

Health and Social Care Bill on Public Health

Online discussions on the implications of the Bill



Introduction

This is a report on the online discussions held between the 5th and the 8th September 2011 on the implications of the Health and Social Care Bill on Public Health.

The five discussions discussed in this report, ran over four days*, that were based on a series of articles written by the speakers detailed in the following pages. The articles illustrate the huge potential of the transition of public health to councils, and some of the concerns. This report will list the main speakers (click on each of the named authors to access their full article)* and include a summary of each discussion that took place between Community of Practice (CoP) members and the speakers (click on each discussion title to link to the full debate)*. This report will finally draw out some concluding points.

* Please note the discussions took place on the Healthy Communities CoP. The Healthy Communities CoP is one of many CoPs. The CoPs are a series of websites that support collaboration across local government and the public sector. It is a freely accessible resource that enables like-minded people to form online communities of practice, which are supported by collaboration tools that encourage knowledge sharing and learning from each others' experiences. The Healthy Communities CoP provides a forum for all who are committed to promoting good health in its widest context and reducing inequalities.

You need to be a member of the CoP to access these. To join you need to:

1. Go to <http://www.communities.idea.gov.uk> and under 'Register and become a member today' select 'Register'
2. Enter your details as requested and select 'confirm and complete'
3. You will receive a confirmation email. Click the link to activate your account and search for 'healthy communities' to locate the CoP.

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Discussion 1

Click [here](#) to view, 140 CoP members attended (viewed online), 40 responses from the panel and CoP members.

The speakers were: (click on their name to view their full articles):

- **Liam Hughes** (*National Advisor for the Healthy Communities Programme*)
- **John Middleton** (*President of the UK Faculty of Public Health and Director of Public Health Sandwell Primary Care Trust and Sandwell Metropolitan Borough Council*)
- **Frank Atherton** (*President of the Association of Directors of Public Health*).
- **Richard Parish** (*Chief Executive, Royal Society for Public Health*)
- **David Kidney** *Head of Policy, Chartered Institute of Environmental Health supported by Ian Gray (Principal Policy Officer, Chartered Institute of Environmental Health)*
- **Supporting article Councillor David Rogers** (*Chair of Local Government Association Community Wellbeing Board*)

This lively debate involved five key national leaders of Public Health (PH) organisations and 40 responses. Liam Hughes started the debate by welcoming PH ‘coming home’ with the opportunities that will give to influence the large building blocks for health such as education, planning and housing. He outlined many of the dilemmas that will be faced as the reforms are implemented.

Frank Atherton has long argued that the levers of influence for health lie largely within the remit of local government and sees the White Paper as offering a framework for an integrated public health system. He clearly outlined the benefits and the potential risks ahead detailing urgent action needed to overcome some of the risks.

Richard Parish recognised the enormous role elected members and council staff have to play but emphasised the need for employing an appropriately qualified Director of Public Health (DPH) to ensure effective action, impact and public safety.

David Kidney, whilst welcoming the reforms, is concerned that public health resilience remains robust through the transition and that national and local strategies are put in place to match the scale of the PH and wellbeing agenda facing us.

John Middleton sees it as vital that councils pick up the baton of health, not as a ‘new burden’ but as a crucial matter of ‘civic pride’. He posed a series of questions including whether we are engaged in an adoption or a marriage and if a marriage whether it is arranged or one with love.

One of the initial debates was about the need for councils and the National Health Service (NHS) to work with their workforces to improve their health, outlining the economic argument and setting a good example with this work for other employers to follow.

The 'ripple effect' that this could have on improving the health of both families and friends was discussed with the additional impact if front-line staff were to be supported to give brief advice and good signposting to patients and clients.

Developing and supporting both the public health and environmental health workforces, during this period of transition, were seen as key in ensuring a positive impact from these reforms. The DPH, in particular, was seen to need to step up to a significant leadership role. In addition, it was agreed adjustments were needed to modernize the PH training syllabus.

There was a lively debate about the opportunities to move away from the NHS dominated emphasis on sickness and ill-health to PH being about the creation of wellness and resilience with co-production of good health with communities. This was supported, but there was concern that the NHS should not be allowed to walk away from its responsibility for PH with the need for the National Commissioning Board (NCB) and the Clinical Commissioning Groups (CCGs) making investments that deliver the best outcomes. There was some reassurance given by the speakers that the Future Forum is considering this.

