particular the district of Dover, saw the maximum benefit from the shift to clinically led commissioning. The Kent Health Commission's report was launched by the former Secretary of State for Health, Andrew Lansley, in July 2012, and we have undertaken to continue to work closely with GPs, clinical leaders and local government in this way to act as a critical challenge to the new arrangements and in particular, ensure that we see a shift in activity away from the acute sector to the community sector.

3.3 Taken as a whole, the preparations for the new arrangements locally have been well organised, with a joint NHS and Local Government Board established (the Strategic Oversight Board) to provide an over view of activity and direction. However, more recently there seems to be less timely decision making particularly from the Centre. The issue of transferring public health budgets is probably the most pressing area of uncertainty. However, this is largely administrative and organisational. Work addressing culture and opportunity for radical change has been less evident and effective.

3.4 From the children services perspective over the past year, new and receiving organisations have been working in shadow form in preparation for the new arrangements. A governance structure is in place in relation to Children and Young People's (C&YP) services. The Health and Well-being (H&WB) Board has been in place for some time as has the Children and Young People's Joint Commissioning Board (C&YPJCB) with subgroups for the latter. It is through these that arrangements have progressed. Child Health and Maternity Commissioning groups with Local Authority members are now in place. However, the team is concerned that there is not yet a shared understanding of governance arrangements across the wider landscape and this poses a risk to the effective implementation of the new arrangements.

3.5 A crucial outstanding issue relates to Information Governance and the ability to share non-patient specific information between the NHS and local authorities. Whilst Kent has engaged at both a national level (Caldicott review) and locally in various work streams to address information exchange, as well as welcoming the opportunities the private sector offers (Patients Know Best). If this is not resolved, the effective delivery of transformative services between social care, public health and health will be critically compromised.

### *4. The objectives of the new arrangements and how their impact can be measured*

4.1 The objective seems to be a measured and steady transition and so far this has been reasonably successful. There has been less of a sense of real devolution of control and CCGs may not be feeling as empowered to make fundamental changes as intended in the spirit of the legislation. Initial opportunities for radical shift to GP led commissioning risk being lost as former NHS structures reassert themselves in newly named organisations. The absence of a transparent risk and benefit sharing framework as a possible platform for dealing with shifting resources from secondary to primary care/community, as advocated by the NHS Future Forum has attendant difficulties compared with 6.3 below.

4.2 We will continue to see an emphasis on investing in community services; any impact will be measured by how we can evidence avoidance of admission and early discharge from hospital.

4.3 Much will also depend on the effectiveness of the various outcomes frameworks and whether they work as intended to complement each other. The other real test of the new arrangements is whether they support and encourage the development of new and effective relationships between the component parts, especially with the CCGs that bring the only really new element into the process, to deliver better outcomes for patients and the public. This will be difficult to measure but should be reflected in better patient outcomes.

### *5. The intended role of Health and Wellbeing boards in coordinating the NHS, social care and public health at the local level*

5.1 The H&WB Board has the potential to be a very powerful agent for change. The JSNA and H&WB Strategy offer new tools that can make a real difference to how the system understands the services and resources available to deliver health, social care and public health. However, in large authorities, especially two tier areas, the Board will need to be constructed and supported to discharge its role or it will be swamped by the amount of business it is required to conduct.

5.2 Kent was one of only three local authorities nationally to have both an upper tier and lower tier (Dover District Council) local authority as an early implementer of Health and Wellbeing Boards. Kent took the

decision to work proactively with Dover and its CCG to ensure that any developing board architecture supported the delivery of the Health and Social Care Act provisions.

5.3 There was a strong commitment by KCC Cabinet Members to the development of the Kent H&WB Board infrastructure and developing relationships with GPs, from an early stage (autumn 2010). The Cabinet lead for Health Reform, Roger Gough, played a key role in the development of H&WB Board and now chairs the Board.

5.4 The provisions for Health and Wellbeing Boards in the Health and Social Care Act do not give any formal role or responsibilities to District Councils. However, Kent County Council recognised the important role of District Councils in the agenda and is engaging proactively with them in developing the Health and Wellbeing Board. Kent has taken the unique step, amongst two tier authority areas, of developing a formal sub architecture based along CCG boundaries to support the upper tier Health and Wellbeing Board. These CCG level Health and Wellbeing Boards will be constituted as formal sub committees of the upper tier HWB (in accordance with the Local Government Act 1972 and the up and coming secondary regulations of the Health and Social Care Act 2012).

5.5 Whilst the upper tier authority will retain the legal duty to establish a Health and Wellbeing Board; that the CCG level sub committees will need to focus on a number of key areas to add value. These areas are:

5.5.1 CCG level Integrated Commissioning Strategy and Plan.

5.5.2 Ensure effective Local Engagement.

5.5.3 Local monitoring of outcomes.

5.6 Kent is also developing an integrated commissioning process to be used in each CCG area, which, for the first time brings together both tiers of local government (KCC and District Councils) with health to develop integrated commissioning strategies and plans. This is the first time that District Councils have been included in joint commissioning arrangements, reflecting the more holistic approach to health and wellbeing that the JSNA and JHWS have identified.

5.7 By establishing this approach to commissioning, Kent is using the opportunities to encourage integration to be reflected at both commissioner and provider level. The commissioning strategies produced in this way will then be signed off by the upper tier Kent Health and Wellbeing Board.

5.8 The HWB Board will need to move from promoting and securing engagement to focus more on its core purpose. It has a commissioning oversight role, but it is not a commissioning board. The HWB will need to balance its relationship with arrangements for scrutiny.

## 6. *Barriers to integration, including issues in their multi-tier areas*

6.1 The key barriers can be summarised as follows:

- 6.1.1 The need for each organisation to understand the structures and roles and responsibilities across the commissioning landscape and the associated complex governance structure.
- 6.1.2 Achieving the correct balance of district level versus county level commissioning to ensure local needs are met and efficiencies can be identified across the patch.
- 6.1.3 Ensuring strong public health involvement in local planning is maintained at both district and county level.
- 6.1.4 The complexity of Health and number of individual organisations that make up the local health economy, and the need to engage appropriately with Hospital Trusts.
- 6.1.5 Understanding the financial complexities between organisations.
- 6.1.6 NHS Trusts need to achieve Foundation Trust status leading to an inward looking approach by them.
- 6.1.7 CCGs are “young” organisations, which need time to mature and develop their own culture of commissioning and partnership engagement.
- 6.1.8 Kent is a peninsular area, this has a significant impact in attracting new entrants to the market place, restricting the ability to integrate services or develop new models of delivery.
- 6.1.9 Information Governance.
- 6.1.10 Multiple outcome frameworks.

## 7. *The financial arrangements underpinning local authorities’ responsibilities, including the ring fencing of budgets and how the new regime can link with the operation of Community Budgets*

7.1 This is a complex issue which provides commissioners with challenges in the current economic climate when budgets are squeezed. Ring fencing is not as common as it used to be and thereby lies one of the challenges in relation to pooled budgets and joint commissioning. The transfer of budgets should be defined within a commissioning framework which is monitored by H&WB Boards to ensure that budgets for public health initiatives are protected and the prevention and early intervention programmes are maintained and extended.



7.2 There remains a lack of effective mechanisms to help with shifting resources from acute to the community. Kent County Council's Bold Steps for Kent document states that it aims to see a shift in resources from acute to community.

7.3 Following the Cabinet reshuffle there are major concerns over the public health budget and its protection from other financial pressures in the health system. In the South East the inadequacy of the likely Public Health budget has already been the subject of correspondence with the Secretary of State as the region fares very badly in comparison to others. The ability of the new system to link to Community Budgets is yet to be ascertained.

#### *8. Public Health—The introduction of a public health role for councils*

8.1 The transfer of Public Health responsibilities to Local Authorities is widely welcomed, subject to sufficient resources being allocated to Councils to fulfil their roles. Local Authorities have far greater influence over the wider determinants of health than the NHS and this should lead to better co-ordination of resources across the spectrum of Local Authority functions at both tiers.

8.2 Kent has had a jointly appointed Director of Public Health for a number of years and a long history of partnership working between Local Government and Public Health. This has been reflected at a local level by the development of Health Inequalities Partnerships (Health and Wellbeing Partnerships) at district level over the last six years. District Councils have also taken the opportunity to actively engage in Public Health services.

8.3 Kent County Council is enthusiastic about its new responsibilities; it has put in place a clear transition plan to ensure effective transition of staff and has a Cabinet lead for Public Health.

8.4 The critical element that needs to be resolved urgently is the allocation of adequate public health budgets to fulfil the new responsibilities for local authorities from April 2013.

8.5 From a children's services perspective a number of concerns have been raised, and in particular there will be challenges around interfaces and areas which require synergy eg Health Visiting and School Nursing. However, the changes provide the opportunity for more collaborative working on children's preventative services and potentially better information and improved trend analysis to inform the JSNA which will result in better commissioning.

#### *9. How all local authorities can promote better public health prevention with the link to sport and fitness, well-being, social care, housing and education*

9.1 This is not seen as new activity within Kent. Local Authorities in both tiers have a long history of health promotion and prevention, ranging from the House project and ActivMobs run by Kent County Council, through to significant number of joint activities with District Councils.

9.2 This is being further enhanced in the new integrated commissioning arrangements, which sees a clear role for housing alongside services that promote health and wellbeing (eg sport and fitness). The first fully integrated commissioning strategy in development in the South Kent Coast CCG area has prevention as a key aim of the strategy.

9.3 This is an area where Local authorities will potentially have better outcomes because of their links and ability to influence at a local level eg District Councils, Borough Councils. Closer strategic alignment of Public Health with other Local Authority areas such as Social Care, Education and Housing could lead to the implementation of more innovative solutions. Measuring outcomes could potentially be more problematic across a number of diverse resources so more in-depth analysis may be required in the planning stages to ensure the appropriate metrics are developed and monitored.

9.4 Kent County Council has adopted the Marmot report and recommendations and has based a comprehensive approach to health inequalities upon them, including a Health Inequalities Action Plan. This is important because it emphasises the social model of public health, rather than the medical model, which will incorporate the contributions of all the elements referred to as well as many others. It also promotes the involvement of the district councils and the voluntary sector.

#### *10. The accountability of Directors of Public Health*

10.1 Public health—The accountability of the Director of Public Health (DPH) to their Local Authority will improve joint working and promote the necessary partnership working. The professional responsibilities of the Directors, including professional leadership of public health, also need to be recognised and facilitated to ensure that the best possible impartial professional advice is available to policy makers. The role of the DPH within the H&WB Board is crucial and needs to develop as H&WB Boards become more established.

#### **11. ANY OTHER COMMENTS**

11.1 Kent County Council has embraced the opportunities of the Health and Social Care Act 2012. It has used them to build on a significant history of joint working, and has also taken the opportunity to challenge the system as it develops to ensure that activity is shifted from the acute sector to delivery in the community. It continues to be concerned at the complexity inherent in the system and the central control that is still exerted

over the NHS locally. It is also concerned that the focus on clinically led commissioning will be lost as structures establish themselves. The scale of the problem is being met by an ambitious approach by Kent, as evidenced by our proactive approach to Health and Wellbeing Board development, the transition of Public Health, and our willingness to challenge and engage all local partners in health and care provision as seen in the work of the Kent Health Commission. We welcome the opportunity to engage with the Communities and Local Government Committee to discuss our approach on the future role of Local government in health.

October 2012

### Written submission from Dr Mike Grady

## HEALTH INEQUITY, PARTNERSHIP AND THE ROLE OF LOCAL GOVERNMENT

### CONTEXT

The global financial crisis and widening health inequities in England raise significant questions about the relationship between the state and individuals and communities and especially about approaches to deprivation within this changed context, challenging more traditional models of the welfare state.

The direct impact of the recession will mean fewer jobs, less spending, higher personal debt, and greater demand for services.<sup>62</sup> Whilst the position is complex, it is likely to impact adversely on mental health and wellbeing, and potentially exacerbate the health inequalities gap especially in communities facing multiple disadvantage.<sup>63</sup>

This paper considers the policy issues raised by health inequalities and argues for a strengthened role for local government in creating a new culture and contract to deliver greater health equity and social justice for local communities.

