



Association of North East Councils Improving Health Task & Finish Group Report

Health Improvement
Expertise
Engage
Efficiency
People
Needs
Leadership Value
Challenges
Equality
Wellbeing
Commissioning
Transition Partnership
Best practice
Opportunities

Association of North East Councils

Improving Health Task & Finish Group Report

Introduction

1. Task & Finish Groups (T&FGs) have proved to be an important way of working for the Association. They are a means of engaging the experience and expertise of elected members across the area, helping to shape thinking and unite behind actions and activity in support of local government's role. They allow members to undertake a rapid, time-limited, in-depth and non-bureaucratic examination of some of the key issues facing councils.
2. Task & Finish Groups focus on outcomes in terms of clear recommendations for action. Typically, outcomes can include:
 - identifying scope for working across local government and with partners;
 - identifying, disseminating and building on best practice;
 - getting key stakeholders to contribute to the debate and bring an external perspective to bear on the issue;
 - developing advocacy positions;
 - recommendations targeted at local authorities, partner organisations and government; and
 - adding value and making a difference – whether in terms of reducing costs, creating efficiencies, achieving cultural change etc.
3. Each Task & Finish Group report is presented to Leaders and Elected Mayors for approval and then widely disseminated.
4. Early in 2011, Association members considered proposals to set up Task & Finish Groups in a number of areas, one of which was around the wider impacts of health in the North East – having regard to the fact that the Government was embarking on a programme of reform to the National Health Service, as summarised below. This Group – the Improving Health Task & Finish Group – was consequently established. Its remit has been to consider the NHS reforms and other relevant evidence, and to make recommendations – to the 12 member authorities, Government, NHS bodies and other partners – as to how they can take advantage of the opportunities presented by the NHS reforms to improve health outcomes for the people and communities of the North East.

5. This report explains how the Task & Finish Group approached its role, and goes on to set out the Group's findings and recommendations.

Background - the NHS reforms

6. Reforming the NHS has been a significant – and sometimes controversial – element of the coalition Government's legislative programme. The Government's proposals are set out in a number of documents including:
 - two White Papers: '*Equity and Excellence: Liberating the NHS*' (July 2010) and '*Healthy Lives, Healthy People: our strategy for public health in England*' (November 2010);
 - a number of consultation papers on specific aspects of the above;
 - the Health and Social Care Bill, introduced into Parliament in January 2011; and
 - the Government's response to the report of the NHS Future Forum (June 2011) – the Forum had been established during a 'pause' in the passage of the Bill to carry out consultations on a number of expressed concerns.
7. The Government's proposals, as they now stand following the response to the NHS Future Forum, can be summarised as follows:
 - the Secretary of State will as now be accountable for the NHS, though rather than secure services directly, he will exercise his responsibility through his relationship with the bodies, such as the NHS Commissioning Board, to be established through the Bill;
 - Primary Care Trusts and Strategic Health Authorities will be abolished;
 - clinical commissioning groups (CCGs) will take responsibility for the bulk of NHS commissioning. They will be led by GPs but their membership will ensure involvement of patients, carers, the public and a wide range of health professionals. They will be under a duty to promote integrated services and will be required to operate in an open and accountable manner;

- local authority led Health and Wellbeing Boards (HWBs) will be responsible for promoting joint commissioning and integrated provision between health, public health and social care. They will lead the development of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. They will also be involved as CCGs develop their commissioning plans and there will be an expectation, set out in statutory guidance, for the plans to be in line with the Health and Wellbeing Strategy;
- membership of HWBs will bring together locally elected councillors with the key commissioners in the area, including representatives of CCGs, directors of public health, children's services and adult social services and a representative of local HealthWatch. It will be for local authorities to determine the number of councillors on the HWB, and they will be free to insist on having a majority of elected councillors;
- the existing statutory powers of local authority scrutiny will continue to apply, and local authorities will still be able to challenge any proposals for the substantial reconfiguration of services;
- on the provider side, all acute trusts will become Foundation Trusts with greater freedoms, but will face competition from 'any qualified provider'. However, competition will be on the basis of quality not price, with safeguards against price competition and 'cherry-picking'. The core duty of the regulator, Monitor, will be to protect and promote patients' interests; and
- local authorities will take responsibility, alongside Public Health England, for improving the nation's health. They will be allocated a ring-fenced public health budget, with a 'health premium' for those authorities that achieve specified health outcomes.

