



the care forum
voluntary sector service

Bristol Health and Social Care Network Meeting

3 February 2011

Attended:

Sue Bateman, Action for Blind People; Derek Dominey, Alzheimers Society - Bristol Branch, Ian Lawry, Wellspring Healthy Living Centre; Angelina Shoemare, St. Monica Trust; Sam Taylor, Brunelcare; Catherine Wevill, Bristol City Council – Health & Social Care; Jo Reed, Well Aware, The Care Forum; Michelle Mansfield, Brunelcare; Kate Stobie, St. Monica Trust; Hugh Annett, NHS Bristol & Bristol City Council; Beverley Craney, Swallow; Nicola Ferris, Bristol City Council; Zehra Haq, Dhek Bhal; Steve Heighan, Help Counselling; Mike Hatch, Princess Royal Trust – The Carers Centre; Tara Melton, RNIB; Victoria Morris, Knowle West Health Park; Christina Rees, Brunelcare; Paula Shears, Alzheimer's Society; Cllr. Jon Rogers, Bristol City Council; Mel Dunseith, Serenity House; Mark Hubbard, Voscur; Lorna Robertson, Alzheimer's Society – Bristol Branch; Michelle Santosuosso, Brunelcare; Gillian Seward, NHS Bristol/Bristol LINK; Maggie Telfer, Bristol Drugs Project.

Apologies: Sam Lane, Black Carers Project

Presentation:

Public Health White Paper- Healthy Lives, Healthy People and how this might affect people in Bristol - Hugh Annett, Joint Director of Public Health for Bristol City Council and NHS Bristol

http://www.thecareforum.org/publication_uploads/White%20Paper%20DPH%20%28Feb11%29.pdf

The Department of Health (DH) carried out an analysis on health needs. Bristol is a prosperous city, but there are families, individuals and communities that do not share in that prosperity. The rising cost of prescriptions around mental illness, for example, has had a negative impact. The intention of the white paper is to attempt to address the reduction in health inequalities. A few years ago, health inequalities was politically contentious, but progress has now been made. In future, directors of public health will be based in local government. The DH is dividing into the NHS Commissioning Board and the DH core is becoming Public Health England. There will be much negotiation around how protected the ring fenced money is when budgets are set. Evidence around public health needs to be developed. The Secretary of State is particularly concerned about health protection. For example, with pandemic flu, a coordinated on a national level and local interface between local government and NHS is critical.

Hugh Annett's time is split 50:50 between local government and NHS at the moment. There will be big changes for most of his staff and there is a lot of uncertainty about the future of jobs. By September, the public health function will be closely aligned/integrated with teams in the city council.

Q: The white paper mentions a Strategic Health and Well Being Board.

A: I'll mention that later. It came out in the NHS white paper.

Q: Green spaces are in danger and public transport is an issue. What control does public health have over this?

A: I hope that it has an influence already and I hope advantage can be taken of public health being at the city council.

Q: Is a health impact assessment being done on local government's plans for green spaces?

A: In Bristol, we are doing health impact assessments, but not on the full range of things that are happening. We are developing a process and seeking to identify the most critical ones on which to carry out a health impact assessment. We need to make sure this does not become a box ticking exercise, but involves local communities. I envisage that there will be a screening tool which identifies the most important and then we will work with local community groups on an interactive health impact assessment.

A: The healthy cities group has done three exercises with community groups in Knowle West, Lockleaze and Avonmouth.

What local government does has an effect on the health and wellbeing of all our communities. The Director of Public Health will have a duty to try and influence across local government and that is a good thing. With regard to the "responsibility deal", Hugh mentioned that he had written to all the Chief Executives of local supermarkets about their responsibilities over food.

Q: Is that being pursued at a national level?

A: Yes. Potentially there could be a huge impact. The Secretary of State chairs a group which brings together leaders of industry around food.

The JSNA will become the basis of a commissioning strategy of local government and GP consortia in relation to health and social care. The voluntary sector can influence the development of the JSNA.

Q: Will that include service user groups?

A: Yes. There has always been a patient voice and carer voice, but that will be stronger now. The Voluntary sector and carers will have a strong say in the overarching health and wellbeing strategy.

Two additional documents were published in December: Outcomes Framework for mental health; Commissioning and Finance for public health. The DH has developed three outcomes frameworks which are meant to be aligned and overlapping: NHS; social care; public health. If the city council is measured, it is more likely to do it, for example, active aging for older people. Eighty four percent of practices in Bristol are engaged in drug treatment. It is important not to lose at local level, the interface between primary care, social care and public health. The health and wellbeing board should be a way of ensuring links are maintained. Hugh's main concern is that a lot of public health spend will get skimmed off to fund Public Health England and he wants to make sure that the spend for public health in Bristol is not reduced to give to a centralised Public Health England.