### STRATEGIC REVIEW OF HEALTH INEQUALITIES IN ENGLAND

Fair Society, Healthy Lives, a strategic review of health inequalities in England post 2010 (*The Marmot Review*),<sup>64</sup> gathered together the best global evidence to guide policy and practice in the coming years, in order to achieve a fairer distribution of health: narrowing the gap.

The evidence is clear. People with higher socio-economic status have a greater range of life chances, more opportunity to lead flourishing lives and better health. The links between the social conditions in which people are born, grow, live, work and age and their health status is critically important.

There is a clear social gradient in health in England. People in the poorest neighbourhoods die seven years sooner than those in the richest and have 17 years fewer of healthy life years

The human costs are there for all to see. If everyone enjoyed the same mortality rate as the most advantaged, those people who are currently dying prematurely as a result of health inequalities would, in total have enjoyed between 1.3 and 2.5 million extra years of life.<sup>65</sup> They would, in addition, have had a further 2.8 million years free from limiting illness or disability.<sup>66</sup>

The financial cost of health inequality is enormous too. It is estimated that productivity losses of £31–33 billion per years are incurred as a consequence of health inequality. Lost taxes and higher benefit payments are approximately £20–32 billion per year.<sup>67</sup> The NHS health care costs are well in excess of £5 billion and if no action is taken the costs of treating the various illnesses from obesity alone will rise from the current £2 billion to nearly 5 billion in 2025.<sup>68</sup>

Both the human and the economic case for measured and concerted action is compelling and action to improve public health needs to be taken at both national and local levels. The evidence is more socially cohesive societies with developed welfare states; high quality education and good access to health services for all have created the conditions within which citizens flourish. However health inequities in some countries continue to increase with widening inequalities in people's living conditions and declining social mobility and social cohesion. Health inequalities are widespread, persistent, unnecessary, detrimental to us all and unjust.<sup>69</sup>

<sup>62</sup> Cabinet Office (2009). Learning from the past: Tackling worklessness and the social impact of recession. HMSO

<sup>63</sup> Friedli L (2009). Mental Health, resilience and inequalities. WHO Europe.

<sup>64</sup> Marmot M (2009). Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England. The Marmot Review.

<sup>65</sup> Frontier Economics (2009). Overall costs of health inequalities. Submission to the Marmot Review. [www.ucl.ac.uk/ghcg/marmotreview/Documents](http://www.ucl.ac.uk/ghcg/marmotreview/Documents): Suhrcke M (2009) The economic benefits of reducing health inequalities in England Submission to the Marmot Review.

<sup>66</sup> Frontier Economics (2009) op cit

<sup>67</sup> Frontier Economics (2009) op cit

<sup>68</sup> Morris S (2009) Private Communication.

<sup>69</sup> Marmot M WHO European Review of the social determinants of health and the health divide. Lancet Vol 380 September 15 2012.

The Marmot strategic review recommended action is taken on the social determinants of health through six policy objectives:

- *Give every child the best start in life.*  
Early childhood experience has a profound effect on health and development throughout life with the foundations of key aspects of development (physical, intellectual and emotional) laid at this stage.
- *Enable all children, young people and adults to maximise their capabilities and have control over their lives*  
Educational attainment is one of the key predictors of physical health and mental wellbeing as well as income, employment and quality of life.
- *Create fair employment and good work for all.*  
Being in good employment is protective of health and wellbeing. Getting people into work is of critical importance. Work needs to be able to offer a decent wage, opportunities for development flexible and offer protection from adverse conditions which can damage health.
- *Ensure healthy standard of living for all.*  
Income levels from wages and social protection systems should support healthy living including nutrition, physical activity, social interaction, transport etc.
- *Create and develop healthy and sustainable places and communities.*  
Places and communities are important for physical and mental wellbeing. Social capital within communities promotes resilience and wellbeing.
- *Strengthen the role and impact of ill health prevention.*  
Ill health prevention and early detection should be scaled up across the social gradient.

Action consistent with these policy recommendations is essential if the social determinants of health inequalities are to be tackled across the social gradient and if greater fairness and social justice are to be developed. It is unlikely that any single strategy or action which relies on intervention in one part of the system will be effective or create the synergy necessary to reduce overall health inequalities. Concerted effort, of sufficient scale and intensity, will be required across the whole range of interacting factors that shape health and wellbeing—in particular, early child development and education, employment and working conditions, housing, urban planning and neighbourhoods, transport and an adequate standard of living to participate fully in society.

The social gradient is important. Social policy on health inequalities has for the most part been focussed on the most disadvantaged in our society. It is right to focus special efforts on the poorest but if the focus is only on the poorest everyone above the bottom, bar the richest, lose out. The social gradient in health demonstrates that health is progressively worse as the socio-economic hierarchy is descended.

It is possible to have a much shallower gradient than is currently the case in England. Action to achieve this should be universal but with a scale and intensity that is proportionate to the scale of disadvantage. Greater intensity of effort and investment is likely to be required to address the greater social and economic disadvantage; but focussing only on the bottom of the gradient means tackling only a part of the problem.

The white paper on public health “Healthy Lives, Healthy People recognises that health is determined by wider social influences throughout life right from the beginning. Action is proposed across the policy objectives set out above with the exception of the policy objective relating to a healthy standard of living for all. There was a helpful emphasis on the key role of local government in leading local collaboration to address health inequalities and the orchestration over time of local action to reduce the health inequities gap by addressing the social determinants of health taking a life course approach and addressing the “causes of the causes” the conditions in which people are born, grow live, work and age and in the inequalities in power, money and resources which give rise to those conditions.<sup>70</sup>

#### THE ROLE OF LOCAL GOVERNMENT IN TACKLING HEALTH INEQUALITIES

The Marmot Review argued for a greater emphasis on the potential roles of local government in addressing the social determinants of health. This is entirely consistent with local government’s roles in:

- Providing community leadership, to extend civic participation and deepen democracy.
- Exercising its powers to secure the health and wellbeing of local people and communities.
- Promoting community safety, place shaping and place shielding.
- Commissioning and providing a range of regulatory and support services.
- Acting as a major source of investment, employment and income for the local economy.

Together these roles and responsibilities place local councils in a unique position to take a whole population view of the local area and bring together all agencies—public, private and the voluntary sectors to tackle the cross-cutting local issues which affect local residents and communities and in mobilising action to tackle health inequalities and wellbeing.

<sup>70</sup> Marmot M (2012) op cit

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## CREATING AN ENABLING SOCIETY WHICH MAXIMISES INDIVIDUAL AND COMMUNITY POTENTIAL

Extending democracy and giving individuals and communities a voice is an essential prerequisite to addressing health inequalities.<sup>71</sup> “Democracy has to be judged not just by the institutions which formally exist but by the extent to which different voices from diverse sections of people can actually be heard”.<sup>72</sup> This means moving beyond routine consultations to creating active engagement and mobilising local contributions, and creativity in both defining local issues and developing local solutions.

Alongside this, a sharper emphasis and focus on the social determinants of health and wellbeing would provide a natural extension for democratic local government, building on current powers to promote health and wellbeing through sustainable community strategies, local enterprise partnerships and health and wellbeing boards.

This role becomes the more important at a time when the impact of the global fiscal crisis is placing greater pressure on individual and communities and public services, and where many people feel alienated from formal political processes and active local engagement.

In this context, there is a danger that the focus of public service shifts to prioritising the most vulnerable and striving to do this with fewer resources, rather than seizing the opportunity for more radical reform. Such reform would seek to transform the ways in which services are designed and framed, taking an upstream perspective on the whole population, and complementing remedial work with earlier intervention and prevention, through a focus on promoting health and wellbeing, building resilience, capacity and capability within the community.<sup>73</sup>

In addressing deprivation and inequalities, too many governments and welfare services have regarded users and the public as passive recipients of services. This deficit model, focused on problems, needs and deficiencies, served to further disempower already disadvantaged groups and communities fostering dependency and undermining collective resilience.

A fundamental shift to a more asset based approach is needed, which would value and mobilise local contributions, skills, understanding and capabilities.<sup>74</sup> This developmental model, focused on co-production of health and wellbeing, encourages people and communities to participate in public services on an equal basis with professionals, and to exercise their knowledge and capabilities with increased self-confidence and reliance.<sup>75</sup> This approach challenges existing professional and political power structures, removes barriers to participation and aims to maximise community capacity and social capital.<sup>76</sup>

Taking a proactive approach to developing social capital would pay long term dividends. The quality and level of social capital is shaped by the ability of communities to define and organise themselves, and by the ways in which they are involved in decisions about their lives.

The evidence is strong that social networks reduce risks to mental illness and leave individuals and communities healthier, happier and more capable of providing mutual support. The most powerful sources of stress are low status and lack of social networks especially for parents with young children.<sup>77</sup> Resources invested in prevention can decrease service costs in the longer term.<sup>78</sup>

## TAKING A WHOLE SYSTEM PARTNERSHIP APPROACH

The Marmot review of recent policies and strategies to reduce health inequalities highlighted the need to confront the complex, multi causal and multi factorial causes of the problem. This means adopting a “whole systems” approach to addressing the inter-connected issues, with concerted, systematic and scaled up interventions based on the available evidence.

The implementation challenge includes building robust partnership working within Health and Wellbeing Boards between a wide range of public private and voluntary organisations, and strengthening the leadership role of local government as an orchestrator of these inter-organisational partnerships. This is not to suggest a dominant role for local government, but to capitalise on its role as a democratically elected body to act as the leader of the orchestra of different players facilitating active engagement by the public, the NHS and other public services, and the private, voluntary and informal community sectors

The aim of this kind of whole system partnership working is to secure shared understanding, priorities and alignment of national and local agendas underpinned by shared values and the collective use of resources to deliver.<sup>79</sup>

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<sup>71</sup> Marmot M (2009) op cit

<sup>72</sup> Sen A (2010) *The Idea of Justice*. Penguin Books London. p xiii.

<sup>73</sup> Sen A.(2010) op cit

<sup>74</sup> IDeA (2010) *A Glass half-full: how an asset based approach can improve health and wellbeing*.

<sup>75</sup> Sen. A (2010) op cit

<sup>76</sup> Schuller T and Watson D (2009). *Learning through life: Inquiry into the future for lifelong learning*..NIACE. Leicester.

<sup>77</sup> Wilkinson R and Pickett K (2009). *The Spirit Level: Why more equal societies almost always do better*. Allen Lane.London

<sup>78</sup> Birmingham Total Place Pilot Final Report February 2010. (2010) @ [www.bebirmingham.org.uk](http://www.bebirmingham.org.uk)

<sup>79</sup> Malby B (2010). *Peer Leadership for joint impact*. Health Service Journal 8th April 2010.

The Health and Social Care Act 2012 places specific new duties for addressing health inequalities on the Secretary of State for Health, the NHS Commissioning Board and Clinical Commissioning Groups but does not explicitly include Health and Wellbeing Boards. Establishing the duty on a wider statutory basis could facilitate action to narrow the inequalities gap and enhance accountability of the individual stakeholders to deliver on the social determinants of health for their communities.

The aim must be a new direction for local authorities and public services with a focus on partnership working with local service users, local communities, and across all national and local government agencies, helps not only to define the problems to be addressed in “whole systems” terms, but also to redefine priorities in terms of outcomes for citizens and communities, to iron out the contradictions between different policies, and to reduce inefficiencies and duplication between programmes.<sup>80</sup>

Place based budgeting and collaborative action holds the potential to bring about a shift in culture which would see services focused on empowering individuals and communities and creating the conditions within which people take control of their own health and well-being. It moves away from over—reliance on small scale health improvement projects to harness mainstream spending in a clear strategy of co-production to address individual and collective health and wellbeing.

This lies at the core of a progressive universal approach to early years development and schooling taking a whole population focus with programmes such as Surestart and whole school approaches.

This calls for new forms of political, civic and executive leadership grounded in public participation and whole systems thinking to create the conditions in which individuals and communities take control.<sup>81</sup> Leadership and capacity must be nurtured within communities and championed by local partnerships focussed on delivering health and wellbeing with the local population. The current unprecedented reductions in Local Authority allocations present significant challenges.