8. The Task & Finish Group noted that there are still many 'unknowns', some of them significant. Government has still to publish its proposals on such key issues as the public health outcomes framework and funding regime; these are expected during the autumn, and will be a critical factor in determining whether local authorities are actually in a position to fulfil their ambitions.

Government will also be issuing guidance, such as the statutory guidance on Joint Strategic Needs Assessments, which we have yet to see. There are also uncertainties about the roles of national bodies including the NHS Commissioning Board, Public Health England and Monitor and how they will impact on local authorities. In short, we are still in a period of transition. However, with local authorities already advanced in their preparations – in setting up their HWBs for example – we feel that it is essential to disseminate our recommendations as soon as possible, while there is an opportunity to influence new structures and working arrangements.

The Context for the North East

9. Health is a critically important agenda for the North East. Whilst great progress has been made on a number of issues, health inequalities still exist both between the North East and other regions, and between different parts of the North East. These inequalities manifest themselves in terms of:

- the determinants of health, including housing, employment, education, the environment, alcohol, smoking, diet;
- inequalities in access to some services; and
- inequalities in outcomes such as life expectancy.

10. To give just a few examples:

- the North East has the worst levels of deprivation and the lowest life expectancy in England;
- it has the highest rate of early deaths from cancer; and
- the North East's rates of smoking in pregnancy and breast feeding initiation are the worst in England.

11. However, much good work has been done:

- in recent years, life expectancy has been rising faster in the North East than in any region except London;
- cardiovascular disease has been falling more quickly than the national average; and
- smoking prevalence has fallen dramatically since 2005.

12. There are also significant inequalities within the region – for example there are considerable differences between Northumberland and Middlesbrough in terms of male life expectancy, cardio-vascular heart disease and stroke, and cancer. But there is still much more to do, and a number of people who gave evidence to us pointed out that preventative spend has not been as significant as claimed.
13. The issue of health inequalities is not of course a new one. Professor Michael Marmot's significant report '*Fair Society, Healthy Lives*', published in February 2010, pointed out that the people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life. Marmot argued that health inequalities result from social inequalities, and that action on health inequalities requires action across all the social determinants of health. Delivering this would require action by central and local government, the NHS, the third and private sectors and community groups.
14. The case for change is clear but in an environment of resource reduction and tightening budgets, how might this happen? Will there be pressure on social care or other budgets, for example, to fill gaps? In an age of austerity, will this be possible, even if it is desirable? We return to this point later in our report.
15. The North East has long recognised the necessity of tackling these inequalities often through a collective effort between partners – in the health service, local government, the third sector and elsewhere. In 2008 regional partners agreed an ambitious strategy for health and wellbeing that aimed to make the health of the North East the best of any region in the country over the next 25 years. The Strategy – entitled *Better Health, Fairer Health* – was based on a number of principles including:
- improve health for all, achieve equal health where possible and ensure fairness always;
 - add value to local and national action;
 - move the North East further and faster in improving health; and
 - address fundamental causes of health and wellbeing and their absence.
16. The strategy identified ten key themes for action:
- economy, culture and environment;
 - mental health, happiness and wellbeing;
 - tobacco;
 - obesity, diet and physical activity;
 - alcohol;
 - prevention, fair and early treatment;
 - early life;
 - mature and working life;
 - later life; and
 - a good death.
- Each of themes was taken forward by a inter-agency regional advisory group (RAG).
17. Particular mention should be made here of the approach that has been taken to tobacco and alcohol. The Fresh programme was established in 2005 as the UK's first dedicated office and programme for tobacco control. Its approach is one of *de-normalisation* – shifting the social norms around tobacco so that it becomes less desirable, less acceptable and less accessible. Outcomes to date in the North East include the furthest and fastest decline of smoking rates of any region in the country, from 29% in 2005 to 22% in 2009. Fresh is currently funded by the 12 Primary Care Trusts in the North East until March 2012, with a budget of £713,000 for 2011/12.
18. Balance, the North East Alcohol office, was set up in January 2009 to deliver a similar de-normalisation approach, calling for changes in the way alcohol is priced, promoted and sold and thus helping individuals to reduce their consumption. Like Fresh, it is funded by the 12 PCTs until March 2012, with a budget of £680,000 for 2011/12.
19. The future of the Regional Advisory Groups (which for tobacco and alcohol are linked to but separate from FRESH and BALANCE) is now under consideration, given the imminent removal of the regional tier in health service management (SHA, PHNE), which co-ordinated and provided support for this activity. There needs to be open and constructive dialogue with those who will be key players in the future; local authorities, Directors of Public Health, Clinical Senates/clinical networks, Public Health England and others, on agreeing a way forward – which we pick up later in the document.

