APPENDIX 1

HEALTHY LIVES, HEALTHY PEOPLE – THE PUBLIC HEALTH WHITE PAPER

Leeds CITY COUNCIL

Scrutiny Unit Briefing Note – Scrutiny Board (Health)

Purpose

1. To provide an outline of the most recent NHS reforms set out in the White Paper of public health – *Healthy Lives, Healthy People: our strategy for public health in England* and consider the proposals in the context of the previous health White Paper – *Equity and Excellence: Liberating the NHS* and supporting suite of consultation documents.

Background

2. In July 2010, the Government set out its vision and radical reforms for the NHS through its White Paper – *Equity and Excellence: Liberating the NHS* and supporting suite of consultation documents. The proposals include a significantly enhanced role for local councils in assessing local needs, promoting integration and partnership working, and supporting joint commissioning and pooled budget arrangements. It also proposed a transfer of public health and health promotion responsibilities to local councils.

3. The White Paper – *Healthy Lives, Healthy People: Our strategy for public health in England (30 November 2010)* – expands on the Government's previously outlined proposals around public health responsibilities, which are summarised in more detail below.

Main considerations

Overview

4. The White Paper outlines the government's vision for pubic health being a higher priority area with dedicated resources. It complements another consultation document: *A Vision for Adult Social Care: Capable Communities and Active Citizens,* which emphasises more personalised and preventative services and also forms the government's substantive response to the Marmot Review, outlining a commitment to:

   - protecting the population from serious health threats;
   - helping people live longer, healthier and more fulfilling lives; and,
   - improving the health of the poorest, fastest.

5. In this regard the Government is seeking to build on evidenced base approaches to improving health, with a proposed focus on improving health through the life course, as follows:

   - Starting well – giving children the best start in life
   - Developing well – delivering better outcomes for children and young people
   - Living well – encompassing all of the factors that contribute to heath such as housing, transport, planning and the natural environment
   - Working well – promoting work as providers of good physical and mental health
   - Ageing well – helping people to live longer, more active and healthier

6. The White Paper also proposes a new approach to public health that will aim to address the root causes of poor health and wellbeing, based on being:

   - **Responsive** – owned by communities and shaped by their needs
   - **Resourced** – with ring-fenced funding and incentives to improve
   - **Rigorous** – professionally-led and focused on evidence; efficient and effective
   - **Resilient** – strengthening protection against current and future threats to health

7. The White Paper comments on the achievements of public health services and outlines the overall health inequalities agenda alongside some of the specific current-day public health challenges, including;

   - Maternal health;
   - Children's health and development;
   - Better physical and mental health; and,
   - An increase in emphasis on preventing ill health (preventative services).

8. There is a clear intention for councils to regain a leading role in improving, promoting and protecting the health of local communities. From April 2013, it is proposed that upper-tier and unitary local authorities will have enhanced freedoms and responsibilities to improve the health and wellbeing of communities and reduce health inequalities.

9. Furthermore, aspects of the White Paper suggest an increased emphasis on localism – acknowledging the breath of local government activity that can have a direct influence on public health outcomes. This includes a commitment from the Home Office to overhaul the Licensing Act 2003, to give local authorities and the police stronger powers to remove and refuse licenses.

   <u>Partnership Working and Accountability</u>

10. The White Paper builds on the previous proposals to establish statutory local Health and Wellbeing Boards – stating that, subject to Parliament, Health and Wellbeing Boards will be statutory in all upper-tier authorities, with a proposed minimum membership of:

    - Elected representatives
    - GP Consortia
    - Director of Public Health
    - Director of Adult Social Services
    - Director of Children's Services
    - Local HealthWatch; and,
    - NHS Commissioning Board (participation where appropriate).

11. Local Health and Wellbeing Boards are clearly seen as the main vehicles to bring together key elected representatives with NHS, public health and social care leaders: With the main purposes of such Boards being to:

    - Establish a shared local view about the needs of communities; and,
    - Support joint commissioning of NHS, social care and public health services to meet such need.

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12. Health and Wellbeing Boards will be responsible for making arrangements for the production of the local Joint Strategic Needs Assessment (JSNA) – with GP consortia and local authorities (including Directors of Public Health) each having equal and explicit obligations for its preparation.

13. As such, and in line with the Government's previous proposals outlining the vision and reforms for the NHS, it appears highly probable that Leeds City Council will be required to establish a local Health and Wellbeing Board. It is likely that this will be required to be established in shadow form for April 2011.

14. In addition, local authorities will be free to take joint approaches to public health where it is believed to offer the best approach to tackle health improvement challenges. Consequently, consideration of appropriate regional and sub-regional arrangements may also be necessary.

15. Nonetheless, it will be important for the Council to be fully accountable to its local population for its record on health improvement and health inequalities. The full and proper involvement of locally elected members will be a key aspect in this regard and it will also be important for all staff working in its public health function, including the Director of Public Health (DPH), to be properly and fully accountable to the Council. As such, the transfer of public health responsibilities and staff to the Council is likely to create a number of complex employment issues, which will need to be managed effectively.