Progress is more likely to occur in mature partnerships which have negotiated an agreed strategic vision, shared values and priorities, and collective authority, to focus resources and joint action on the social determinants of health and well-being -namely early childhood development, education, good employment, income maximisation, good urban planning and design and sustainable communities.<sup>82</sup>

A whole system focus of this kind on the health and well-being of people and of places will not only help to tackle the social determinants of health, but also to extend our understanding of the potential role of citizens and communities in creating and developing a more cohesive society.

## CONCLUSION

Key policy issues raised by health inequalities in England have been highlighted together with action necessary to address the health gap through partnership and public service.

Social inequalities in health arise from inequalities in the conditions of daily living: early years, education, work, income, housing, transport and social position and shape health and wellbeing. Single agency responses to such complex problems are insufficient to address these social determinants of health. Effective responses call for more radical action across the whole system with a strengthened role for local government providing transformational leadership in partnership with local people and communities. This would be centred on extending democracy and participation using a more asset based approach to facilitate co-production of strategies and services in new power relationships between professionals and the public. The aim is to build greater self-confidence and resilience among individuals and the local communities in which they live, work and grow up by using a population approach to health and wellbeing focussed on place to deliver local solutions using common local resources in partnership. The development of such corporate action, communal resilience and stronger social networks become all the more important as Local Authorities and other Public Services face significant budget reductions and increasing demand.

*November 2012*

<sup>80</sup> H M Treasury and Community and Local Government Department (2010) Total Place: A whole area approach to Public Services. [www.hm-treasury.gov.uk/gs/\\_total\\_place.htm](http://www.hm-treasury.gov.uk/gs/_total_place.htm)

<sup>81</sup> Benington J and Hartley J (2009). Whole Systems Go: Improving Leadership across the whole public system. National School of Government Sunningdale Institute.

<sup>82</sup> Seymour M (2009). Do LSPs provide collaborative advantage for health improvement? Unpublished paper.

## Written submission from Leicestershire County Council

### THE ROLE OF LOCAL AUTHORITIES IN HEALTH ISSUES

#### BACKGROUND

Leicestershire County Council was keen to embrace the opportunities presented by the Health and Social Care Act. With its history of working through meaningful partnerships, both with the NHS and other agencies, it recognised the potential for improvements through collaboration and was keen to begin this by being an early implementer of Shadow Health and Wellbeing Boards. The Leicestershire Shadow Health and Wellbeing Board held its first meeting in April 2011.

Specific details relating to Public Health Transition are set out below.

#### *The introduction of a public health role for councils*

- Leicestershire County Council has had a joint appointed Director of Public Health (joint with NHS Leicestershire County and Rutland and Rutland County Council) for a number of years and Public Health staff have been co-located with the County Council since January 2011. The Health Protection Agency has also been located at County Hall since the beginning of this year.
- Mr White was appointed Cabinet Lead Member for Health in February 2011. He chairs the Shadow Health and Wellbeing Board and is advocate for public health amongst elected members.
- The Public Health Transition Plan is a programme containing four distinct projects. They are:
  1. Ensure a robust transfer of systems and services.
  2. Meet Public Health Delivery Plan and targets during the transition year (2012–13).
  3. Transfer and maintain an effective public health workforce.
  4. Transfer infrastructure to support public health delivery.
- Robust governance arrangements are important. The Governance of the Transition Plan is primarily through the Public Health Transition Steering Group, which reports to the Joint Change Programme Board. (This comprises executives from the Primary Care Trust, the Council and leaders of GP Clinical Commissioning Groups.)
- The most challenging area of Public Health Transition is the transfer of contract from the NHS to the Local Authority.
- The other significant issue of concern is the budget. The final allocation for 2013–14 is due to be announced on 19 December. A budget pressure in excess of £1 million is anticipated.

#### *The adequacy of preparations for the new arrangements*

- In 2009 Leicestershire County Council already had a Joint Change Programme Board operating at executive level between the Council and local NHS. Following the announcement of the NHS reforms programme, the terms of reference for this Board were amended and its focus directed at overseeing the transition. The Joint Change Programme Board is responsible for four key strands of work:
  1. Transition of public health services from the NHS to the Council.
  2. Development of local Healthwatch.
  3. Joint commissioning (now called integrated commissioning).
  4. Implementation of the Shadow Health and Wellbeing Board.
- Co-location of Public Health staff with the County Council has been beneficial, particularly in terms of the development of individual relationships between public health officers and the relevant county council officers and elected members. It has also given Public Health staff an understanding of the political and departmental set up of the County Council.
- It is difficult to prepare fully for the transition to the County Council without knowing the 2013–14 budget allocation.

#### *The objectives of the new arrangements and how their impact can be measured*

- Smooth transition is one of the objectives of the new arrangements and in Leicestershire this is being achieved.
- An important objective is to make the most of the impact that Public Health can have by being part of the Local Authority. This has been achieved through close working with County Council departments, examples include the library health and wellbeing offer, wellbeing Wednesdays, substance misuse in young people, healthy schools, teenage pregnancy, active travel.
- The impact of the new arrangements will be measured by successful delivery of the outcomes of the Joint Health and Wellbeing Strategy.

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*The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level*

- The Shadow Health and Wellbeing Board, has set up five subgroups to help shape commissioning decisions and to support the delivery of more joined-up service provision.
- One of these subgroups is the Integrated Commissioning Board, which has the following two aims:
  1. To oversee the management of relevant areas of existing joint NHS and local government investment.
  2. To manage a targeted programme of investment that exploits new opportunities where greater alignment between health and social care expenditure could lead to improved outcomes, greater resource efficiency and potential decommissioning plans.

*How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, wellbeing, social care, housing and education*

- New commissioning arrangements and a new model for the delivery of sport and physical activity within Leicestershire have been developed in the past year. Leicestershire and Rutland Sport (LRS) is the lead commissioner with a move towards a family centred, physical activity model targeted on those who do no, or little, physical activity. The Leicestershire District Councils deliver this model at a locality level.
- The commissioning model for sport and physical activity is now up and running throughout Leicestershire. Half yearly review meetings are being organised with District Councils to review progress. Case studies and monitoring data are being collected, including data informing the Social Return on Investment evaluation exercise. There are promising signs that the new model has been productive in changing the nature and settings of activities delivered and in extending the partners involved in delivering physical activity.

*Barriers to integration, including issues in multi-tier areas*

- Prevention and early intervention work is not aligned between Public Health and other County Council Departments. A new strategy is being developed to address this. There is also a culture issue relating to the definition of early intervention and prevention.
- Public Health has to commission from NHS providers until April 2013—this has prevented alignment with County Council commissioning.
- In Leicestershire, the Public Health team has a good relationship with District Councils. Each District Council has a public health link advising on evidence, priorities and needs assessments as well as ensuring join-up with county-wide services.
- There is a specific District Council Chief Executive designated as health lead. She co-ordinates the work of the District Councils.
- Good personal relationships are at least as important as structures to make partnerships work.

*How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level*

- A Leicester, Leicestershire and Rutland Health Protection Board is being established as a sub committee of each of the three Health and Wellbeing Boards in Leicester, Leicestershire and Rutland. Local authorities will take on a new role of assurance with regard to health protection issues and the establishment of this Board will be the principal means of achieving this assurance.

*The accountability of Directors of Public Health*

- The Director of Public Health is a Chief Officer and a member of the County Council's Corporate Management Team.
- The Director of Public Health has direct accountability to the Chief Executive.

*The financial arrangements underpinning local authorities' responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets*

- A budget pressure for Public Health in excess of £1 million is anticipated.
- The County Council has already invested in public health, in addition to the funding through the PCT.

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### Supplementary written submission from Leicestershire County Council

Thank you for the opportunity to give evidence to the committee and for your request for further information in relation to question 269:

*269 Chair:* Just turning to the question I asked at the end to the other witnesses, does your public health strategy for your area include the investment strategy of your pension fund, and have you, for example, decided not to invest in or withdraw investment from tobacco companies? Could I have a short answer from each of you as to how you are thinking on this?

Leicestershire's draft Joint Health and Wellbeing Strategy does not include the investment strategy of the pension fund.

The issue of pension fund investment in tobacco companies has been raised. The council is aware of public concerns about this issue, particularly as it is taking responsibility for public health services. The council must balance the need to make a return on investments for pensions with wider concerns such as public health and will, therefore, keep such investments under review.

Please let me know if you require any further information.

December 2012

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### Written submission from Professor Chris Bentley

#### PUBLIC HEALTH AND LOCAL AUTHORITIES

##### INTRODUCTION

This submission is based mainly on the experience gained by the Health Inequalities National Support Team (HINST) in supporting local areas to pursue a national target to reduce the gap in mortality between the most deprived twenty% of local authority areas and the national average, by 10% by 2010. This testing target brought into focus two important disciplines. How do you make a percentage change in a measure at population level? And how do you do that in a relatively short timescale? In attempting to achieve these goals, a new, very pragmatic focus needed to be brought to the work. HINST helped to develop and refine such approaches in the course of in depth appraisal and support visits to all 70 of the most deprived local authority areas, and in the course of this established a series of "how-to" principles that would be necessary. As a starting point it was necessary to "de-mystify" the problem. Inequalities targets would not be achieved by a form of "white magic" practised by public health professionals and practitioners, or by a series of small but eye-catching projects. Rather, success would require systematic and scaled-up, public health intelligence-driven, evidence based programmes, with a business plan and programme management.

Although HINST and other components of the strategy came into play rather late, evidence is now suggesting that the Target was largely achieved (Hennell 2011).

With a change of focus from national targets to Localism, it was important to ensure that the learning not be lost. In effect, Local Authorities and their partners, through the statutory Health and Wellbeing Boards (HWBs), are being asked to make measureable changes in local health and wellbeing of their population. They will be accountable to their local constituents for this, and this means delivering change (in indicators, if not in outcomes per se) presumably within the electoral cycle of four years. The question then is not whether the learning of recent years is relevant, but rather how can the principles be adapted to the new context, with its new structures and processes?

For the last 18 months I have been working with public health departments, HWBs and Clinical Commissioning Groups (CCGs) across England to provide challenge and support during the developmental phase of the transition. Based on my previous experience as a DPH and as Head of HINST, I think the new arrangements have the potential to provide tailored approaches to take forward the challenges of improving health and addressing inequalities. However, the risk is of patchiness and variability in quality and effectiveness. I am concerned that there are some widespread weaknesses in the way systems are being established.

#### *10 Steps to Measureable Improvement of Population Health and Wellbeing*

In working to support developing HWBs and CCGs, I have established 10 steps to focus on, largely based on my learning with HINST and modified by my recent learning in contact with 15–20 local areas. These are outlined below, together with some commentary on the current state of play with each.

##### *1. Governance: who is running the show?*

- If HWBs are to deliver on the Joint Health and Wellbeing Strategy (HWS) they will need to establish strong governance arrangements. As statutory bodies they will be held accountable for their own delivery, by local residents/electorate, constituent bodies eg Cabinet, Overview and Scrutiny; CCGs and through some national agreements eg Public Health England (PHE) Health Premium plans.



- 
- Style will include decisions as to whether they constitute a “strategic forum” for collective action, or whether they develop a performance management function with which to deliver integrated programmes.

The challenge here is fundamental. Most HWBs have spent time with constituent partners establishing a series of priorities as the core of their HWS. A number of Boards have then gathered together a description of pieces of work already underway through constituent commissioners and their providers in relation to this priority (eg dementia). This “strategic forum” output adds little value. As a local resident, or Overview and Scrutiny Committee, I would be asking, “so, what has changed as a result of the HWB selecting this priority?” Are there mechanisms in place for the Board to hold individual organisations to task for their contribution? Even more important, is the whole strategy greater than the sum of its parts. How does joint working make step change possible, and what levers can the HWB pull to make this happen.

Commonly now, Boards are planning to meet quarterly. How much momentum can be generated and maintained that way? How can the large and complex agenda of health and wellbeing for any population be done justice? How can the HWB become the “beating heart” of local process for improving health and wellbeing?

A number of these meetings will then have a large membership, and impossibly long and tight agendas, in which it can be difficult to do justice to the length and breadth of the agenda.

