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Final Response of the Health Scrutiny Panel to the Public Health White Paper: *Healthy Lives, Healthy People*

SENT VIA EMAIL

Dear Secretary of State,

The purpose of this letter is to submit the Health Scrutiny Panel's formal response to the Public Health White Paper: *Healthy Lives, Healthy People*.

The Health Scrutiny Panel welcomes the central tenet of the Public Health White Paper in placing Public Health within Local Government. A great many of the possible approaches to improving public health lie more within the gift of local government than the NHS, so the Panel sees the proposal as sensible and to be welcomed.

It is, however, the detail that flows from the policy direction, that the Panel would like to comment on.

The Panel notes that a key relationship will be between Public Health Directors/Directorates within local authorities and Public Health England. Particularly, the Panel will be interested to see the size of the ring-fenced Public Health budget and how that will be divided between local authorities and Public Health England. The Panel would also take this opportunity to argue that it is absolutely essential that public health budget allocations to any given area, take appropriate cognisance of the public health profile of that area. It is the Panel's strongly held view that those with higher levels of deprivation and 'worse' public health profiles should receive appropriately weighted allocations. The Panel fears that anything else would undermine the credibility of the proposals and leave the new public health directorates with a very difficult task. The Panel looks forward to greater clarification on how the resource allocations will be weighted and the focus it will place on meeting evidenced need.

The Panel is conscious that whilst public health services can address problems and even prevent some problems from developing, the Panel has not seen sufficient focus, thus far, on the 'causes of the causes' of ill health. It is clear that poor lifestyle choices are a fundamental cause of poor health outcomes, although there is insufficient acknowledgement in the documentation published thus far, of the reasons for some of those lifestyle related choices. Low levels of income, lack of aspiration, poor life chances and a lack of accessible information and facilities are hugely significant determinants on people's health, which need appropriate recognition in policy.

The Panel recognises that under the proposals, the Director of Public Health will be the lead officer within a local authority, responsible for the deployment of Public Health resource. The Panel notes that localities will have a degree of flexibility and freedom about how they deploy those resources to meet local need. The Panel would like to highlight that localities should be able to strike a balance in public health initiatives that have strong evidential basis and services that represent something of a 'leap of faith' which are less evidence based. By way of example, there is a very strong evidence base for the benefits of the *Get Active on Prescription* service, for patients identified as morbidly obese. It is clear what benefits can be delivered and why the service is being commissioned. There is less clear evidence to highlight, for instance, that free swimming for school age children, contributes to a child growing up to be a healthier, and more health conscious, adult. Still, on the balance of probabilities, this is probably the case. As such, there is a role for central Government to offer their support for such schemes, should such schemes be questioned.

The Panel considers it vital that the Director of Public Health is given sufficient authority to act urgently in the public interest, should it be necessary to do so. This is especially important in areas such as flu outbreaks or responding to pandemics. Whilst it is crucial that democratic oversight of Directorates of Public Health is a strong feature of the new structures, Directors should have sufficient powers to exercise their professional judgement at times to 'get things done', when going through traditional decision making routes would create a threat to public wellbeing. The Panel would call on the Department of Health to ensure that Directors of Public Health have sufficient statutory powers to make this a reality.

In the last two or three winter periods, the Health Scrutiny Panel has been an interested observer in our health and social care system's resilience to associated winter pressures, such as flu. The Panel has heard from a number of senior sources that the regional planning dimension, facilitated by the Strategic Health Authority with Directors of Public Health, has been critical in co-ordinating responses to the challenges posed and ensured that spare regional capacity has been utilised in the best possible way. An example of this is the mutual assistance agreements that hospitals have had in place about bed capacity for those patients requiring inpatient treatment, due to flu. The Panel is concerned that the abolition of Strategic Health Authorities and their regional oversight role, means that the public will be less safe at times of outbreak or pandemic. It is not acceptable that such resilience in the future should have to rely upon informal networks, or good relationships between professionals to function or not. Planning for, and responding to, such regional threats requires a systematic approach, which the Panel is far from convinced is delivered by the proposed arrangements. The Panel would look to the Department to outline how this critical facilitator/convenor role will be maintained as the new structure is established. In addition, the role of SHAs and PCTs in Emergency Planning must not be forgotten. The Panel is aware that PCTs have a particular input into