The risks of political philosophy overriding the evidence and assets being stripped from PH before, during and after the transfer were raised. The debate recognised that although money is important, much can be achieved with strong political will and decisions about local priorities (through the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Board's (HWB's) strategy) and current policy tools, fiscal incentives and financial penalties, as well as local regulation and planning decisions.

The need for new technology to help citizens with their long-term conditions, whilst also reducing the financial pressure on the NHS, was debated and it was recognised there was a need for support from PH to ensure new technologies were evidence based and good practice shared.

There was a long debate about the tension between localism and central control and how the public health outcome framework would play into that as well as the relationship between two tier local authorities. Factors to strengthen localism included the effectiveness of the local HWB the strength of public engagement in the process of the JSNA and the local PH strategy, the leadership of the DPH and the degree of buy-in to the local strategy by other partners (including CCGs, housing providers and so on) as well as by all the council's own Departments.

Discussion 2

[Click here](#) to view the discussion, 134 CoP members attended (viewed online), 33 responses from the panel and CoP members.

The speakers were (click on their name to view their full articles):

- **Linn Phipps** (*Freelance Consultant*)
- **Dominic Harrison** (*Joint Director of Public Health, Blackburn with Darwen*)

Linn Phipps recognises that there is still plenty of “water to flow under the bridge” before proposals are finalised, and still an opportunity to influence the shape of the proposals, and to participate in testing them.

Dominic Harrison is DPH for Blackburn and Darwen, which is one of the national network of early adopters of HWBs. He initially raises the issue of how these boards might hold national government to account if it fails to take evidence into account for its action to improve population health. He then covered practical issues in establishing a HWB, drawing on the experiences from Blackburn and Darwen. The balancing of prioritising health issues without disenfranchising certain sectors was explored.

Finances were discussed with the knowledge that local areas are currently working out their prevention spend into money going to local government, infrastructure costs and the National Commissioning Board (NCB). With the NCB covering broader geographical areas than previously held by PCTs the point was made that less money would be under

local control in the future than that currently overseen by PCTs. The concept of pooled or joint commissioning over much wider areas was being discussed nationally. The idea of sharing a DPH between local areas was rejected in the debate.

Performance management and development were debated and it was recognised that a range of accountability issues were not yet resolved (e.g. the relationship between HWB and Monitor/CQC). The push for CCGs to cover broader areas to achieve financial balance, resulting in them having a very different footprint to councils, was seen to undermine localism.

Measurement of progress was seen as being key. The need to collect softer qualitative data as well as quantitative data was covered in the discussion to ensure we establish intermediate outputs when outcomes would take so long and to ensure local views were heard.

The need for a supportive national infrastructure for HWBs was raised with one of the issues being that some chairs are paid and others are not. It was agreed that to capture the public interest in HWBs, media involvement was needed - dealing with hard issues such as disinvestment in hospital services, re-investment in primary care as well as health promotion issues.

The relationship of HWBs with Overview and Scrutiny Committees (OSCs) was discussed and picked up more fully in the next discussion.

Discussion 3

Click [here](#) to view the discussion), 100 CoP members attended (viewed online), 22 responses from the panel and CoP members.

The speakers were: (click on their name to view their full articles):

- **Su Turner** (*Principal Consultant, Centre for Public Scrutiny*)
- **Councillor Patrick Vernon** (*London Borough of Hackney*)
- **Hugh Annett** (*Joint Director of Public Health, Bristol*)
- **Supporting article David Phillips** (*Director of Public Health, Dorset*)

Su Turner sets out the stall for the added value that scrutiny can bring in helping to tackle the health problems that exist across the country. She revealed the current work being conducted in seven geographical areas by the Centre for Public Scrutiny (CfPS) to explore the role of scrutiny in the health reforms and to begin to build effective working relationships with the emerging HWBs, CCGs and Healthwatch. Conclusions are due to be published later this year on the CfPS website: www.cfps.org.uk/what-we-do/tackling-health-inequalities/.

Councillor Patrick Vernon welcomes the new powers that councillors will have in influencing the commissioning and running of health services for their communities. He recognises that the trick will be to

demonstrate how this can contribute to improved health outcomes for everybody, but especially the most marginalised.