For this to work, there needs to be a cohesive infrastructure. There are examples where this is the case. One Borough has made the HWB itself a slimline Commissioning Body, with a membership of 12. Below this there are a number of tightly specified sub-committees, including a Provider Forum. These sub structures are themselves entitled to establish task-and-finish groups. There is to be an annual open public meeting. However, all are answerable to the HWB itself, which is of course, statutorily accountable.

Governance arrangements are particularly an issue for Two-tier authorities. A number of these have established a set of sub-HWBs, based on District Authority or CCG boundaries. These can provide a good pragmatic focus for local knowledge, ownership and accountability. The question is, how are the separate processes and contributions brought back together to form a cohesive whole in relation to strategy, priorities and outcomes. What governance levers are there for the over-arching HWB to bring it all in line so that it is, itself, accountable?

While arrangements are still evolving, I have concern that many local arrangements are not coming together with the definition and precision in governance necessary to generate step changes in population health and wellbeing.

## 2. *Joint Strategic Needs Assessment (JSNA)*

- This should start from a systematic balanced, non-judgemental overview of health, social care and wellbeing issues, followed by a more detailed drilling down on emerging important issues.
- It should combine a top-down more quantitative analysis with bottom-up more qualitative inputs from communities, service users and frontline staff.
- It should break down each prioritised topic into meaningful causative elements that might be addressed.
- It should not stop at describing problems, but should proceed to highlighting the “so-what”, possible consequences and potential actions.
- Ideally needs based assessment could be balanced with an assessment of assets.
- JSNA should be a process, not a document (or website). Findings should ideally move from dry analysis, to “marketing” the findings to a range of audiences (elected members; LA Officers; GP Commissioners; HealthWatch and the public).

## 3. *Priority Setting : how does it really work?*

- Priority setting will usually involve a consultation process, and debate, for which officers will be involved in making cases and options appraisal.
- This is the part of the process where corporate ownership of issues is won or lost, reaching for the hearts and minds of members and the public. The “anatomy” of a decision is said to be in three parts: evidence; ethics and politics. Case-makers will need to take into account all three elements, not just rely on evidence.
- Debate in a Local Authority setting is more often emotive rather than scientific/technical. A good example of working with this is using a number of less men or women dying for comparative purposes, rather than differences in mortality rates projected for each sex.

The JSNA is an important part of the statutory new arrangements. They have been in existence for quite a few years now, and over that period have been patchy and variable. Very few have adopted the principles outlined above. A number have been re-cycled for a new year, and not many completely refreshed to meet their new purpose, forming the basis of the HWS.

The uneasy balancing act is to combine top-down, largely quantitative analysis with bottom-up more qualitative intelligence, concerns and opinions from communities and front-line staff. Few seem to be doing this well.

In principle, the JSNA should develop a long-list of potential priorities emerging from analysis. It should be a broad sweep across the whole field of health and wellbeing, then drilling down on key areas for more detail and interpretation. The long list of “possibles” can then be put into the public domain, with supporting information, and through informed debate and consultation, rationalised into a set of priorities. Few areas appear to have followed this theoretical approach. Consulting the public about priorities is often unsupported by information in a form suitable to support educated debate. In some cases consultation has been almost asking for a yes/no response to a short list of already established priorities. In some cases, priorities from public consultation have been followed by a quick catch up, to “get something in the JSNA about that”. Often, there has been good technical analysis of data, but the presentation of the resulting information has not been converted into user friendly formats to inform and “tell the story” to a range of audiences.

Some examples of presentation that drive home their point are shown below. The first (Figure 1) shows 2 maps of Birmingham. The map on the left grades the numbers of patients registered with their GP as having heart disease, darker colours representing higher proportions of patients. The map on the right shows the mortality rates for heart disease, darker colours representing higher death rates. The complete mismatch is inescapable. It demonstrates that patients with greatest need (in the City centre) are not connecting effectively with services, while patients in the more well-to-do northern parts are registering and getting the benefits of reduced mortality. This leaps out as a priority for the City to act upon.

Figure 2 then shows an analysis of application of evidence to people with long-term conditions, also in Birmingham. From this it is clear that only half of people with heart disease or diabetes know they have the condition. Educating the public about this, and then helping to search for the “missing thousands” is something that all partners in the HWB can contribute to through their outreach into communities, and contacts with residents and their families. GPs will then be able to improve their own performance in relation to registering patients, and getting them on the best treatment, while social care and voluntary sector workers can then help health services support patients to make the most of their treatments and therapies. Similar approaches apply to alcohol related harm or fuel poverty initiatives, for example.

Figure 1

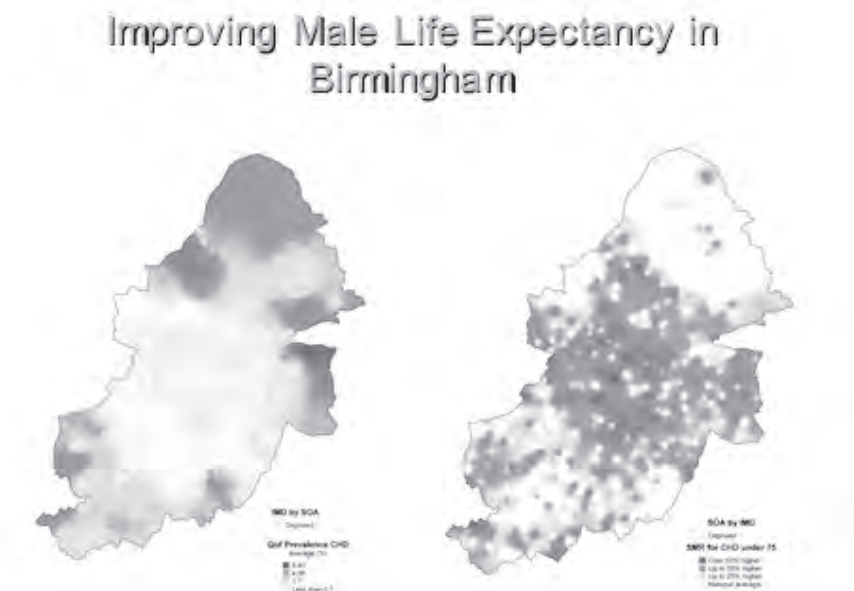
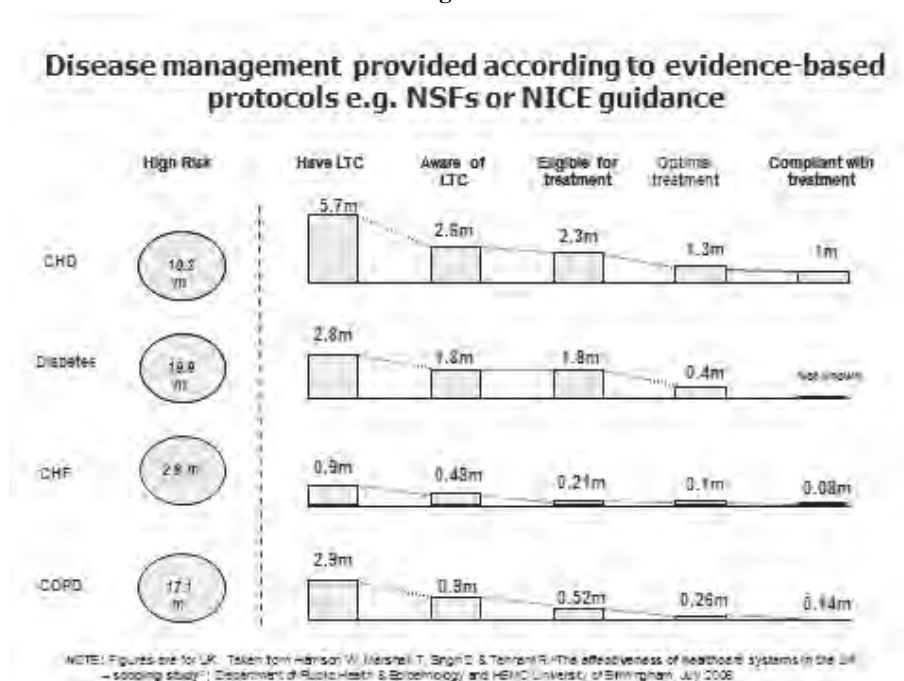


Figure 2

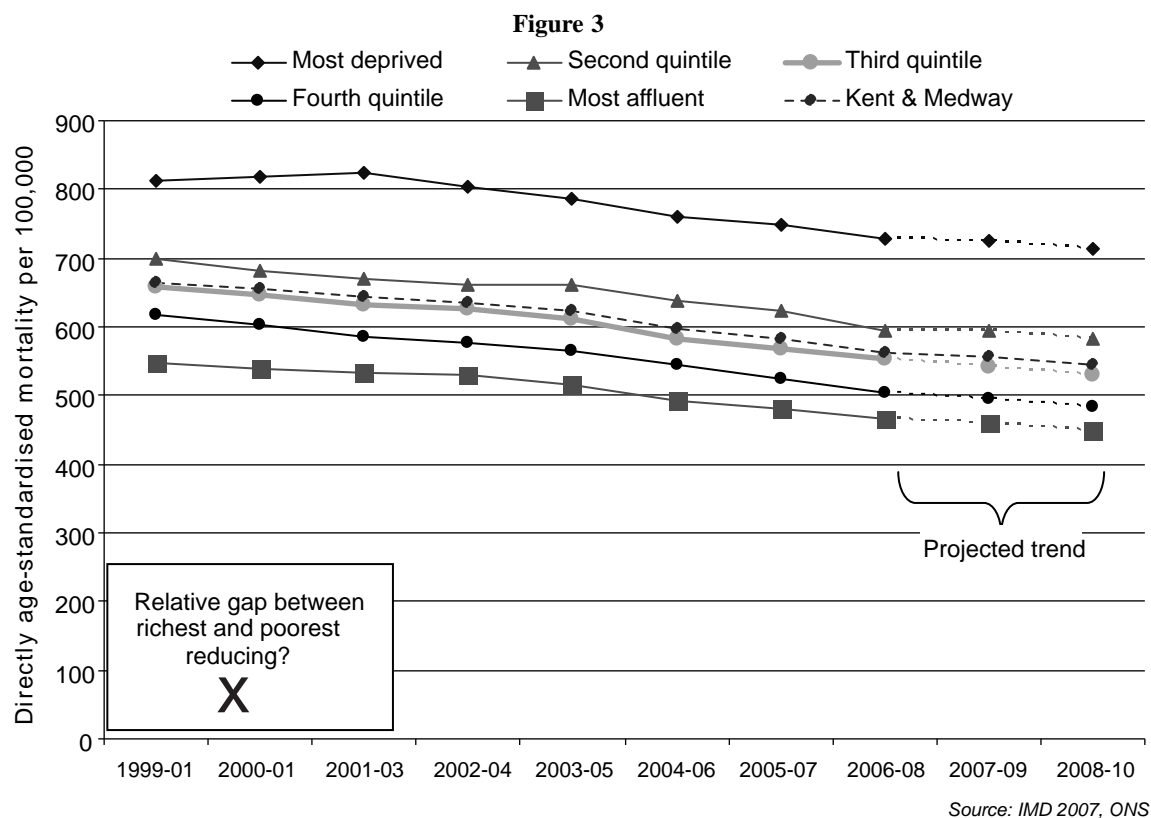


This “filtering out” of the key features of the broader analysis, and using presentational techniques to make the issue clear to a wide audience is an important step. The ability to do this depends on the availability of population health analysts, together with public health specialists, and even communication specialists. The transfer of public health professionals and practitioners into local authorities has been very variable, and some do not have the critical mass to do other than the minimalist “churning out” of an annual JSNA report. In some areas, the analytical capacity has been pooled, which may work, unless it results in “formulaic” product for its constituent areas, without the local capability to manipulate and use the analysis.

In Kent, a two tier Authority, the County HWB has established through its public health analytical support that there is a major gap in mortality experience between those parts of the community in the most deprived quintile, and the rest. The graph demonstrating this is stark (Figure 3), and has left the Board in no doubt that this needs to be a priority.

