MAIDSTONE BOROUGH COUNCIL
TUNBRIDGE WELLS BOROUGH COUNCIL

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY SUB COMMITTEE MEETING HELD ON WEDNESDAY 16 MARCH 2011 AT THE TOWN HALL, TUNBRIDGE WELLS

PRESENT: Councillor Elliott (Chairman)
Councillors Basu, Mrs Crowhurst, Mortimer and Mrs Paterson

Mike McGeary (Overview & Scrutiny Officer, Tunbridge Wells Borough Council)
Orla Sweeney (Overview and Scrutiny Officer, Maidstone Borough Council)

Witnesses:
Jim Boot, Community Development Manager, Maidstone Borough Council
Meradin Peachey, Kent Director of Public Health
Helen Wolstenholme, Communities and Health Manager, Tunbridge Wells Borough Council

1. Apologies

Apologies were received from Councillors Marchant and Mrs Stockell.

2. Notification of Visiting Members

There were none.

3. Disclosure by Members and Officers

a) Disclosures of interest

Councillor Mortimer declared a personal interest in minute 6 below, on the basis that he worked in the rehabilitation sector.

Councillor Basu declared a personal interest in the same minute as a retired consultant pathologist and former employee of the NHS.

b) Disclosures of lobbying

There were none.

c) Disclosures of whipping

There were none.

4. To consider whether any item should be taken in private because of the possible disclosure of exempt information

Resolved: That all items be taken in public.

5. Minutes of the meeting held on 21 September 2010

Resolved: That the minutes of the meeting of the Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee held on 21 September 2010 be agreed as a true record and duly signed by the Chairman.

6. Public Health White Paper and Consultation Documents

The Chairman explained that the Committee had been convened in order to consider the key issues set out in two consultation papers issued by the Department of Health under the overarching theme of their white paper 'Healthy Lives, Healthy People'. The principal focus of the meeting was to understand the extent of the impact of the proposals on local authorities and their residents and respond to the consultation papers accordingly.

The following witnesses were introduced and welcomed to the Joint Committee:

- Meradin Peachey, Kent Director of Public Health;
- Helen Wolstenholme, Communities and Health Manager, Tunbridge Wells Borough Council; and
- Jim Boot, Community Development Manager, Maidstone Borough Council

First, Helen Wolstenholme summarised her report, which provided greater detail on the health service reforms originally announced by the Government in July 2010, following publication of the 'Healthy Lives, Healthy People' white paper in December 2010. The Committee was advised that, with the proposed abolition of Primary Care Trusts (PCTs), the public health function would be shared between local authorities (at a county council level) and a new body, Public Health England (PHE), the latter taking on responsibility for national level interventions.

The officer added that this latest white paper explained how an 'Outcomes Framework' would be central to the delivery of the public health function of local authorities. Within the Framework, members noted, there would be five 'domains' (health protection and resilience; tackling the wider determinants of health; health improvement; prevention of ill health; and healthy life expectancy and preventable mortality). Each domain would contain a number of indicators, by which progress could be measured.

The Joint Sub Committee was also advised that a ring-fenced budget would be allocated to Kent County Council (KCC) for the delivery of services. In addition, a 'health premium' was proposed, which would be paid to local authorities retrospectively for progress against the indicators, which would be weighted to the level of inequalities and progress made.

All of the above was set out in an associated consultation paper entitled: “Transparency in Outcomes: proposals for a public health outcomes framework”. A second consultation paper, “The funding and commissioning routes for public health”, had also been published. The report circulated as part of the agenda summarised the key features of the proposals set out in the second consultation paper, as follows: (i) the Department of Health will set the NHS budget and the ‘public health’ budget which will go to Public Health England (PHE) who, in turn, will allocate a ring-fenced budget to local authorities (at county council level for Kent); (ii) PHE will manage commissioning for specific public health services via the NHS commissioning structure; (iii) the work that local authorities have and will continue to provide (e.g. health protection, leisure, housing, education and social care) will be separate from the ‘public health’ budget; (iv) a new ‘health premium’ will be available to local authorities (at county council level in Kent), based on progress made and inequalities faced; and (v) the establishment of health and wellbeing boards, that would offer a mechanism for bringing together discussion about investment in cross-cutting services such as social care; representation on the boards would include local authority councillors, the new ‘HealthWatch’ (currently, the Kent LINk role, looking after patient interests), and commissioners for health and social care, including GP consortia and directors of public health, adult social care and children’s services.