Q: What proportion will go through the three streams to providers?

A: The majority will be through the Commissioning Board. The potentially biggest single change is what the government is saying about providers. There is an opportunity for services to be provided by Foundation Trusts, VCS (voluntary and community sector) and private providers. In ten years from now, services could be provided in more diverse ways.

Q: What is your view on payment by results? There is difficulty demonstrating outcomes in public health, as you mentioned.

A: There is quite a lot of experience of payment by results in terms of how hospitals will be funded. In principle it is a good concept, but thus far incentives have worked to the benefit of providers, rather than NHS as a whole. There are places in the country where the NHS is

bankrupt, but the providers have done well. It is all about negotiation and getting incentives and penalties right so the interests of the wider community are served and not just providers. It is about the scrutiny of it, too.

Q: Will the GP consortia be commissioning services previously funded by social care?

A: Not at the moment. In future, there will be two main commissioning bodies at a local level: GP commissioning consortia and the city council. There is a lot of emphasis in both white papers of taking advantage of commissioning health and social care in a more integrated way. There are good partnership arrangements in Bristol and encouragement to do it better.

Q: Where do you see VCS representation in the development of these things?

A: The main forum for influence is the health and well being board. Core membership does not specify VCS apart from HealthWatch. There are clear clauses indicating VCS can and should have a place around the table in the board. It would probably benefit from a clear VCS voice on it, but the VCS need to think about this. It can involve providers, but due attention needs to be paid to being even and fair to all providers. The VCS has an important role as a provider and it is my expectation that it will grow. It probably has a more important role as a voice for the community it represents. If the VCS had a separate place on the health and wellbeing board, it would be there with a voice for its stakeholders not as a provider.

Q: The white paper refers to the involvement of the local HealthWatch.

A: It will be a core member of the health and wellbeing board, but not there as a voice for the VCS.

Network members formed groups to discuss the consultation on the public health white paper. A response is going to be drafted based on the following flip chart comments.

Flipcharts

Role of GPs in public health

- GPs large budget but not direct responsibility for public health
- Local understanding – GPs one perspective on local need
- More people health inequalities less likely to go to GP
- Will GPs have time to be GPs
- GPs enhanced role in JSNA
- If GPs given more budget – need to be much stronger statutory requirements around or one practice will focus on one thing randomly and another GP board will choose mother service.
- Public health needs to be clear cause. Preserve the ring fence for public health.
- Need mapping exercise of what is going on in commissioning because GPs do not know about VCS services
- VCS needs to promote preventative work.
- Equal partnership

Public health evidence

- Nothing on eye health. Localities are a good way to collect evidence and link it up nationally.
- Need to make links with public health and eye health e.g. related to diabetes/smoking
- Why
- Credibility of non medically funded research to determine public health needs.
- Need a “library” of what research has been done rather than do work again.
- NEF been evaluating public health interventions – no universal system for evaluating public health systems – need tool to evaluate quality. Concern that anything preventative is too short term for funders.

- Good more important about JSNAs but quality of them differs.
- Monthly reports still finance based rather than outcomes.
- Marmot/JSNA evidence there
- Local research
- Thinking about how to gather evidence, for example, via case studies
- Trying to get people to be more responsible is going to widen the gap
- Got to keep funding services despite Big Society
- Health economics needs to be looked at. Invest now to save later. UWE/Bristol Uni
- Credibility of non medical organisations doing research
- Disseminate information that exists – how disseminate information?
- Feels like career development for small group of people
- Not effective means of spending money
- Not happy about “voluntary”. Needs to be “statutory”. Should be existing register/body to save money such social care council. Why should it slip through the net.

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- Don't want all influence to be national because that will be to the detriment of local VCS
 - Welfare reforms contradict health and wellbeing works. Needs to be looked at in the round.
 - Campaign for survival of local VCS in Bristol. It is big but fragmented. Don't let national organisations take work.
 - Quality assessment framework must be completed because must not be all about saving money/buying services on cheap and meeting needs of individual.
 - Skimmed off money to PHE. Concern may become medicalised because of GPs background should be encouraged to review non-medicalised interventions e.g. mental health
 - GP consortia should be made to find what is really happening 'on the ground'. Voluntary sector/patients need opportunities to promote issues to GPs
 - Dementia Champions – include some GPs now QUOF payments
 - Vol sector funding – an opportunity to raise profile
 - 3 parts of consortia have boards that public and VCS may be able to sit on
 - (b) Central point for evidence great, but characteristics of community important. Must be good assessment in range of areas – rural, urban etc
 - Influencing social background e.g. crucial point where most people don't smoke. Can people influence his with provision of information e.g. dementia services information flow influence patients boards. Information key. VCS need to develop better systems for collecting outcomes. How we commission/work collectively. Make sure VCS work is outcome focussed.
 - Impact of public health can take 20/30 years to evidence.
 - VCS organisations often contribute to same outcome – need to work together.
 - Need to get messages from VCS clearly to PHE.
 - Need facilitation to support VCS to work towards commissioning aims. E.g. nutrition and hydration – needs improving. E.g. LINKs, Age UK, Alzheimers Society working together. How trusts can positively respond to these interesting challenges to decommission services to free up money for public health
 - Economic argument – public health
 - SW Forum research on economic savings and R Institute
 - Resources issue of VCS addressing gaps – need to come together e.g. YP sessions at GPS young people did not go. Would have made sense for youth organisation.
 - VCS know clients/needs of people supported
 - Way services commissioned restricts access. E.g. sexual health outreach and for example, rearranging meeting for people with dementia partnership working with whole society.