However, the analysis is also being extended below County level, and this shows that each of the different sub-HWB areas, based on CCGs, has a different pattern of inequality. Each will be generating its own local (JSNA) analysis, and prioritising action. However, those actions will need to add up to County level impact, under the coordinating action and governance arrangements of the HWB.

Unfortunately, for many areas, due to capacity or capability issues, population health and wellbeing priorities are not being persuasively promoted.

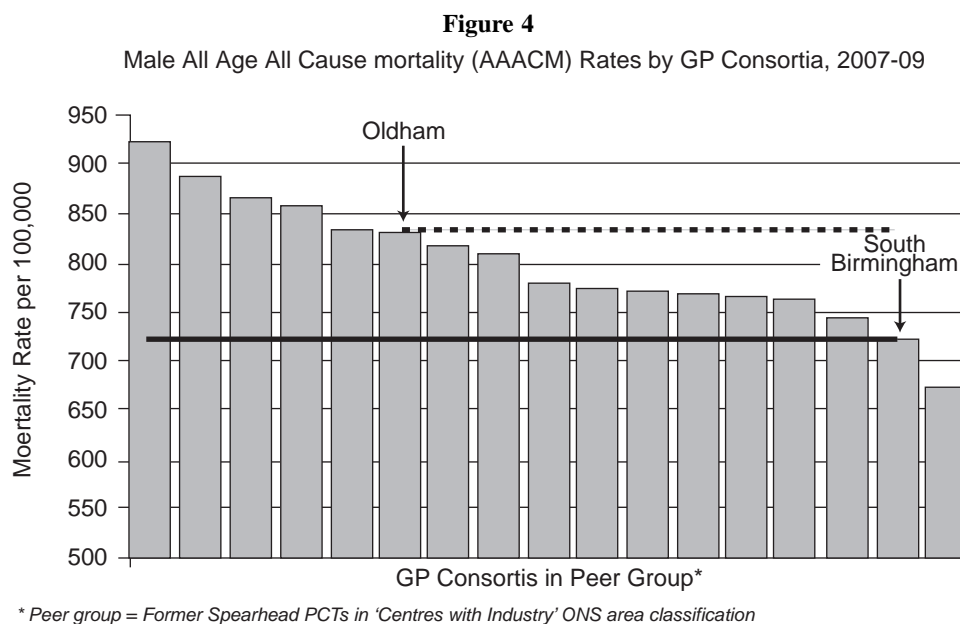


#### 4. Setting targets: locally relevant and meaningful

- Choose testing but achievable benchmarks for change.
- Set “SMART” outcomes with numbers where possible.
- Comparison should be meaningful to local stakeholders.
- Where relevant, makes sense to take account of National Outcomes Frameworks and indicators.
- What distributional factors need to be considered? Use needs assessments and equity audits to establish the need for graded or targeted responses within an area.

Many Joint Health and Wellbeing Strategies I have seen have established a series of priorities, but without setting out targets for achievement. For example, they might establish Care of the Elderly as an overarching area of concern, and then might select Dementia as a specific. The challenge is then: what will be different here in three—five years’ time as a result of the HWB having selected it as a priority? Many strategies I have seen are what I call “pink and fluffy”. They are well intentioned, but will often not commit to what exactly needs to happen for us to get from where we are now, to where we want to be. And how will we know we have got there?

HINST worked with Oldham, who kindly agreed to be a pilot for the approach, to establish a practical approach to setting local targets. This focussed on the chosen priority to continue to address the high mortality rates in the Borough. The starting point was that the national average mortality rates were too extreme for them to aspire to in the short term. They first of all needed to choose a relevant benchmark. For this purpose, the Office of National Statistics (ONS) publishes information which clusters like-with-like local authorities together. It was possible to place the Oldham baseline together with mortality rates from all the areas in their cluster (Figure 4).



From this it is possible to see where they were placed relative to other “Centres with Industry” with similar characteristics to themselves. South Birmingham, were best in class, illustrating what rates might be possible in similar conditions. Oldham might, therefore, decide to set the South Birmingham rate as their own target.

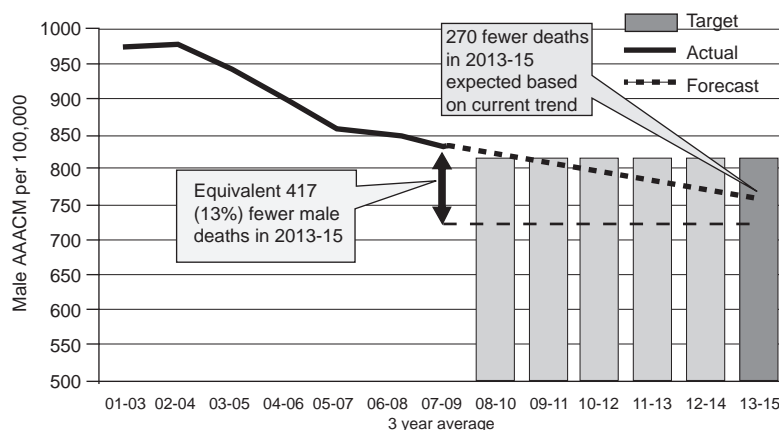
The next step was turning this ambition into an understandable one to a range of stakeholders, including GPs, local councillors and the public. This is best achieved in this case by converting mortality rates into the number of people dying. It is seen therefore that in Figures 5 and 6 numbers more men dying in Oldham compared to South Birmingham (standardised to population size) now appear on the charts. There would need to be 417 less men dying in Oldham by 2013–15 if current South Birmingham rates were to be achieved. Turning the rates into “people” opens up the discussion. Elected members will ask how many of those would be in their constituency. GPs ask how many in their Practice; members of the public might want to know how many in their neighbourhood. Public health practitioners might ask how many might be South Asian.

There is already a downward trend in Figure 5, so there may well be 270 less deaths by 2015 anyway. How many more deferred deaths would, therefore, be needed to reach the target. The Table (Figure 6) shows that this number would be 147 for men, but a much higher 339 women.

This then would provide Oldham with a very tangible, ambitious but realistic target, understandable to a wide audience—the number less people who would be dying in Oldham by 2015.

**Figure 5**

Oldham Male AAACM rate 2001-2009, forecast and trajectory to 2012-15 ambition

**Figure 6**

Reductions in mortality numbers necessary to meet 2013-15 targets

	2007-09 AAACM (rate)	2013-15 ambition (rate)	2007-09 deaths (number)	2013-15 ambition (number)	Required reduction (number)	Expected reduction (number)	Additional reduction Required
Males	833.6	721.2	3100	2683	417	270	147
Females	597.7	497.8	3410	2774	636	297	339
Persons	-	-	6510	5457	1053	567	486

This approach can also be used to address inequalities within a local authority area, benchmarking one part of the population against another.

While Localism requires the setting of locally relevant outcomes, there is encouragement that where appropriate these should contribute to National Outcomes also. These are set out in the three National Outcomes Frameworks. In many areas there has been little reference to these so far in the HWS. This may change when Public Health England comes on stream.

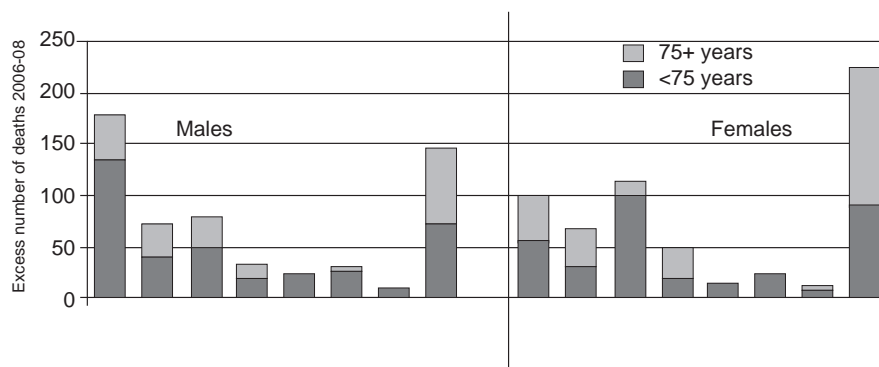
#### 5. Select interventions: strongly evidence based

- Review the evidence base to establish interventions that could make a substantial contribution to the target. This should capitalise on evidence sources across the sectors involved (eg health; social care; housing; community engagement).
- Model or estimate the size of the potential contribution for each proposed intervention.
- Explore the scope for improvement utilising the proposed interventions. What systems will be necessary to deliver the scale of intervention necessary?

Having established, preferably, a numerical target, or otherwise at least an estimate of the dimension of change required, it should be possible to identify the evidence-based interventions that might be expected to give the potential for the level of change needed in the timescale required.

For Oldham, an analysis of the causes of the extra mortality, Figure 7, shows what the causes of the excess deaths had been. It can be seen that key issues were heart disease mortality for men, but cancer for women.

Figure 7



It was then possible to identify the main evidence based interventions that might give Oldham the ability to reduce male deaths due to heart disease and stroke, and estimate the numbers of lives that could be saved with them in three years. This is shown in the table Figure 8. The right hand column, labelled NNT, is numbers needed to treat. This shows how many people would need to be treated to save the one life. This number begins to give the basis of costing the intervention.

It can be seen that choosing interventions from this table allows development of a portfolio programme plan, very far from the “pink and fluffy” strategies seen elsewhere.

Figure 8

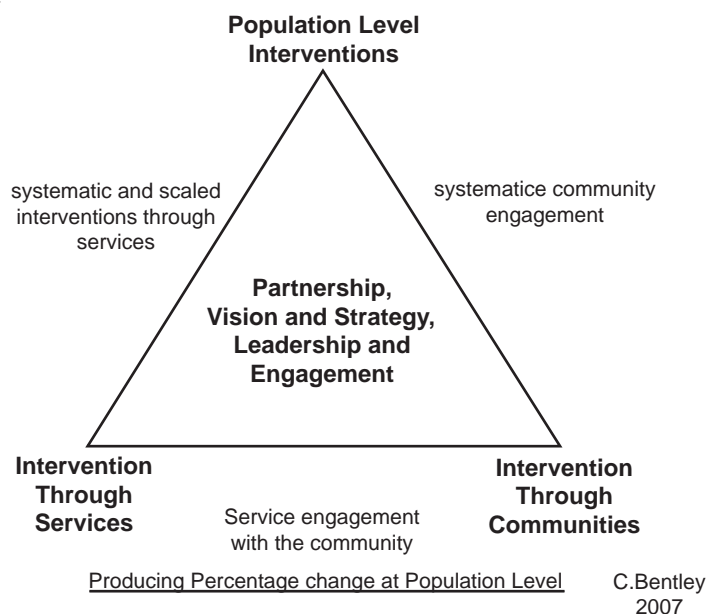
Intervention	Deaths postponed	Treatment population	NNT to postpone one death
<b>Secondary prevention following CVD event</b> Four treatment (beta blocker, aspirin, ACE inhibitor, statin)			
Currently untreated: CVD deaths averted	31	4,345	136
Currently partially treated: CVD deaths averted	61	15,335	253
<b>Additional treatment for hypertensives</b>			
Additional hypertensive therapy	62	38,053	425
Statin treatment for hypertensives with high CVD risk	27		
<b>Warfarin for atrial fibrillation &gt;65 years</b>			
Stroke deaths averted	17	609	35
<b>Improving diabetes management</b>			
Reducing blood sugars (HbA1c) over 7.5 by one unit	13	3,092	232
<b>Treating CVD risk among COPD patients</b>			
Statins for eligible mild & moderate COPD patients	45	1,833	40
<b>Total</b>	<b>258</b>	-	-

NNT = Number Needed to Treat to postpone one death

While the example shown here has the benefit of good numerical estimates, it provides a model of what might be aimed for, including programmes addressing lifestyle/behaviour change and the social determinants

of health. It will often be possible to model the dimensions of possible change required, even if not more precise numbers.

#### 6. Whole System Approach



- Complex programmes for population level change will not all be delivered through conventional services, and may well involve all three points of the population level intervention triangle (see Figure 9):
  - (i) Population level interventions (healthy public policy; legislation; regulation; licencing).
  - (ii) Systematic and scaled intervention through services (Tiers 1 -4 health service; wraparound social care; Third Sector support).
  - (iii) Systematic community engagement.
- The Triangle could provide a good framework and specification for the population based working of the Health and Wellbeing Board

In developing intervention strategies, one of the benefits of moving the focus of population health and wellbeing into the local authority is to potentially provide a range of ways to impact on outcomes other than through services.