Members of the Joint Committee raised a number of key issues with the expert witnesses, as follows:

(a) *Funding for district council public health services:* Helen Wolstenholme advised that while West Kent was in a more favourable position than other parts of the County for instance, it should be remembered that not all health issues faced in the region related solely to deprivation and poverty. Meradin Peachey added that there would be a significant reliance on Kent district councils to help address the inequality issues the county faced. She advised that the £17m budget which KCC would have for this work would be the subject of detailed discussions with the districts. Jim Boot stressed the importance of existing district council knowledge and experience in achieving successful outcomes in addressing inequalities and poverty, sometimes within very small geographical areas where the greatest need had been identified.

(b) *Continuity of funding:* Members stressed the importance of being able to provide an assurance to voluntary or independent organisations over continued funding beyond a 1-year limit. Meradin Peachey advised that KCC’s approach would be to agree 2- or 3-year contracts, to provide the reassurance needed and assist with proper planning of services.

(c) *Behavioural change and the environment:* Meradin Peachey drew attention to the importance of bringing about successful behavioural change in encouraging healthier lifestyles. She advised that there were some fundamental environmental issues involved – in building design for

example – which could build on best practices elsewhere. Meradin stressed the importance of greater use of 'health impact assessments' at the planning stage of new development.

Members next considered the questions in the consultation papers listed above and, with the guidance of the expert witnesses, were able to identify what they considered to be the key issues – either supporting the detailed proposals or where significant concerns existed.

(NB – Meradin Peachey, Kent Director of Public Health, was present for the consideration of the consultation paper questions relating to Appendix A but not for those in Appendix B.)

Appended to these minutes is the Committee's recommended response to the issues raised in those consultation papers. The Chairman advised that these proposed responses would next be submitted to the portfolio-holder for health within each authority, for approval under their delegated powers, before submission to the Department of Health by the due deadline, i.e. 31 March 2011.

Resolved: That the responses attached as Appendices A and B, be submitted to the Department of Health.

7. Duration of the Meeting

2.30 p.m. to 5.05 p.m.

APPENDIX A

MAIDSTONE BOROUGH COUNCIL AND TUNBRIDGE WELLS BOROUGH COUNCIL – JOINT RESPONSE

The following is the response of Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee's response to the questions raised in the Department of Health's consultation paper entitled "Transparency in outcomes – proposals for a public health outcomes framework".

In formulating this response, the Joint Scrutiny Committee heard evidence from a range of witnesses, including local authority professional staff.

General Comments:

The Joint Committee was mostly supportive of the key proposals set out in the Outcomes Framework. Issues of concern at district council level are largely related to understanding the level of activity that will be devolved by the County Council. There is a strongly-held belief – backed up by evidence – that it is at district council level where most of the knowledge, experience and awareness of greatest need lies.

Two key points: (a) it would be unacceptable to waste the beneficial outcomes that district councils have achieved to date, should they fail to be given the opportunity to continue their targeted health improvement work; (b) West Kent might be seen as having a relatively healthy population, but significant inequalities still exist across this part of the County (e.g. a 7-year age gap in life expectancy) and require a continuation of this targeted – and demonstrably effective – work.

Alongside the key issue of district council involvement is one of the associated funding, to be able to commission and deliver the health improvement work. Finally, there is real concern about the transitional arrangements; this is hardly a new concept but it is vital it is planned thoroughly, in order to protect (above all) the most vulnerable people.

There will therefore need to be regular and detailed discussions held between Kent County Council and the district councils.