Our approach

20. The membership of the Task & Finish Group included representation from all 12 local authorities in the North East, on a cross-party basis (a list of members is at Appendix A). We met three times. We worked closely with our health partners and throughout our deliberations we had the advice and support of Ian Parker, Chief Executive of Middlesbrough Council and Chris Willis, Transition Programme Director, NHS North East. At the second of our three meetings we had a panel discussion with senior NHS representatives from a variety of NHS organisations including commissioners and providers (also listed in Appendix A) which enabled us to explore the key issues in depth. At our third meeting we had a presentation from Kevin Rowan and Tom Ross of the Northern TUC on the Healthy Workplaces Project; more is said about this in paragraph 34. We are grateful to all those who contributed for making their time available. We were supported by ANEC staff Melanie Laws, Andy Robinson and Jonathan Rew.

21. Throughout our deliberations, members expressed a strong view that they wished to focus on how local authorities could use the opportunities presented by the NHS reforms to bring about improvements in health outcomes for the people and communities of the North East. These opportunities include:

- the lead role that local authorities will play in setting up and running Health and Wellbeing Boards;
- the strong role that HWBs will have in joining up health, public health and social care, as well as wider local authority services that impact on health, through the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy;
- the involvement of HWBs as clinical commissioning groups develop their commissioning strategies; and
- the return of public health functions to local government (alongside Public Health England) with a ring-fenced budget, and the location of Directors of Public Health with local authorities. (A list of the specific public health responsibilities assigned to local authorities is set out at Appendix B).

22. In considering how best to take advantage of these opportunities, the Group identified four key questions which it felt needed to be addressed. These questions are:

- i) what are the key public health challenges for the North East, and how do we address them?
- ii) how do we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?
- iii) are there any 'must dos' (or must don'ts) that apply to every authority? and
- iv) what are the opportunities for political leadership in improving health – for example, allocating resources, shaping the agenda, scrutiny?

23. Our conclusions on each of these questions are set out below.

Question 1: What are the key public health challenges for the North East and how do we address them?

24. We support the view that *Better Health, Fairer Health* remains valid in terms of its evidence base and its analysis of the public health challenges facing the North East. While the political landscape and the financial situation have changed since it was produced, our ambition to tackle the issues it identifies should not, and it would be useful for the 12 authorities to make a collective declaration of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being. We would see this declaration not as 'top down' but as something developed by the 12 authorities as a high-level statement of our collective vision to achieve the best and fairest health and wellbeing, while recognising that each authority has a different health profile and priorities.

25. However, it is one thing to identify the issues, another thing to prioritise them, especially in a period of financial constraint and when the future public health budget is far from clear. Some things are more complicated to deal with (eg: mental health). Equally, each local authority will have its own local priorities and will need to work out for itself both how it allocates its ring-fenced public health budget and to what extent it is able to bring

its mainstream budget to bear – although the strategic role of Health and Wellbeing Boards should ensure that their work is based on evidence and oversight of budgets to avoid budgets being used inappropriately to plug holes when funding should come from other sources.

26. Local authorities and health partners will also need to consider, in the light of all factors including finance, how the ambitions set out in *Better Health, Fairer Health* should be taken forward, by whom and at what spatial level. Though the final decision must rest with each local authority or principal partner, some collective discussion from a local authority perspective through ANEC would be very helpful. The role of Public Health England, clinical senates and networks in this respect is as yet unclear and needs also to be better understood before final decisions are made. Scarcity of resources (human and financial) will be a factor, and economies of scale will need to be taken into account.