16. However, the full impact of the NHS reforms and the Council's enhanced role on current local partnership arrangements are yet to be finally confirmed and, therefore, the practical implications will need to be worked through. Key considerations associated with the new Health and Wellbeing Board are likely to include:

    - How the new arrangements will complement / replace current partnership arrangements;
    - Support and governance arrangements; and,
    - Decision-making processes.

    Some consideration of the above is outlined in the Executive Board report – xxxx – due to be considered on 15 December 2010.

    <u>National Public Health Service</u>

17. A new national integrated public health service, Public Health England (PHE), is also proposed. The purpose of this service will be to ensure excellence, expertise and responsiveness – particularly around emergency preparedness and health protection, bringing together what is described as a 'fragmented system'. However, it is also unclear how the centralisation of functions into PHE supports the otherwise localist vision of the White Paper.

    <u>Budget allocation</u>

18. The overall Public Health ring-fence budget is suggested to be in the region of £4 billion, however this estimate will be revised as the detailed design of PHE develops and more information is gathered around existing services and spend. Nonetheless, it is unclear how much of the ring-fenced budget will support the work of PHE and how much of that will filter down to local authorities for delivery of this important agenda for which they are going to be held responsible.

19. PHE will be responsible for allocating ring-fenced budgets to upper-tier and unitary authorities, weighted for inequalities and asking the NHS Commissioning Board to commission specific services and elements of GP contract. PHE will also commission or provide services directly – such as national purchasing of vaccines.

20. Within the overall public health budget, a new health premium is also proposed, which will form part of the local public health budget for health improvement. Initially targeted towards areas with the worst health outcomes and most need, the Council will receive an incentive payment (or premium) that will depend on the progress made in improving the health of the local population.

21. Further specific details around public health funding and the outcomes framework are due out before the end of 2010, however it is already clear that to support this enhanced role, it will be vitally important that councils have sufficient financial and human resources, along with the freedom and flexibilities to determine how they are deployed locally.

Summary and conclusion

22. While the most recent White Paper is wide-ranging in its proposals, further details on a number of issues are still outstanding. Without these details it remains difficult to have a completely clear picture of the proposed new public health landscape and the role of the Council within it. The outstanding details include:

- the outcomes framework for public health (covering 5 broad domains of public health);
- more precise details of public health funding; and
- 10 further consultation documents on specific aspects of health improvement and health protection.

23. That said, the details in the White Paper add to what has previously been proposed in terms of NHS reforms. As such, it is perhaps worthwhile to consider and restate some of the identified key milestones:

Key date		**Reform**
During 2011	–	Establish Public Health England (in shadow form) within DH
April 2011	–	Arrangements in place to support Health and Wellbeing boards (in shadow form).
	–	Begin transformation of patient Local Involvement Networks into local HealthWatch
	–	Begin to establish GP commissioning consortia in shadow form
	–	Re-focused carers' strategy
October 2011	–	White Paper on sustainable funding and legislative framework for social care
April 2012	–	new statutory functions of local authorities come into effect: Health and Wellbeing Boards in place
	–	Public Health England in place

Key date		Reform
April 2012	–	local health improvement led by Directors of Public Health in local councils: Ring-fenced budget in place
	–	NHS Commissioning Board fully established
	–	Formally establish GP commissioning consortia
	–	HealthWatch launched (nationally)
Autumn 2012	–	NHS Commissioning Board makes allocations to GP consortia for 2013/14
2012/13	–	Shadow public health grant allocations to local government
April 2013	–	Strategic Health Authorities (SHAs) abolished
	–	Primary Care Trusts (PCTs) abolished
	–	GP consortia take full responsibility for commissioning
	–	Upper-tier and unitary local authorities to have enhanced freedoms and responsibilities to improve the health and wellbeing of communities and reduce health inequalities
2013/14	–	Complete transition of all NHS trusts to Foundation Trust status

24. The above timeline outlines some of the major NHS reforms and provides an indication of some of the significant challenges likely to affect the Council and its partners across the local health economy. As such, local councillors are likely to want to know, and arrangements will need to be put into place to advise, how members will influence:

- the local transition to the new arrangements?
- appropriate outcome measures for commissioners and providers?
- how well GP Commissioners evaluate whether the services they commission meet local needs and change services that don't meet needs?
- the effectiveness of Health and Wellbeing Boards as co-ordinators of healthcare, social care and health improvement?
- the NHS Commissioning Board, especially around regional and specialist services?
- the development and support of an effective local Healthwatch?
- key relationships: For example, between the Council and the Care Quality Commission and between local Healthwatch and national Healthwatch?
- the experience of patients and carers and the quality and safety of services?
- the influence local people have to develop options for changes to services?
- the process for assessing service reconfigurations?

25. The risks associated with the proposed changes to the health landscape, could be described or summarised by two extremes:

(a) that the Council fails to address / take account of its new responsibilities; or,

(b) the new health responsibilities dominate the Council agenda at the detriment to other areas.

26. While it has recently been reported that the anticipated draft Health and Social Care Bill has been delayed until January 2011, striking the balance between these two extremes will be a key aspect during the transitional period. Nonetheless, it is clear that, whatever the final proposals, greater local public accountability will be a significant feature. As such, continuing to build on existing relationships and developing new ones will be essential – in particular the relationship between locally elected members and the emerging local GP consortia.

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