Question 1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

Key points:

(a) You cannot over-stress the importance of continuing 2-way communication;
(b) Many of the outcomes fall within the remit of district councils (e.g. housing, leisure etc) and many are cross-cutting, involving both counties and districts which, taken across the board, results in a good understanding of the outcomes and a healthy willingness to work together towards improvements; and
(c) Vitally, the need for a 'bottom up' approach from parishes and communities.

Question 2. Do you feel these are the right criteria to use in determining indicators for public health?

Generally, yes, with support for the principles behind the Marmot Report of a whole-life approach, but with a greater focus on early years' provision.

In addition, it was suggested that more qualitative measures would be helpful and that there should be flexibility so as not to be bound by national indicators alone. This would allow local areas to address their local issues, reflecting the localism agenda. In counties such as Kent, districts can have very different priorities and so the indicators should be flexible enough to reflect this.

Question 3. How can we ensure that the Outcomes Framework and the health
premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

There needs to be clarity as to which level the health premium and outcomes framework can be applied, for example will it be at upper tier level or can districts and parishes also seek health premium funding?

In addition, concern was voiced about the retrospective nature of the health premium, which might deter innovation and activity in a time when other resources are scarce.

Question 4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

Generally, yes.

Question 5. Do you agree with the overall framework and domains?

Again, generally yes.

Question 6. Have we missed out any indicators that you think we should include?

Possibly 'inequalities over access to health services', but generally not in favour of adding too many more indicators.

It was also felt that some indicators might be difficult to collate at a local level so it was important to choose those where one could differentiate amongst some very small geographical areas.

Question 7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

'Early years' are seen to be crucial and those indicators which relate to the first years, including the ante-natal period, of a child's life should be retained, including wider determinants such as housing.

Apart from that, the strongly-held view is that the choice of ranking indicators should be very much a local decision.

Question 8. Are there indicators here that you think we should not include?

General comment: it is better to use indicators that are strongly embedded, that have a proven track record in terms of showing trends.

The Joint Committee discussed that while some indicators could be seen to be unnecessary for the measurement of health such as 'life years lost from air pollution' indicator (under Domain 1), these should be kept due to the serious and long term health risks.

Question 9. How can we improve indicators we have proposed here?

In two ways:

(a) By ensuring the measures use established indicators therefore allowing comparison and the ability to assess change and improvement; and
(b) By ensuring they are accessible in a centrally-held place and available at the lowest spatial level possible.

Question 10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

Again, two key points:

(a) By concentrating on those behaviours which are the most disadvantageous to health (e.g. smoking, excess drinking, obesity etc); and

(b) Incentives should only be provided for outcomes, not processes, for example incentives for successful weight loss rather than for simple weighing or counting.

Question 11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

Key points here were:

(a) Hospitals also have a vital role to play in prevention/health improvement and this should also be linked with successful outcomes; and
(b) From local experience, there exists a need to better engage GPs in the referral of patients for initiatives such as 'good neighbour programmes', to ensure positive outcomes and a lower risk or re-admittance.

Question 12. How well do the indicators promote a life-course approach to public health?

(a) There might be scope for further development of 'key transition events' which people experience, e.g. starting school or beginning work or becoming a parent for the first time, where there might be greater willingness towards healthier behavioural changes;
(b) Is there scope for better-informed dietary habits to be formed through the school curriculum? (The old 'domestic science' approach, the principle of which had significant advantages, but within a modern context.); and
(c) Another key life-course period is at pre-natal stage, so that reducing teenage pregnancy rates and avoiding smoking during pregnancy are both major issues.

APPENDIX B

MAIDSTONE BOROUGH COUNCIL AND TUNBRIDGE WELLS BOROUGH COUNCIL – JOINT RESPONSE

The following is the response of Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee's response to the questions raised in the Department of Health's consultation paper entitled "The funding and commissioning routes for public health".

In formulating this response, the Joint Scrutiny Committee heard evidence from a range of witnesses, including local authority professional staff.

General Comments:

The Joint Committee was generally supportive of the key proposals on funding and commissioning routes, with some important observations: (a) the need to allow for local flexibility to the maximum; and (b) the importance of 'up-front' payments as much as possible, in order to provide for proper planning and reassurance for voluntary/independent service providers.

