



Plymouth LINK Support Team
Unit 15
HQ Building
237 Union Street
Plymouth
PL1 3HQ
Tel. 01752 202407
Email: info@plymouth-link.co.uk

23rd March 2011.

Plymouth LINK's response to proposals contained in the Consultation *Healthy Lives, Healthy People*: consultation on the funding and commissioning routes for public health

This response is based on feedback themes received by the Plymouth LINK and individual responses (the latter are shown in yellow boxes).

Question 1: *Is the health and wellbeing board the right place to bring together ringfenced public health and other budgets?*

Feedback to Plymouth LINK highlights the importance and need for improved partnership working and pathways through services (both health and adult social care). Discussions at health and wellbeing boards with partners across trusts and a strong patient voice will allow for valuable discussion of service and commissioning needs of a city/area. These discussions could ensure that priorities for budgets (both public health and other) take a wider perspective and help to ensure a patient's journey through the healthcare system is improved.

The paper talks of incentives for service providers, but what incentive is there for the current controllers of the other budgets referred to, to both relinquish that budget and the control and power that comes with being a budget holder?

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?*

In order to provide increased choice for patients, there needs to be commitment in widening the scope of services available. In order to extend the breadth of services to incorporate the third sector, there will need to be clear communication of opportunities, funding and support for organisations stepping into the market to ensure equality of opportunity. Local authorities need to work with their third sector to consider the existing preventative healthcare work and opportunities for the sector evolving. Recognition that the third sector offers often more cost effective and innovative practice could be considered in terms of partnership with healthcare providers, bringing the best of both together.

This goes to the core of the issue of ensuring quality standards are maintained and preventing an increase in the post code lottery problem. Whilst 'healthy' competition should be encouraged to ensure value for money and encourage innovative approaches, quality and standards must not be sacrificed at this altar.

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

If commissioning is to evidence that the appropriate public and patient involvement has occurred in the process, public health advice could be cited as an area of evidence for consideration, alongside

HealthWatch. A Place for public health on the Health & Wellbeing Boards will also add this element to decision making about services.

As well as the examples quoted there must be a role for organisations like Healthwatch to feed into the process local needs and concerns so that the appropriate balance between a uniform approach and a purely local approach can be achieved.

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?*

Plymouth LINK receives feedback that GPs are not always the most accessible and flexible services to access; therefore flexibility that allows health promotion services to be provided outside GP surgeries would be supported. In a recent Professional Executive Committee meeting of NHS Plymouth, the Plymouth LINK representative suggested that an alternative to podiatry services to meet the needs of older people in the city (who have raised with the LINK the issue of access to toenail cutting, etc.) could be training other agencies to perform this service. This has led to agreement to train Plymouth Age Concern staff to fulfil this need and is a perfect example of how flexibility in delivering services can better meet the needs of local people.

Again this issue seems to highlight the need for a two pronged strategy based on compliance with minimum standards of quality and local feedback on satisfaction with service provision, through Healthwatch.

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?*

In the list of public health funded activities there is reference to specific groups for whom activities are focussed (young people, those in prison).

Based on feedback to Plymouth LINK there are a couple of areas of focus which will have a negative impact from the policy. Plymouth LINK receives a lot of feedback about the barriers to health and social care for people from BME communities in the city. Issues of access to healthcare highlight inequalities that will impact on health. Local initiatives, for example to train health champions in different communities, have been shown to improve access and subsequent health of that community. Levels of feedback suggest that this area needs specific focus and activity alongside others listed.

Carers form another group that Plymouth receives much feedback about. We are aware that carers' health and access to healthcare is significantly impacted by their caring responsibilities, which again highlights the need for focused activity from public health.

An issue that must be faced up to is 'buy in by the public'. For example central government has for decades been advising on the harm from smoking, and has consistently levied increasing taxes on tobacco products. And yet no tobacco company has reported significant losses and the numbers smoking remains high. Similarly vast sums of money, have been spent on advertising the harm of other substance abuse, and each year at Christmas we have a drink driving campaign, and yet again many city centres are virtually no-go areas on Friday and Saturday nights due to drunken so called revellers, and A&E departments and the emergency services are often over-run with drink fuelled acts of vandalism and violence.

As such there must be a question as to the effectiveness of these campaigns and whether in these times of financial austeriv. monies could be better spent elsewhere.

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?*

Yes, these functions seem to fit sensibly in the public health arena.

Difficult to understand exactly what was being asked.

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?

A lot of the functions are to be commissioned via the local authority, which will be able to commission services flexibly to meet the needs of local people, rather than centrally.

Difficult to understand exactly what was being asked.

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

Any services which will need flexibility to respond to local needs. Local authorities will, however, need to work with GP commissioners, health providers, HealthWatch and others to ensure that commissioning works in partnership.