For example, a whole system approach to addressing alcohol related harm might include:

- *Population level inputs:* licencing; bylaws on street drinking; controls on advertising; enforcement of trading standards/sales to minors
- *Community level inputs:* extended school education programmes; health trainers; community lifestyle initiatives; health champions
- *Service level inputs:* Tier 1—4 alcohol services; social care wraparound services (debt management; housing support; job support)

Currently, many areas are focussing on sharing information about priorities and initiatives, and on joint commissioning of services between CCGs and social care. It is hoped that more holistic approaches will evolve. The population intervention triangle could provide a specification for the work of the HWB, making it ideally set up to create significant improvements in health and wellbeing.

#### 7. Develop business plan: economic case for population level change

- With systems, scale and timescale established, model cost and potential return on investment to make a viable business case.
- Needs to stand up to competition in the persuasiveness of the case.
- May often be a case for changing focus of existing programmes, rather than starting a whole new programme afresh.
- Would be supported by resulting from a well-managed and widely owned prioritisation process (see above).
- Will need to take into account the different business planning models and cycles of the component sectors and organisations.



Particularly at a time of austerity, strategies and action plans need to focus on productivity and efficiency, reduction of waste and improvements in quality, and prevention. Approaches such as Community Budgeting, shared community engagement infrastructures, and integrated service models are totally compatible with, and even preferable for improved health and wellbeing outcomes and addressing health inequalities. However, good professional business cases still need to be able to stand up against other organisational priorities, and may need to fit multi-sectoral models.

8. *Programme planning: who is responsible?*

- Bring the components of strategy contributing to a priority outcome together in a defined cohesive programme.
- Different components will often be delivered by different organisations.
- However, it would be preferable if there were a single empowered lead answerable to the Board for each prioritised HWS Outcome.

In a proportion of areas I have come across, priorities are being addressed by aggregating up a list of initiatives by different agencies that might be relevant. Some joint commissioning is underway, involving new players. In some areas, for example, GPs are involved in commissioning of community health and social care, so bringing a primary care perspective to bear where it hasn't been before.

The concern would be if a nominal "programme", say to address dementia, or alcohol related harm, came back to the Board as a series of fragmented reports from each agency or even, part of agency. By what mechanism could this be addressed for cohesive impact; how would the differential success in impact across different services or projects be monitored, and adjustments made?

Much more effective would be to have one appointed programme "manager", empowered and appointed to report to the Board on the whole programme. This would involve dedicated time for communication, co-ordination and even intervention to support bringing in the programme on target and on time. The "manager" responsibility would be different for different priorities, perhaps being DPH for one or two, Director of Adult or Children's services for others, CCG leadership for some. This kind of arrangement is likely to be necessary if jointly delivered population level outcomes are to be realistic.

9. *Maximise impact: minimise inequalities*

- In relation to delivery through services, there are many factors that influence whether an intervention, or group of interventions have the optimal impact at population level. HINST used a checklist of 13 factors, pulled together as the "Christmas Tree" diagnostic.

Factors 1–5 on the right side of the diagram are a range of factors relating to the service itself. The result of productive focus on these issues will be improved service outcomes.

Although important, this is not the same as good population level outcomes. These will not be achieved without focus also on factors 6–10 on the left side of the diagram. These relate to how the population uses the services, and is supported to do so.

Factors 11–13 in the middle of the diagram are important factors in balancing population need with service provision:

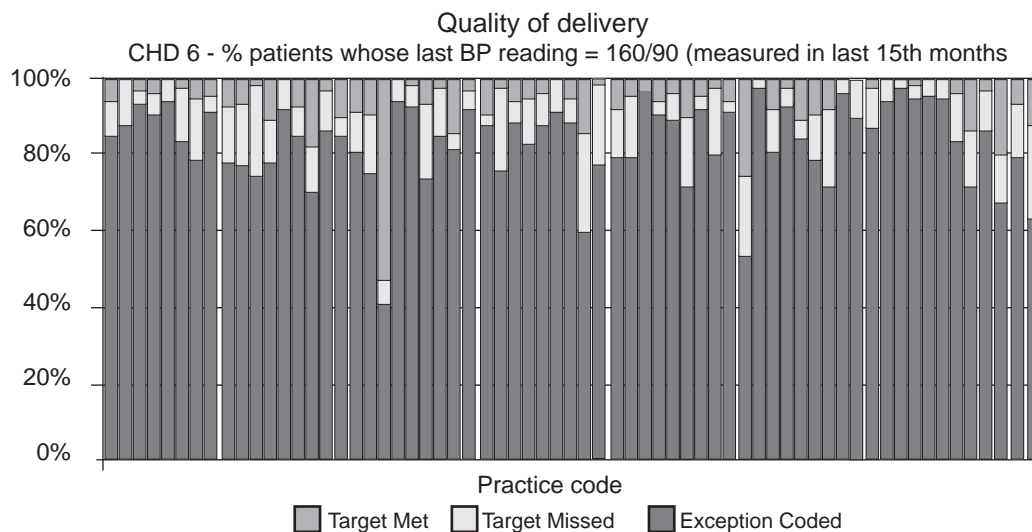
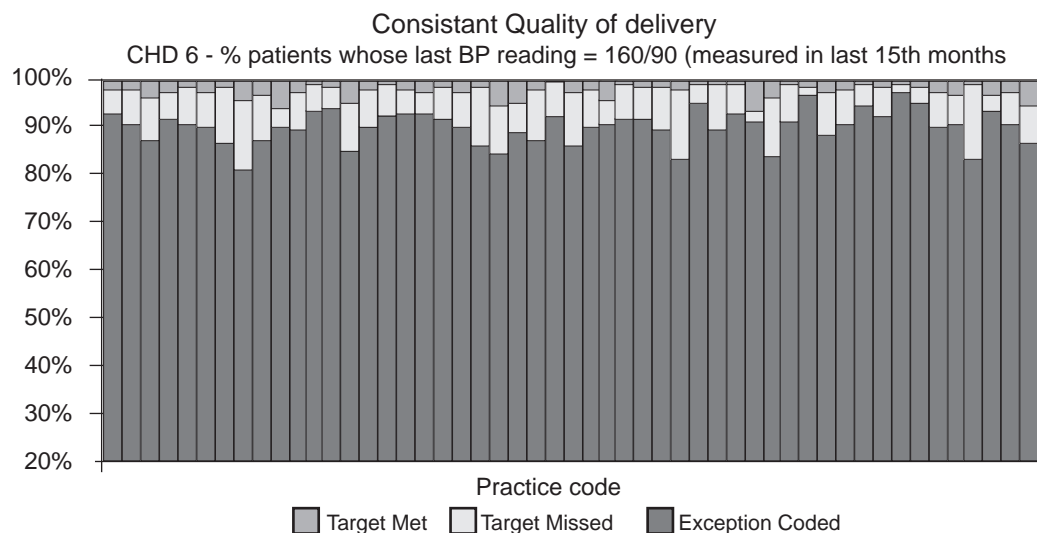
- Many of these 13 factors are often neglected in designing and running programmes, resulting in patchy delivery, well below the programme potential.

**Figure 10****Commissioning Services to Achieve Best Population Outcomes**

Deciding on targets and planning towards delivery of the numbers is not the end of the story when looking to address health inequalities. Many service based initiatives focus on service quality, and delivering best service outcomes. This is worthwhile, and often necessary. Patchy service delivery itself produces inequalities, and programmes must work to iron these out.

The kind of issue addressed by the right hand side of Figure 10 is demonstrated by some work with the GP Quality and Outcomes Framework (QOF), illustrated by Figure 11. Each bar in this diagram represents a GP register of patients with Heart Disease. The blue part of the bar represents the proportion of patients with their blood pressure under control, the orange those not under control, and the white patients that the GP has excluded for various reasons from the reckoning. The key point is how variable the results are, practice by practice. This is important, as whatever else is being done locally to address health inequalities, patients represented by the orange and white bars are likely to still die prematurely from heart disease. The variability does not need to be the case as shown by the CCG area in Figure 12, where despite having the same deprivation score as the previous area, there is very little variation practice to practice, as a result of significant levels of supportive action.

However, even where service delivery is of consistent quality, equality is not assured. The left hand side of Figure 10 addresses how the population uses services, and is supported to do so. If patients do not connect with services, then however good those services are, there will be little impact. Figure 13 shows another QOF diagram, where this time the green part of the bar represents an estimate of numbers missing from the disease register. Supporting these patients to connect with service is a role for the whole HWB partnership.

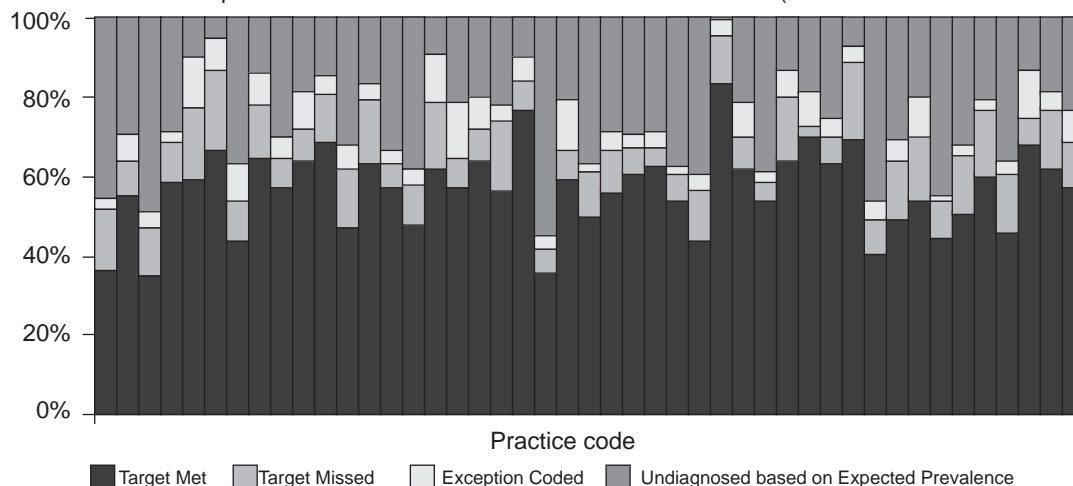
**Figure 11****VARIABLE CONTROL OF BLOOD PRESSURE IN PATIENTS WITH PRIMARY CARE.****Figure 12****MORE CONSISTENT CONTROL OF BLOOD PRESSURE ACROSS PRACTICES**

**Figure 13****ILLUSTRATING PATIENT NUMBERS MISSING FROM DISEASE REGISTERS BY PRACTICE****Identifying the untreated patients (GP practice)**

CHD: expected vs Qof Registered Prevalence (Percentage)

A quarter of patients with a history of CHD are estimated undiagnosed (untreated)

CHD 8 - % patients whose last measured cholesterol = 6mmol/l (measured in last 16 months)



Although these examples are from primary care, the principles have been found to apply to most service based programmes. The Christmas Tree diagnostic framework provides one way to systematically appraise a range of factors that are likely to impact on inequalities, and population level outcomes.

Not many HWBs I have seen are currently considering this level of systematic commissioning. Without it, health inequalities will persist and even increase.

**10. Information Governance: sharing intelligence**

- The HWS would benefit by being accompanied by a number of support strategies. In particular:
  - An Information Governance Strategy exploring and facilitating the flows of data and information around the system, necessary for delivery of the strategy and its programmes.
  - A Communication Strategy, marketing information through partner organisations and the wider public, about the JSNA findings, and the HWS strategy and its progress.

In my experience, neither of these are in place so far in most Health and Wellbeing systems.

**CONCLUSIONS**

As Health and Wellbeing Boards become established, and come out of shadow, there are some key features of structure and process that will be critical if they are to be fit for purpose to deliver measureable population level changes, for which they will be held to account. At present, while there is already good practice emerging, the situation is patchy and variable.