planning for local disasters, outbreaks and the like, through Local Resilience Forums. The Panel is far from clear who will ensure that SHAs' and PCTs' existing responsibilities will be picked up and carried forward. Again, the Panel would strenuously argue against a scenario where we apparently rely on informal networks of professionals to ensure an appropriate NHS contribution to Emergency Planning. The Panel has also been made aware by senior professionals that the reforms to the NHS, and particularly the challenging transitional reorganisations, could bring about the loss of important skills and knowledge. The Panel would like to know what steps are in place to ensure that organisational memory is not lost and ensure that the new arrangements are safer, or at least as safe, as what is currently in place. The Panel has also discussed these concerns with our local Emergency Planning Team, which shares the Panel's concerns. The lack of certainty about where Health related emergency-planning expertise will come from and where it will sit, is a genuine concern. The Panel has heard a persuasive argument from our local Emergency Planning Unit, which says that it would be beneficial for the PCT emergency planner to come under the future remit of the Director of Public Health. This is a particular issue for Middlesbrough and the wider Tees area, as of the 47 COMAH (Control of Major Accident Hazards) sites in the North East, 37 are contained within the Tees area.

The Panel wishes to make comment on the topic of Public Health and GP Commissioning Consortia. The Panel feels it is absolutely critical that GP Commissioning Consortia have a clear and explicit methodology for taking advice on public health measures and ensuring that a fair proportion of their Commissioning activity targets public health related work. Presently, it is not clear how GP Commissioning Consortia will work with Public Health Directorates, nor whether emerging GP Commissioning Consortia see themselves as having a role in public health promotion and commissioning, as well as the Commissioning of traditional intervention based health services. The Panel would like to see the Government articulate some sort of expectation of the level or the amount of public health work that it expects GP Commissioning Consortia to become involved in. Whilst the Panel fully understands that public health initiatives will ultimately be the responsibility of Public Health Directorates and Public Health England, it is crucial that GP Commissioning Consortia are aware of the impact they could have in relation to public health and preventative services. The examples of talking therapies or debt advice are services, which are not necessarily 'clinical' interventions, but could have a huge impact on people's wellbeing and could prevent a condition worsening. The Panel feels it is essential that GP Commissioning Consortia understand this point and can actively demonstrate their understanding of how someone's environment or position in life, influences their health outcomes.

It is possible that Public Health becoming a Directorate within a local authority could have one of two conclusions. Firstly, it could bring about a situation where it operates discretely within the local authority, pursuing public health goals, without ever really impacting upon the wider operation of the local authority. Alternatively, the local authority could ensure that the Directorate of Public Health becomes a crucial component of decision making, with the health impacts of proposed major decisions being taken into account before those decisions are made. In the same way as a local authority would not take a major strategic decision without seeking legal and financial advice, the public health impacts of a proposed decision could be sought from appropriate professionals before it is made. In so doing, local authorities would be genuinely ensuring that public health becomes a major component of what they do. The Health Scrutiny Panel has advocated this previously within the local authority and although the idea of health impact

assessments was accepted, they have never fully been used. There is, therefore, a huge opportunity for Government to create an environment where Directors of Public Health are expected to be placed at the centre of decision making within a local authority and to be an advocate for health improvement and health protection, across all aspects of the local authority's work.

The Panel wishes to make comment on the critical role of the Health & Wellbeing Boards. The Panel considers it vital that there is sufficient Elected Member representation on the Health & Wellbeing Boards to add an appropriate degree of democratic legitimacy to their function, direction and decision making. The Panel notes that current proposals stipulate a minimum of one Elected Member on the Local Health & Wellbeing Board. The Panel is concerned that having a minimum of only one democratically elected representative on a Health & wellbeing Board is too low and the Department of Health should consider raising it to two. The Health & Wellbeing Board will perform a critical role in establishing Strategy and act as an interface/facilitator between a GP Commissioning Consortium and a Local Authority. As such, the Panel feels that there should be greater mandated political involvement and accountability in that forum, together with the local authority providing administrative support to the Board. Further, by having appropriate Executive Members heavily involved in the work of the Board, there will be appropriate political input for areas such as Children's Services, Leisure, Public Health and Social Care. The Panel understands that the Local Health & Wellbeing Board will be a critical forum where debate is held and health and wellbeing strategy for the area concerned is set. The Panel has some concerns that, under the current wording of the Health & Social Care Bill, there is only a requirement on GP Commissioning Consortia to be represented on the Local Health & Wellbeing Board, not for GPs to attend. The Panel remains concerned that if (specifically) GPs are not required to attend, the engagement of GPs in wider debate about the area's wellbeing, as opposed to commissioning priorities for a Consortia, is unlikely to happen.