- Example of good partnership working – national dementia strategy, good leadership

Local authorities

- JSNA – comprehensive. LINK and Alzheimers have had input
- VCS to keep up to date and input
- Different strategies need to be tied together, e.g. obesity
- Design/plan so that people can do an activity – not just bike racks
- Subgroup from the health and wellbeing partnership board to look at outcomes, e.g. obesity and blindness – links often not seen. People get defensive. Positive way of getting messages across
- Outcomes focused results (as above)
- Regulation – too much? Need targeted regulation. How to become director of public health?

Role of GPs in public health

- NHS commissioning board/PHE needs knowledge of all national strategies and how they are being delivered. What are implications about regional changes?
- Interrelationship between national and local critical
- Continuing to deliver national strategies
- Embed national strategy targets within public health outcome framework
- Don't lose the knowledge/information we already have

Public Health Evidence

- Opportunities to develop availability/access and use of public health intelligence. Simplification not over complication.
- What can VCS contribute? Local and very local information. JSNA and smaller picture.
- What constitutes evidence?
 - measures within outcomes framework. Critical within this. Communication critical.
 - lack of broad understanding of vast range of interventions/services provided by the VCS.
 - outcomes are more difficult to evidence: cost of demonstrating this.
 - feedback on quality of services within JSNA: how use feedback
 - JSNA evidence and measures critical within this: relationship between national/local measures and targets. Role of neighbourhood forums/pact in relation to public health?
 - using effectively commissioning information/measures gathered through VCS to local authority
- Demographic information: understanding local population/facilities/mapping local services and gaps.

Public Health Evidence: how address gaps?

- Simplicity of use: use of maps
- Breadth of information we consider and inter-relationship of that is critical: eg public toilets and older people maintaining their independence/activity.
- Use local network information.
- Role of VCS on health and wellbeing partnership board
- Overlaps? Duplication? Need to ensure have clear understanding of who doing what? Also based on detailed needs analysis
- VCS needs more information about how things are going to be commissioned. Also an understanding of overall impact of e.g. funding cuts from variety of sources.

Regulation of public health professionals

- Role of joint health scrutiny
- Quality of commissioning practice? In relation to commissioning (broader than public health)

Evaluation:

What was the most significant outcome of the event for you?

- Hearing the positive take Hugh has on the changes
- Outcome frameworks, engaging business in Bristol
- Good overview of current situation. Good to understand issues from other groups' point of view
- Better understanding of the public sector moving forward
- Workshop discussions were fruitful
- A bit more understanding about public health white paper and issues surrounding
- Gaining a better understanding of how things will be structured and most importantly feeding in points that need to be understood and addressed in order to make the models useful and accountable
- Being able to listen and share of information and concerns being raised in workshop
- Good explanation of content of white paper
- Greater understanding of the white paper

Do you have any suggestions regarding topics/speakers for future meetings?

- Coordinating the provision of services by separate VCS organisation - particularly in mental health
- How the small/local VCS providers might prepare to be providers of the newly commissioned services - capacity building maybe around key themes e.g. health and social care, environment, homelessness, resettlement, arts etc etc. This is wider than just the changes to public health but changes to commissioning across the board.
- How does the VCS develop to fight off the threat of all work going to the private sector and work collaboratively to bid and deliver?
- How to access the GP consortia in a way that will ensure different voluntary organisations and others can demonstrate what is going on out there and what they provide.
- More meetings to discuss the new way things are moving - changes to public health and GPs and Budget Holding Consortium
- How it is all going to work once GP consortia are established. Budget and roles of GPs, NHS, public health, BCC etc

Are there any other comments you would like to make?

- More meetings to understand the changes.
- Useful session

Content	Average mark (out of 5)
Understanding of subject at start	2.4
Understanding of subject at end	3.7
Sessions	
Speakers	4.3
Other elements	4.0
Organisation	
Pre-event information	4.0
Facilitation	4.2
Organisation on day	4.2
Venue	

Access	4.7
Refreshments	4.5
Standard of room	4.7