While central direction is not an option, there is a strong case for better guidance and developmental support on what will be needed to achieve population level change.

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- December 2012

**PROFESSOR CHRIS BENTLEY FRCP; FFPH**

Chris's professional focus turned from hospital medicine to public health during eight years in Somalia, working in the emergency refugee programme, in village based health care, and finally as advisor to the Government for UNICEF. In the UK he held DPH posts in West Sussex, Sheffield and South Yorkshire over a 15 year period. In 2006 as Head of the Health Inequalities National Support Team for DH he carried out

appraisal and support visits to 50 of the most deprived areas with the poorest health in England, helping them to achieve measureable improvements at population level. From this role, he was also commissioned to advise on national public health policy. Now as an independent consultant specialising in health inequalities and the social determinants of health, he has contracts at local, regional and national level, currently focussing on support to emerging HWBs and CCGs. As a consultant with WHO Europe recent contracts have included missions to Slovenia, Turkey and Poland.

### **Written submission from the Department of Health and the Department for Communities and Local Government**

#### **INTRODUCTION**

1. The Government welcomes the Committee's inquiry into the future role of English local authorities in health. This memorandum outlines the Government's vision and objectives for local authorities' role in the new health system.

2. The Health and Social Care Act 2012<sup>83</sup> ("the Act"), gives local government two critical new roles in relation to health in England. Firstly, local government will lead on local public health, and secondly, they will have a strengthened leadership role in relation to the wider local health and care system, through health and wellbeing boards.

3. The 2010 White Paper *Healthy Lives, Healthy People*<sup>84</sup> set an ambitious vision for public health in the 21st century, aiming for a nation living longer, healthier lives, and to narrow inequalities in health between rich and poor.

4. One size-fits-all solutions are not effective when public health challenges vary from one neighbourhood to the next. A new approach is needed that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs, putting local communities at the heart of public health.

5. The Act aims to achieve this. In April 2013, unitary and upper tier authorities take responsibility for vital public health activity, ranging from cancer prevention and tackling obesity to drug misuse and sexual health services.

6. Bringing public health into local government allows services to be planned and delivered through the full range of their business in the context of determinants of health like poverty, education, housing, employment and pollution. The aim is that local councils look for opportunities to focus their efforts on positive health outcomes for the population and reducing inequalities.

7. The Act also requires health and wellbeing boards to be established in every unitary and upper tier local authority area. Health and wellbeing boards will take an overview of health and care services, and they will guide action to promote population health and wellbeing. This strengthened leadership role for local authorities, working with the NHS and local communities, is intended both to improve outcomes and increase accountability and democratic involvement in health.

8. The White Paper *Caring for our future: reforming care and support*, published in July 2012, underlines local authorities' role in promoting health and wellbeing. It aims to change the focus of care and support to promote people's independence, connections and wellbeing, for example through councils' housing functions, and transform people's experience of care and support. It will put people in control and ensure that services respond to what they want. The draft Care and Support Bill<sup>85</sup> includes a duty on local authorities to commission and provide preventive services.

#### *A public health role for councils and Public Health England*

9. Local responsibility for public health will mean the transfer of commissioning and delivery away from Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to local authorities. By April 2012 each of the 31 PCT clusters and their local authorities agreed comprehensive plans for a robust transition to the new public health system. These plans were reviewed by SHA Clusters in May 2012, with support from local government and all were making good progress.

10. Support for the transition of public health to local government has been developed by the Department of Health and Local Government Association (LGA). This includes case studies from local authorities<sup>86</sup> who are already leading the way on public health.

11. Responsibility for public health in England involves a new emphasis on the role of the Directors of Public Health (DsPH) in the discharge of local authorities' public health duties and a reorganised public health workforce. A new executive agency of the Department of Health, Public Health England (PHE), will be the

<sup>83</sup> <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

<sup>84</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121941](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941)

<sup>85</sup> <http://www.dh.gov.uk/health/2012/07/careandsupportbill/>

<sup>86</sup> [http://www.local.gov.uk/web/guest/media-centre/-/journal\\_content/56/10171/3374673/NEWS-TEMPLATE](http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE)

authoritative national voice and expert service provider for public health in England. It will support the efforts of local authorities.

12. PHE will provide strategic leadership and vision for the protection and improvement of the nation's health in partnership with local government. PHE will carry out these duties in partnership with the wider health and care and public health system and with key delivery partners including local government and the NHS.

13. The rationale for a national public health agency is to bring together for the first time the full range of public health expertise. PHE's three key functions will be:

- delivering services, including specialist public health services, evidence and intelligence services, working in support of local government;
- leading for public health, by encouraging transparency and accountability across the system; and
- developing the public health workforce.

14. In July 2012 Duncan Selbie was appointed as PHE's chief executive Designate. Mr Selbie is leading the work to establish PHE. He is in the process of appointing his top team and ensuring the transfer of staff to PHE. Mr Selbie is working with Local Government and other colleagues to develop the vision for PHE and to ensure it can effectively support the delivery of improved public health outcomes. The Secretary of State for Health also appointed Dr David Heymann, currently chair of the Health Protection Agency, as acting chair of PHE, to provide further assurance of operational independence.

15. Local authorities already have a frontline role in health protection through their statutory functions around notifiable diseases and through their environmental health officer workforce (in district and single tier councils). This will not change in the new system, although there will clearly be opportunities for a more coherent and aligned approach to health protection.

16. PHE will incorporate the functions of the Health Protection Agency (HPA), and thus will be responsible for front line health protection via its local centres which will support their local authorities. The Public health in local government and health protection factsheets<sup>87</sup> along with the Local Health Resilience Partnerships (LHRP) resource pack<sup>88</sup> describe the future Emergency Preparedness, Response and Resilience (EPRR) roles of local government. Work is currently underway to provide assurance that everyone understands the role of the LHRP and how they as individuals and organisations contribute to the whole system of EPRR in planning and in response. The new structures and organisations will work through partnerships of the 39 Local Resilience Forums (LRF), each with a lead DPH from within the LRF area who will coordinate the public health input into planning for, and testing of, responses to emergencies across the LRF area.

17. New incidents are most likely to emerge from reports to PHE or to local authorities through environmental health officers (as is the case with the HPA currently).

18. Initial responses will be led by the DsPH, with PHE, in close collaboration with the NHS lead. Both PHE and environmental health staff have statutory powers and responsibilities in responding to health protection incidents and emergencies.

19. The NHS Commissioning Board (NHS CB) and Clinical Commissioning Groups (CCGs) will commission health care, including specific public health services, such as to the military, prisons and immunisation. The NHS CB will also commission public health services within the GP contract and where the Secretary of State delegates some of his/her responsibilities (via the Section 7A agreement).

#### *Directors of Public Health*

20. To discharge their public health responsibilities and deliver real improvements, the DsPH need an overview and influence on the local authorities' wider activities. Local arrangements are for local decisions, but the Government is clear that there should be direct accountability between the DsPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members. By June approximately 85% of areas had proposed reporting arrangements that are consistent with these expectations. The remaining 15% of areas had yet to agree their model.

21. The DsPH, if a medical or dental health professional, will also be accountable to their respective professional regulating bodies as a doctor, nurse or dentist.

22. DsPH will be statutory members of health and wellbeing boards.

#### *The role of Health and wellbeing boards*

23. Health and wellbeing boards will be the forum for local authorities, the NHS, local Healthwatch, communities and wider partners, to share system leadership of both health and care services and population health.

<sup>87</sup> <http://healthandcare.dh.gov.uk/public-health-system/>

<sup>88</sup> <http://www.dh.gov.uk/health/2012/07/resilience-partnerships/>

24. The Act mandates the statutory minimum membership for health and wellbeing boards to include at least one local elected member, a CCG representative, the local directors of adult social services, public health and children's services, and a representative from the local Healthwatch organisation. The NHS CB must also participate when invited to do so.

25. They will develop a joint understanding of local needs through Joint Strategic Needs Assessments (JSNAs); a shared set of priorities and a strategy to address these in Joint Health and Wellbeing Strategies (JHWSs). JSNAs and JHWSs will form the basis of NHS and local authorities' own commissioning plans, across health, social care, public health and children's services. The Government recently concluded a short public consultation on draft statutory guidance on JSNAs and JHWSs. A formal response to this consultation will be published by the end of the year.

26. Health and wellbeing boards will have duties to encourage integrated working between commissioners of services across health, social care, public health and children's services. This complements duties on CCGs and the NHS CB to promote integration. They will consider how the collective resources of the NHS and local government can combine to improve outcomes, for example through Community Budgets.

27. By involving local councillors and representatives of people using services through local Healthwatch, and through wider engagement with local communities, health and wellbeing boards will strengthen local democratic legitimacy of health services and increase the influence of local people.

28. Healthwatch and Healthwatch England will be the new consumer champion for both health and social care, and Local Healthwatch will feed local people's views and concerns about local health and social care services into the system.

29. Local Government's health scrutiny arrangements will continue to be an important route for accountability to local communities. The Government recently closed its consultation on the proposed future arrangements which reflect the changes brought about by the Act, including the importance of effective partnerships between local government and the NHS. The responses to this consultation are currently being analysed ahead of the Government's response in the Autumn.

#### Preparations for health and wellbeing boards

30. "Shadow" boards are established or being established in every local area, with work underway on refreshing JSNAs and developing preparatory JHWSs to help ensure they are in place in time to underpin 2013–14 commissioning plans.

31. The Government's approach to implementation of health and wellbeing boards recognises that accountability for setting up boards is local—with the approach depending on local circumstances and priorities.

32. The Department of Health, with partners including the LGA, NHS Institute and NHS Confederation, has developed a National Learning Network which:

- brings together health and wellbeing boards to share learning about how they can be most effective—rather than issuing central guidance; and
- supports the collaborative leadership and relationships that will be crucial to the boards' success.

33. We are also working with the LGA to provide support to local authorities to help them prepare for local Healthwatch.

#### Barriers to integration

34. The report of the NHS Future Forum on integration summarised the barriers and enablers to integration, as "culture, incentives, regulation and relationships". Both the Future Forum and the recent Health Select Committee Inquiry<sup>89</sup> highlighted the importance of the role that health and wellbeing boards will play as a "crucible" for integration in each local area.

35. The Care and Support White Paper commits us to taking integration further across health and social care, involving wider services such as housing.

36. In the next year the Government will publish a framework, co-produced with partners across the new health and care system (patients, people who use services and carers), that will support the removal of barriers to making evidence-based integrated care and support the norm over the next five years.

37. As set out in the White Paper, the draft Care and Support Bill also sets out a duty on local authorities to promote the integration of services, along similar lines to the duty on the local NHS already enacted by the 2012 Act. In addition, the draft Bill will provide for further duties of co-operation which encourage local partners to work together to improve the wellbeing of local people. This includes new duties to be placed on adult social care and housing departments to work together.

<sup>89</sup> <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/social-care1/>

38. Upper-tier and unitary local authorities are best placed to take on health improvement functions. There is a clear parallel between public health and adult social care and children's services where leadership lies at the upper tier level. District councils will also play a critical role, both in contributing their knowledge of local needs to JSNAs, and in contributing to delivery of JHWSs and improved public health, including through housing and environmental health functions. It is for local areas to determine their own arrangements for how best to do this.

#### FUNDING

39. From 2013–14 upper-tier and unitary local authorities will be allocated ring-fenced public health grants to improve the health and wellbeing of local populations. Baseline spending estimates for each local authority published in February 2012 estimated that in 2012–13 around £5.2 billion will be spent on the future responsibilities of the public health system, including £2.2 billion on services that will be the responsibility of local authorities.

40. The Advisory Committee on Resource Allocation (ACRA), an independent expert committee that has overseen the formula used to allocate NHS resources for many years, is developing a formula for the allocation of resources to local authorities for public health. ACRA's interim recommendations were published on 14 June 2012<sup>90</sup> and included an update on the health premium and the proposed conditions on the public health ring-fenced grant. This includes provision for pooling of the ring-fenced public health budget, including as part of a Community Budget.

41. Final allocations for 2013–14 will be announced by the end of the year. A new health premium incentive will reward improvements in health outcomes, and incentivise action to reduce health inequalities. Disadvantaged areas will see a greater incentive, recognising that they face the greatest challenges.