27. We suggest that ANEC should consider holding a Health and Wellbeing summit to take forward key health issues and get councils, and elected members, thinking about them. It should also be considered whether there would be merit in having a permanent member group to take forward the health agenda. The Task & Finish Group approach has been valuable and effective in ensuring that attention is given at an early stage to health transition issues; to ensure that the health agenda retains a high priority into the future, there is a case for setting up a working group consisting of health lead members (possibly the Chairs of HWBs) from each of the 12 authorities. If such a group is set up it could prepare the declaration of intent referred to in paragraph 24.

28. We noted the achievements of Fresh and Balance in relation to tobacco and alcohol use and the cost-effectiveness of their approach which focuses on those areas which are best done once rather than 12 times. We also note that the current funding regime through the 12 Primary Care Trusts expires in March 2012. We would wish to see the current approach maintained, at least for the time being, so that when the responsibilities pass to local authorities, we have a 'steady state' position from which we can move forward and determine a way forward for the future.

29. On a separate but related point, it is sometimes suggested that some of the public health challenges facing the North East, for example those relating to alcohol, are a product of North East 'culture'. Without wishing to get into a philosophical debate about this, we would urge that to the extent that such a culture exists, it needs to be challenged; it must not be used as an excuse for doing nothing.

30. We therefore recommend:

- that local authorities recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions;
- that ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively;
- that consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda;
- that a declaration of intent is developed and agreed by the 12 authorities, to seek to ensure that the population of the North East will have the best and fairest health and well being;
- that there is further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts');
- that as part of this discussion, we would seek the retention by PCTs of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (so for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward); and
- where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.

31. One issue that was put to us strongly is the balance between acute services and public health – the importance of tackling the sources of ill health rather than spending money on treating illness. This is an issue that particularly affects the North East where the figures show that hospital use is the highest in the country. However, if we are going to reduce demand for services in hospitals, effective services in the community will be needed and this might also impact on hospital configuration in due course. The implications of this would need to be worked through in a collaborative way. It was reported to us that GPs are keen to do more in this respect but conflicts of interest arise in their role as provider as well as commissioner which have yet to be resolved. GPs need to ensure that they are working very closely with their council(s) when considering their role in the commissioning and provision of community services. Equally, all partners need to think carefully about their commissioning roles and ensure a joined up approach is taken – otherwise this could lead to destabilisation in the supplier/provider market which, apart from anything else, could lead to significant difficulties.
32. We note that management of long-term conditions has an important role to play in reducing pressures on the public health budget; this includes helping patients to manage their own conditions.
33. Local authorities will also need to think carefully about how they will use their wider responsibilities – such as employment, education, children’s services, environment, housing and transport – to improve the health and wellbeing of their communities and achieve change at the local level. There is a great opportunity here for addressing the wider, social determinants of health but it will not happen automatically; local authorities will need to embed public health across all their services (see also the discussion on the role of Health and Wellbeing Boards).
34. Another role of local authorities that should not be overlooked is as the employer of a substantial workforce. In this context, we were greatly impressed by a presentation from Kevin Rowan and Tom Moss of the Northern TUC on the TUC’s Healthy Workplaces project. The aim of the project is to improve public health by promoting wellbeing and health activities through workplaces; over 200 North East employers, and 250,000 employees, have been involved so far, mostly in the private sector. There have been some remarkable results, not least in reaching members of the workforce who do not normally engage with health services, enabling potentially threatening conditions to be picked up before they become serious. We would encourage member authorities, and their partner organisations, to consider adopting similar workplace health initiatives. They should also consider how their workforce, through their regular contacts with a wide range of individuals, can act as a resource to promote and improve the health of the community.
35. We considered the relationship of the HWB, as a committee of the council, to other partnerships and structures. We noted that the changes, particularly the creation of HWBs, present the opportunity for councils to review and refresh their approach to partnerships, including the LSP, should they wish to take it. The role of the HWB in relation to the Local Strategic Partnership will be important, as will the relationship to Children’s Trusts. On the latter point, we consider that children’s health is a vital issue. We noted that currently, most local authorities are retaining their Children’s Trusts at least until their HWB is properly established. There is an opportunity here to eliminate duplication of roles within the local authority.