Hugh Annett believes that engaging and mobilising the whole council on public health issues is primarily a matter of leadership which takes the long view and is pragmatic; that is characterised by working across the breadth of the council; working in depth with members and officers and staff; and a leadership that over time re-shapes the public health resource so that it is better fitted for its new environment and responsibilities.

A better understanding and communication between members and PH professionals, GPs, nurses and commissioners was seen as important as well as the training for members and senior staff so that the added value of not only PH staff but also all other parties becomes clearer. The role of the DPH in relation to scrutiny needed to be more explicit and their skills developed to work closely with senior managers, members (a range of executive members for issues such as transport as well as health) and communities at neighbourhood level. In addition, the development of Cabinet and neighbourhood leads on public health was recognised as being needed if a social movement is to be created where members, officers and residents have a long-term vision for health.

There were concerns expressed about the risk that the NCB and CCGs will currently



lose whatever interest the NHS currently has in improving health and reducing health inequalities but there was also a view that PH health within the NHS might have provided a fig leaf for hiding the failure of the NHS to improve health. The conditions being set by the Secretary of State for the NCB to work with the HWB (and the JSNA and HWB Strategy) were seen as crucial to changing this.

There were some issues raised about the learning necessary for the health scrutiny members to be proactive (rather than reactive to health service change) and the short-term nature of their role through the election process. However, in general, health scrutiny was seen as a positive force and one that could complement the evidence base by moving to an increased focus on health outcomes rather than services and organisations.

Discussion 4

Click [here](#) to view the discussion), 97 CoP members attended (viewed online), 30 responses from the panel and CoP members.

The speakers were (click on their name to view their full articles):

- **Councillor Jonathan Owen** (*Deputy Leader for East Riding Council*)
- **Caroline Tapster** (*Chief Executive, Hertfordshire County Council*)
- **Robin Stonebridge** (*Freelance Consultant and scrutiny champion*)
- **Supporting article Maggie Rae** (*Director of Public Health, NHS Wiltshire*)
- **Supporting article Phil Coppard** (*Chief Executive, Barnsley Metropolitan Borough Council*)
- **Supporting article John Ashton** (*Director of Public Health, NHS Cumbria*)

Councillor Jonathan Owen believes there is no better place to initiate change in the health of our communities than through local government with the need for council political leaders to champion the cause and let their Members take up the challenge and invest in outcomes that may take years to bear fruit.

Caroline Tapster recognises that the approach we are currently employing to tackle our significant public health challenges is not working and that this return to local government's historic role in health improvement presents us with a key

opportunity to develop a more targeted and effective way of addressing these problems.

Robin Stonebridge poses the question of what we should expect our modern day practitioners to achieve with all their knowledge and techniques when the 'barefoot' PH specialists of the 1900's caused slums to be torn down and clean air and water supplies to be sustained.

The discussion started with the relationship and control between Public Health England (PHE) with local public health and if greater central control would be beneficial in protecting PH from political interference or would prove detrimental. There was a view that there was a lack of understanding from PH staff on how minimally their day-to-day work would be impinged on by councillors and therefore they had exaggerated fears in relation to this. Nevertheless there was concern about members' capability in relation to health issues and a question as to whether it will be beneficial for them to be a majority on the HWBs. One comment in the debate revealed some current research on shadow HWBs that was showing the success of informal forums where NHS staff and councillors could get together to understand each other's work and different perspectives. In that way both the causes of ill health and the 'causes of the causes' could be better understood.

National outcomes were seen as being part of

that national/local tension, with the view that it would be a great opportunity missed if national priorities squeezed out locally determined ones. There was a debate about the need to tackle inequalities within areas and this would lend itself to local priority setting (but potentially with national comparisons). Two tier councils, with the upper tier holding the funding and the lower tier providing the services presented another issue. Cross party political buy-in was seen as being required at a local level to ease this tension.

The debate recognised the need for PH to market their role and skills and present data in a member-friendly form, possibly using a simplification of the current Public Health Observatories' area profiles. A diagram was shared from the Health Inequalities National Support Team (HINST) ('Please see Systematically Addressing Health Inequalities at www.hinstassociates.co.uk/page/useful-resources) on the short, medium and long-term impact from different types of public health interventions to address health inequalities which had been found to help member's understanding.