42. Local government is continuing to respond to the challenge of demonstrating better value for money by implementing slimmer management structures and sharing management resources where appropriate. Planning holistic, integrated services will also enable prevention, early intervention and greater efficiency and effectiveness across care pathways.

43. From April 2013, Government will be introducing a business rates retention scheme to put a strong financial incentive for economic growth at the heart of the local government funding system.

44. The Government intends to roll in a number of currently separate grant funding streams, including the Early Intervention Grant and the Health Learning Disability and Health Reform Grant through the new business rates retention system. This process will help to maximise the size of the local share, thereby increasing the financial incentive for local authorities to drive forward economic growth. It also provides greater local flexibility and freedom for local authorities to make decisions and manage budgets efficiently.

45. The Government will also set up a new care and support housing fund, providing up to £300 million of capital funding over five years from 2013–14. This will support local authorities to plan for a range of accommodation options to meet the needs of their local population.

#### MEASUREMENT OF IMPACT

46. Health and wellbeing boards will set objectives based on the priorities identified through JSNAs and JHWSs. JHWSs should contain transparent measures that local people can recognise and understand, against which progress can be assessed.

47. The Public Health Outcomes Framework,<sup>91</sup> NHS Outcomes Framework<sup>92</sup> and Adult Social Care Outcomes Frameworks,<sup>93</sup> to be updated this autumn, set the national context for the new arrangements. The PH outcomes framework focuses on the most important things we want to do to improve and protect the nation's health and wellbeing and improve the health of the poorest fastest. The framework will be used as a tool for local transparency and accountability, providing a means for benchmarking local progress within each authority and across authorities, and driving sector-led improvement. By April 2013, the Government will also publish an atlas of variation in wellbeing<sup>94</sup> to help local authorities identify areas for improvement.

48. In our response to the NHS Future Forum report on integration, we committed to develop a measure of patient experience of integrated care for use in the Outcomes Frameworks.

49. As with other local services, councils will primarily be accountable to their electorates. The Government expects that the principles of sector-led improvement will apply across local government's new role in relation to health, including public health, local Healthwatch and health and wellbeing boards. PHE will also be able to offer advice and support.

<sup>90</sup> <http://www.dh.gov.uk/health/2012/06/ph-funding-la/>

<sup>91</sup> <http://www.dh.gov.uk/health/2012/01/public-health-outcomes/>

<sup>92</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_131700](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700)

<sup>93</sup> <http://www.dh.gov.uk/health/2012/03/adult-social-care-outcomes-framework/>

<sup>94</sup> *Caring for our future: reforming care and support*, Department of Health, July 2012—<http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/>



## CONCLUSION: NEXT STEPS IN TRANSITION TO THE NEW SYSTEM

50. Earlier this year, the DH and LGA agreed a joint working statement as the basis of further work to assess readiness and prepare for local governments' roles in the new system run up to April 2013, with local government increasingly taking the lead.

51. A further stocktake of progress on the transfer of public health functions, led by local government, will happen in October 2012, enabling:

- each locality to take stock and inform LGA/DH of remaining barriers and risks;
- localities to reflect on approaches taken elsewhere; and
- an overview of progress and remaining issues at national level.

52. The October stocktake will establish an understanding of which localities, if any, are facing significant and specific risks and barriers. This will form the basis for tailored support and mitigation plans. There should be few of these, but where they are necessary they should be the subject of intensified, tailored, support and monitoring.

53. As part of the National Learning Network for health and wellbeing boards, the LGA and partners have produced a tool for boards to assess their own progress.<sup>95</sup> Boards are accessing bespoke leadership support at local level from the LGA and NHS Leadership Academy.<sup>96</sup>

54. The Government believes that preparations are on track for local governments' role in the new health and care system. Accountability for delivery will ultimately, and rightly, be at local level, arrangements are in place to assess progress, and to provide support where needed.

*October 2012*

**Supplementary written submission from the Department of Health and the Department for  
Communities and Local Government (HLTH 19a)**

**COMMUNITIES AND LOCAL GOVERNMENT COMMITTEE SELECT COMMITTEE—ORAL  
EVIDENCE SESSION MONDAY 21 JANUARY**

**THE ROLE OF LOCAL AUTHORITIES IN HEALTH ISSUES**

At the Select Committee session on Monday 21 January, Baroness Hanham and I agreed to provide you with written responses to your questions in respect of:

- the Department's formal and informal powers to hold local authorities to account for their performance of their new public health functions;
- the capacity of the NHS Commissioning Board (NHS CB) to intervene where a clinical commissioning group (CCG) is apparently failing to work with Local Authorities (LAs);
- the timetable for review of the local authority funding formula; and
- the possibility of health and wellbeing boards being obliged to take account of the offer from the English National Park Authorities Association to take parks into account when drawing up healthy living plans.

**DEPARTMENT'S FORMAL AND INFORMAL POWERS TO HOLD LOCAL AUTHORITIES TO ACCOUNT FOR THEIR  
PERFORMANCE OF THEIR NEW PUBLIC HEALTH FUNCTIONS**

The 2012 Act gives local authorities a new statutory duty to take the steps they decide are appropriate to improve the health of the people in their area. The Secretary of State has a duty to take steps to protect the health of the population and a power to take steps to improve health. He has the power to make regulations ("6C" regulations) that prescribe how LAs will undertake their health improvement duty or that delegate his health protection functions to LAs. The Secretary of State can also issue guidance that LAs must have regard to.

When LAs exercise their new functions, they will do so as part of the comprehensive health service. The architecture of the new system recognises that local authorities are more independent, democratically accountable entities than NHS bodies and are experienced in identifying local needs and commissioning complex personal services.

An effective tool in policy terms is likely to be transparency of (relative) performance. Putting robust information in the hands of Health and Wellbeing Boards, local politicians, health professionals and the general public should form a powerful tool to drive improvement.

Central Government has been working closely with the local government sector over the last two years to develop the sector-led improvement approach in children's services and adult social services (developed by local government itself). Local authorities individually and the sector collectively should bear primary

<sup>95</sup> [http://www.local.gov.uk/c/document\\_library/get\\_file?uuid=4d27e893-87a8-4be8-af16-42d2e69ca90f&groupId=10171](http://www.local.gov.uk/c/document_library/get_file?uuid=4d27e893-87a8-4be8-af16-42d2e69ca90f&groupId=10171)

<sup>96</sup> [http://www.local.gov.uk/web/guest/health/-/journal\\_content/56/10171/3510973/ARTICLE-TEMPLATE](http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3510973/ARTICLE-TEMPLATE)

responsibility for driving improvement, rather than national government, reflecting the local accountability and statutory independence of local government.

The key elements of sector-led improvement are:

- Support for local leadership;
- Comparative data allowing the benchmarking of data;
- Peer challenge visits to identify the challenges and areas for improvement for individual councils;
- Sharing of good practice and promotion of innovation;
- Specific improvement offers, and
- Intervention in the case of poor performance.

We are in discussion with the Local Government Association over developing a sector-led approach to the local public health system. We would wish to see a focus on the mandatory services within such a programme.

The sector-led approach would allow us to share concerns that we might have about individual authorities in order that the sector could respond accordingly. The LGA argue that sector-led improvement is a very powerful tool, as it is in practice far easier for peers to deliver hard messages and drive improvement than central government.

LAs will be required to certify that they have spent their grant in accordance with the conditions attached to it—in particular, that it is used exclusively for public health activity.

Under section 6C of the NHS Act 2006 (inserted by the 2012 Act) the Secretary of State can (and will) require local authorities to exercise their health improvement duty by taking particular steps or to exercise health protection functions on his behalf—such as sexual health. These regulations will set out quite detailed specifications of the services to be provided and if necessary could be drafted to apply to a single LA. If a local authority fails to properly exercise a function delegated to it under those provisions the Secretary of State is able to fill the gap and exercise the function himself. He could therefore make alternative arrangements for a given population (although he would not have a duty to do so).

Whether or not a particular service or step is prescribed in regulations, the Secretary of State can publish guidance that LAs must have regard to (“statutory” guidance). We intend to publish guidance on all the functions mandated by 6C regulations and will be discussing that with the Local Government Association and DCLG colleagues.

If any system failure relates to a health protection function that the Secretary of State has delegated, then action could be taken against either the LA or the Secretary of State (on the grounds that the Secretary of State was not intervening in an adequate or appropriate way).

In the case of delegated health protection functions the Secretary of State can also direct a local authority to review the performance of its director of public health, consider taking particular action, and report back.

Section 15 of the Local Government Act 1999 provides a broad set of powers, including intervention in the event that there is significant evidence that an authority is failing to comply with its statutory obligations. These powers allow direction to produce a performance plan, cause an inquiry to be held, or otherwise direct the actions of an authority. The Secretary of State may also direct that a nominated individual exercise the authority’s functions on his behalf.

#### CAPACITY OF THE NHS NHS CB TO INTERVENE WHERE A CCG IS APPARENTLY FAILING TO WORK WITH AN LA

The new section 14Z21 of the NHS Act, as inserted by section 26 of the Health and Social Care Act, gives the CB powers to direct or dissolve a CCG, or to replace its accounting officer where the CB is satisfied that a CCG is failing to discharge its functions, or there is a significant risk of it failing to discharge its functions. This would apply to the functions of working with LAs to develop Joint Strategy Needs Assessments and Joint Health and Wellbeing Strategies.

The Board’s planning and contracting guidance: *Supporting Planning 2013–14 for Clinical Commissioning Groups* (December 2012) says that “there will be further guidance, to be agreed before the start of 2013–14, to describe CCG assurance and covering in-year monitoring and assurance, recovery and support and intervention and escalation”.

#### TIMETABLE FOR FUNDING FORMULA FOR LOCAL AUTHORITIES

Writing to the Secretary of State in October 2012, the Chair of the Advisory Committee on Resource Allocation’s (ACRA) noted that in the medium term ACRA wished to further develop the public health allocations formula to be based more clearly on the underlying drivers of need for public health services, rather than an outcome measure, like a mortality rate. Relying principally on an outcome measure risks creating a perverse incentive, where a local authority that improves its health outcomes would in turn see its target allocation fall.

No specific timetable has been set for the next iteration of the public health allocations formula. However, as we noted in the, *Healthy Lives, Healthy People: Update on Public Health Funding* in June this year, any perverse incentive will be particularly marked were the current formula still in use alongside the Health Premium Incentive Scheme. We expect the first payments to be made under this scheme in 2015–16 and so this will also be a key year in the development of the formula.

*Health and wellbeing boards being obliged to take account of the offer from the English National Park Authorities Association to take parks into account when drawing up healthy living plans.*

The Department of Health welcomed the views of the English National Park Authorities Association (ENPAA) as part of their response to the consultation on Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) statutory guidance for health and wellbeing boards. Indeed there are important links that can be made between the statutory purposes and activities of National Parks and health and wellbeing boards.

However, what JSNAs and JHWSs cover and include is for local determination based on local circumstances as every area is unique. It would not be appropriate for central Government to highlight any care group, activity or area of need over another as this would risk undermining the purpose of JSNAs and JHWSs being an objective, comprehensive and locally-owned process leading to evidence based priorities to inform local commissioning. In undertaking JSNAs and JHWSs local authorities and CCGs have a responsibility to consider the needs of the whole local population from pre-conception to end of life including people who live, work and access services in the area, those not registered with local GP surgeries, the hard to reach and excluded groups. Health and wellbeing boards will need to consider all local health and social care needs, both now and in the future; and many will go wider to look at delivering wider health and wellbeing benefits for their population. As such, health and wellbeing boards are free to explore the benefits of National Parks and the impact this has on local health and wellbeing outcomes, if they so wish.

Throughout the process health and wellbeing boards will involve the local community—taking account of their views in JSNAs and JHWSs to ensure that local services are shaped and influenced by the people that use them. JSNAs and JHWSs will ensure both that health and care services are built around what individuals, families and carers need, and that there is an opportunity to identify and address the wider determinants of health and wellbeing, such as the local economy, education and housing.

The final JSNAs and JHWSs statutory guidance for health and wellbeing boards is under development and will be published in the coming month.

February 2013

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