In addition, the successful planning and establishment of Local Health & Wellbeing Boards, together with their accompanying Health & Wellbeing Strategy and Joint Strategic Needs Assessment, are tasks requiring a great deal of skill and judgement. This area of work requires skills and technical knowledge from local authorities, which are not necessarily the traditional domain of local government. As such, the Panel feels that the Department of Health should expect there to be a certain amount of lead in time, whilst local authorities develop or acquire the expertise to assist in the development of the new structures, ensuring a smooth transition to the new system in 2013.

There are a number of points to be made about the Joint Strategic Needs Assessment. Firstly, the Panel would like to draw your attention to a collaborative piece of work undertaken by all Health Scrutiny Committees in the North East, highlighting the needs of the ex-service community. It is clear that the ex-service community has not had the consideration it has warranted previously, as services have been planned and commissioned. It is of integral importance that the ex-service community is a clear and definable part of Joint Strategic Needs Assessment, to ensure that such a valued section of society has the prominence it requires, when commissioning strategies are established and enacted.

A second point that the Panel would like to make relating to the Joint Strategic Needs Assessment was raised by a member of the public at a recent discussion event, held by Middlesbrough Council on the Health reforms. It was described as paramount that

vulnerable sections of society such as those with mental health problems, substance misuse problems, ex-offenders and asylum seekers are not 'crowded out' of the priority groups within the Joint Strategic needs assessment and receive adequate attention. Such groups are some of the most vulnerable in society and do not regularly have high profile advocates 'fighting their corner'. It would be deeply worrying if the absence of such high profile advocates led to their absence or omission in Joint Strategic Needs Assessments.

In addition, the Panel would be keen to see the Department of Health stress the importance of the Health & Wellbeing Board involving itself in work around the wider determinants of health and not simply becoming a forum to discuss the commissioning of health services, aimed at addressing established health concerns. The Health & Wellbeing Board should see itself as having a critical role in influencing wider public policy, with the aim of tackling wider determinants of health such as poverty and poor life chances. It is precisely such issues as poverty and a lack of life chances that can lead to communities having poorer than normal health outcomes. It should be the job of the Health & Wellbeing Board to ensure that all parts of the new structure, particularly GP Commissioning Consortia, are fully cognisant of that and understand that poor health outcomes for a community rarely occur in a vacuum. If the Health & Wellbeing Board simply concentrates on strategies for health services and established health problems, The Panel would argue it will not be fully meeting its responsibility to the community it represents.

The Panel would like to express concern over the proposed arrangements for the commissioning of the children's services. Under the proposals, the Panel understands that services for children aged 0-5 will be commissioned by the NHS Commissioning Board, although the Public Health Directorate will commission services from 5-19. The Panel does not understand the rationale for that distinction and does not feel that the case for this distinction has been adequately made. It seems that Public Health Directorates are going to be inheriting responsibility for children, when they have presumably had no professional input into the services commissioned from 0-5. In addition, areas of high deprivation may require more substantial services from 0-5 than areas of affluence. Such services also need to be fully integrated with local services, particularly Children's Centres. The Panel is far from convinced that the NHS Commissioning Board has a better understanding of local need for children and families than the local authority in question and would call upon the Department to think again on this proposal.

The Health Scrutiny Panel in Middlesbrough has had a substantial impact on the provision of local health services, which has been confirmed by a number of senior NHS managers and clinicians locally. It contributes a great deal to the consideration of how the locality tackles issues of concern, connected to health of the community. It should be noted that the wide ranging changes to the operation of the local NHS, necessitate a great deal of work for Health Scrutiny in fulfilling its statutory functions, on behalf of local populations, and assuring itself that satisfactory progress is being made.

As such, it should be noted that Health Scrutiny has a significant agenda to pursue and the Department of Health's ongoing support and recognition of the function is appreciated.

Yours sincerely

Councillor Eddie Dryden
Chair, Health Scrutiny Panel