Question 1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

The view of the Joint Committee was that while this might be acceptable at a County Council level, there should be the flexibility to devolve responsibility to a district council level – or even to a smaller (parish or community) more local level. This would provide a better focus for examining local issues and would better fit with the Coalition's emphasis on localism.

Question 2. What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

The Joint Committee felt there were three important factors:

(a) The availability of any 'willing provider' and the use of local knowledge to encourage that;
(b) The assurance that needs to be given to voluntary/independent organisations of continued funding, beyond a 1-year limit; and
(c) The option to commission services at a local (i.e. district) level.

Question 3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Two key points:

(a) The need to ensure that a joint strategic needs assessment is built into the working arrangements; and
(b) Where possible, commission to accredited service providers or else to service providers who can demonstrate they are fulfilling NICE guidelines. The NHS might look to establish accreditation for service providers where a gap exists, e.g. with obesity

Question 4. Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

The Joint Committee – and the witnesses reporting to it – were unclear about the intention and purpose of this question and needed greater clarity over what was being asked.

Question 5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

There is a need to consider the impact of the proposals on other, related services. In other words, the proposals cannot be considered in isolation but account must be taken of the accumulative effect on services such as adult social care, housing, elderly people services etc.

Question 6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

There was a strong feeling that there should be flexibility applied, to allow local priorities to be agreed from the list. One size does not fit all and local knowledge and circumstances must be the determining factors.

Question 7. Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?
If not, what would work better?

Generally, yes, and there was support for the principle of other services (health visiting was one area) which might more naturally and effectively be undertaken by local authorities, to link with their new responsibilities.

Question 8. Which services should be mandatory for local authorities to provide or commission?

The Joint Committee agreed with the view expressed by Kent County Council, i.e. this should be determined locally, according to what is most suitable at a county level.

Question 9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

Three key points, which generally align with Kent County Council's position:

(a) The grant monies need to be paid in full at the start of the year, to ensure security of funding and a proper level of forward planning;
(b) The level of grant should be based on 2009/10 actual expenditure, as this reflected realistic service provision, before cuts were applied; and
(c) Shadow budgets should be issued as soon as possible, to allow for a realistic level of forward planning to take place.

Question 10. Which approaches to developing an allocation formula should we ask ACRA to consider?

The Joint Committee voiced support for the preference (and reasoning) expressed by Kent County Council for the 'population health measures' option. This was largely on the basis that the remaining options worked against local (i.e. Kent County) conditions.

Question 11. Which approach should we take to pace-of-change?

This was difficult to express a view on until key issues such as transitional funding and the full impact of changes were better understood.

Question 12. Who should be represented in the group developing the formula?

The Joint Committee was not able to assist with this and assumed that national experts on the health premium issue were advising.

Question 13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

Two key points:

(a) The need to know whether the health premium can be paid to levels below County Council; and
(b) The need for clarity over the timing of payments, i.e. a preference would be for half the premium to be paid in advance and the remainder retrospectively. This would have a significant impact on planning service provision and any other process would detract from voluntary/independent commitment.

Question 14. How should we design the health premium to ensure that it incentivises reductions in inequalities?

Key points:

(a) Some of the funding needs to be 'up-front', to provide the necessary incentives; and
(b) Clarity is needed in measuring achievements. For instance, take life expectancy: this requires much longer timescales to make a judgement and what geographical area will be used for a comparison to be drawn?

Question 15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

There was a strong feeling that no, this would not be the right approach. For instance, some areas face a significant challenge in bringing about health improvements, with external factors (e.g. large-scale unemployment through the loss of a major employer or if in a largely middle-class area where there is a higher level of positive response to health messages) skewing the outcomes. Such circumstances could lead to unfair treatment and penalty.

Question 16. What are the key issues the group developing the formula will need to consider?

Income
Social profile
What spatial levels will be used? (County? District? Parish/Community?)
Up-front funding
The importance of not overlooking the general benefit of public health improvement by over-concentrating on areas of deprivation and poverty.