There was some comment on Maggie Rae's article that described the development of 18 JSNAs, community area health boards and health fairs that have been developed within Wiltshire to cover the whole county. This model was generally admired with some concern expressed about how those communities who are generally not heard, or are thinly spread over several areas (such as gay men or a specific ethnic minority community), have their views heard. The OSC, depending on securing funding in the future, was seen as one important tool to pick up these issues on behalf of communities in the future.



Discussion 5

Click [here](#) to view the discussion), 66 CoP members attended (viewed online), 31 responses from the panel and CoP members.

The speakers were (click on their name to view their full articles):

- **David Hunter** (*Professor of Health Policy and Management, Durham University*)
- **Jude Williams** (*Freelance Consultant*)

This discussion arrived full circle back to a national perspective, which featured in discussion one, as well as covering insights from the previous four discussions.

David Hunter, whilst welcoming local government as the ‘natural home’ for public health, fears it may turn out to be a poisoned chalice for two main reasons; the financial and organisational pressures currently facing local government and secondly, sections of the PH specialty being keen to keep in the NHS comfort zone. To ensure success David states the need for an agreement to be reached on the optimal balance between central and local control; on the rationale (if any) for having ring-fenced budgets; on the location of the public health specialist workforce; and on the role and function of HWBs to ensure they do not repeat the mistakes of previous partnerships.

He identifies another major risk about how far central government and the new body, PHE, really wants to let go and allow local government to run public health.

In the introduction there was a focus on the need for all players in the system to understand the opportunities and threats that lie ahead for interventions that will have an impact on health inequalities in the short term (such as ensuring good access to treatments), medium term (such as supporting individuals to make healthier choices) and long term (action on the broader determinants of health). This would ensure we make the very best of the changes ahead for those in our society with the poorest health. Jude expressed her concerns that there is national support in place to help develop and share good practice and that national regulation, such as CQC and Monitor, supports health improvement and protection.

There were concerns raised about the relationship between national and local action and whether there was any part of the system that would share local learning and good practice at a national level, with the National Support Teams and the Healthy Communities Team no longer there in the future there maybe less support to local areas in the future. The possibility of the local arms of PHE providing this function was raised with support from NICE. However the ‘top-down’ command and control of the Department of Health was predicted as not working with local authorities so PHE would need a different approach.

Another concern was on how public health expertise could be shared across from local government to CCGs without PH becoming too overstretched and overwhelmed by the NHS agenda. There was a suggestion that the three recognised functions of PH might be revisited with the possibility that the support for healthcare and health protection might be better separated from the health improvement function, although the fear, that so many have expressed of fragmentation and the loss of opportunity to draw health and social care together and into local government, was recognised. To complicate this debate a recent BMJ article (detail in the discussion) revealed that morale and motivation of those in public health working on the healthcare agenda is worryingly low.

Other issues raised in the debate were the way in which the HWBs would sign off the CCG's commissioning plans, the financial constraints of local government and the need to support local areas in making their economic case for health improvement and how child health would feature in the new set up.

Finally the authors were set an exam-type of question of their five main thoughts with David responding from a local government angle and Jude from one with a focus on health inequalities.

Conclusion

In writing this report the author was absorbed by the detail and range of the subjects covered by both the debates and the author's articles and would advise readers to click onto the links to access this material to gain a sense of the full debates covering the opportunities and risks facing public health at this critical point in time.

The central role of HWBs ran throughout the debate with the need for them to become a movement rather than a board tied down with procedures.

There were positives highlighted throughout the discussion of the public health move to local government (seen by many as coming back to their natural home), with the opportunity that will give to influence the large building blocks for health such as education, planning and housing, scrutiny acting as critical friend to the NHS and DPHs as key advisors to the HWBs and corporate leaders in the councils. The move was seen as offering a better integration of health and social care and a reintegration of NHS PH with PH functions that still reside in local authority, most importantly environmental health, emergency preparedness and aspects of child health promotion.

However, there were many controversial strands that ran through the debates including; the tensions between central control and localism; the relationship between the NHS (including CCGs) with HWBs and OSCs with the need for the NHS to maintain and develop its role in health

improvement (with the opportunities and 'trusted brand' that it holds); performance management and national support as well as the developmental needs of public health and local government staff and council members through these changes. In particular the tension within the three domains of public health as to their future location or co-location will need resolving.

There are still questions on how these reforms will result in a better PH system to improve and protect health and reduce health inequalities but by knowing the issues and diverse views we can perhaps endeavour to make the very best of the opportunities on offer and reduce the risks.

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