Again this goes straight to the heart of the post code lottery conundrum and thus the issue may need approaching from a different angle, with the mandatory aspect being much more generic thus still allowing local authorities room to manoeuvre and develop their own priorities.

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

In order to satisfy the need for best use of the grant and that spending is appropriate and relevant, there needs to be accountability. This could be to Health & Wellbeing Boards, where needs assessment (including those relating to public health) are developed. Patient and public transparency and involvement in monitoring use of the grant will add assurance to local people that there is some accountability (either via Health & Wellbeing Broads and HealthWatch involvement or another route).

When members of the public make a donation to Charity they like to know what percentage of that donation actually goes to the intended cause and what percentage is consumed in administration and other fees. Thus one essential condition could be to seek a guarantee on a set percentage of the grant actually being spent on the direct provision / commissioning of services.

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

Out of the three approaches, the "Population Health Measures" is the only one that takes health inequalities into account and therefore seem the most sensible option. This approach could take each authority's views on unmet needs into account to support the inequality data.

As with all change you can only start with what you know and gradually build to the ideal. Thus the approaches must initially be based on available data with a view to introducing new measures and data as they become available and reliable.

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

This may be clearer when the target versus actual allocation is known. In order to allow local authorities to plan and implement changes and absorb budget differences, a time allowance is needed so that people receiving services experience a smooth transition and have the opportunity to be consulted and influence the process. At Plymouth LINK we are aware of feelings of change being imposed without proper consultation and 'Pace-of-change' needs to learn from this and ensure it happens with appropriate public involvement.

One possible approach would be to set a percentage change year on year based over a 3 -5 year period dependent on the size of the gap that has to be bridged.

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

HealthWatch England should be part of the group – or a LINK representative of the HealthWatch Advisory Group if occurring prior to the development of HealthWatch England. This will reassure the public that there has been some 'patient' involvement in the decision making.

One obvious additional representative forum to those listed is Healthwatch, otherwise despite the pledges of openness and transparency it will be seen by many as a formula devised behind closed doors with no representation by or on behalf of service users.

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?*

With the feedback to Plymouth LINK highlighting basic quality standards of services, it is important that the responsibility of services to work to set standards and the basic elements of the Public Health Outcomes Framework are not applicable to the health premium.

We should not incentivise services for doing their job and it is all services' responsibility to improve health outcomes and work in a preventative way. The health premium could be applied to aspects of the framework that have been particularly problematic in the past (for a time-limited period, injecting new energy) or where there is achievement above and beyond targets (rewarding areas of practice for excellence, rather than quality, and inspiring excellence in other areas).

See earlier answer to question 5 concerning public buy-in

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

See answer to Question 13.

A starting point would be a universally accepted definition of health inequality. For example does the term simply cover the differences in service accessibility to our diverse communities or does it also include the differences in service accessibility covered by the phrase post code lottery?

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?*

Potentially as long as the growth is over and above the achievements "expected" as part of funding public health.

There is a well known phrase that what gets measured gets done, and what isn't measured gets ignored. However there is a need to take care that in developing outcome frameworks we do not create a monster in terms of the number of people and amount of time that is taken up in number crunching at the expense of actually positively affecting public health

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

Plymouth LINK is aware that there are some areas of work which have been more difficult to progress than others. The group also needs to take into account local differences in elements of the framework which haven't shown progress or have been less effective.

Given the wide definition of public health one issue that must be considered is the capability and resilience of other stake holders and agencies like the Police and Education Service to be part of all this especially when they already have their own targets and outcomes to measure and report on.

General Observation

There is an inherent, generic risk in responding to consultation documents that form part of series in isolation. This paper is a typical example. Whilst it is to be applauded for recognising that the 'one size fits all' approach is not best suited to health service provision, and acknowledges the need to reduce health inequalities, the repeated desire for localism will cause many to draw the conclusion that the paper actually will increase health inequalities, namely that the government supports and favours what has become called the 'post code lottery' means of health service provision.

It must be noted that paragraph 2.10 states "*The department of health expects that local authorities will want to contract for services with a wide range of providers...*" and paragraph 3.36 in dealing with the mandatory provision of a service, states "*The department of health would wish to make such a list of services as short as possible in order to give the maximum possible freedom*"

As well as seemingly emphasising the point about post code lottery, the paper when taken in isolation does not contain detail of the who or the how standards will be ensured. In short who will be responsible for ensuring that the standards offered by a potential myriad of providers meet basic quality standards. For example there has been much concern in the media over the provision of on-call doctors by using foreign doctors, where command of English and indeed actual registration may be way below the standard normally expected in this country. Thus some feedback could be excessively negative due to this position