36. We recommend that local authorities:

- **work with health partners to examine the balance of resources between acute services, community services and public health;**
- **ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships; and**
- **use their role as major employers to improve to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.**

37. In addition, there are some critical areas where decisions and action by Government will impact on local authorities' ambitions for improving health outcomes. The first of these is finance: we do not yet know how the ring-fenced public health budget will be allocated between Public Health England and local government, and between individual local authorities (although we note that local authorities are being involved in the preparation of 'shadow' public health allocations for 2012/13, a helpful development). Further, while the principle of bringing other local authority services to bear on health is one that we support, this should not mean using mainstream budgets to remedy under-funding of the public health budget. Secondly, it is clear that national bodies including the NHS Commissioning Board, Public Health England and Monitor (and their outposts) will be major players; it is essential that they do not impose 'top down' approaches that hamper local authorities' ability to achieve their goals. Health and Wellbeing Boards will also need to develop working relationships with the new national bodies.

38. We recommend that these concerns are raised with the Government.

Question 2: How can we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?

39. We consider it is essential that each HWB thinks carefully about its purpose. The HWB should avoid becoming part of some bureaucratic process, a 'hoop' that has to be gone through; it needs to play a positive and proactive role, to make things happen, working with partners to shape and redesign services to meet the needs of its locality. It should ensure that it tackles the big issues that have real impact – it should not try to do everything itself.

40. It would be helpful if each HWB was at an early stage to set out its:

- values: what are the shared values that all members of the HWB bring to the table? (In this context it should be noted that the diagnostic tool for the establishment of clinical commissioning groups published by the Department of Health on 4 August makes reference to establishing values and behaviours as a key component of a CCG; read-across and consistency between the CCG's values and those of a HWB will be important);
- goals: What is our vision and what are our key objectives and goals? How do we tackle long-standing issues that have proved hard to address? and
- tasks: What do we need to do to achieve our objectives and who will do this?

41. These issues will be at the heart of a Health and Wellbeing strategy. They will also require strong political leadership (see below).

42. Crucially, the HWB should be a focus for **joining up commissioning and service provision** both within the local authority and with other partners and players who have an impact on health. The scope for exploring and developing integrated commissioning is something which could have potential too.

43. Following the report of the NHS Future Forum, it is clear that HWBs will be expected to be involved throughout the process as clinical commissioning groups (CCGs) develop their commissioning plans, and statutory guidance will set out the expectation that commissioning plans will be in line with the Health and Wellbeing Strategy. **We urge HWBs and CCGs to make the most of this opportunity – the process should ideally be one of co-production and not of checking, after the event, that the clinical commissioning plan is aligned with the HWB strategy.**
44. The Health and Wellbeing Board should have a key role in public and patient involvement: it should be the focus for engagement with the patient and community voice, involving them in the process of identifying local needs and developing the Health and Wellbeing Strategy. CCGs will clearly have an important role in understanding and addressing the health needs of their local population, but HWBs have the advantage of being able to take into account all factors influencing the health and wellbeing of people, and should look to address these through a cohesive approach. As part of this, the contribution that local councillors can make to this process as representatives of their local community will be critical, given the breadth of the role of a local councillor – we noted that councillors are often the only people who can see the whole system from top to bottom.
45. Further, the HWB will need to think through how it will engage with the voluntary and community sector (VCS). The VCS has a number of vital roles to play: in informing need through the Joint Strategic Needs Assessment, in developing the Health and Wellbeing Strategy and in delivery of a range of services. The VCS does of course comprise a very wide range of organisations and the HWB will need to give careful thought to how its voice can be heard and its contribution taken fully into account.
46. The role of scrutiny will also be important and, amongst other things, it will enable HWBs and their health partners to receive third party observations and advice on their important work.
47. One specific issue that each authority will want to address is how to ensure that the perspectives of provider organisations (both inside and outside the NHS) are available to its HWB as it shapes the health and wellbeing strategy. Authorities are approaching this in different ways, with some including provider representation in the membership of their HWB, others not. It is clearly a matter for each authority to decide its own approach – **the essential thing is that there is some mechanism for taking the provider perspective into account – including those providers who cross boundaries (this latter point could benefit from further consideration in the context of how HWBs work together in future).** Where there are any conflict of interest issues, these will need to be addressed through transparent governance mechanisms. Local authorities have scope to both commission and provide in almost every area of their activity and therefore this is nothing new. The key is that HWBs need to be a focus for joining up.
48. Given the commonality of health issues facing the North East, we feel that it is important that the 12 Health and Wellbeing Boards do not operate in isolation from each other; it is vital to share information, learning and good practice. It will also be important to consider how we use scarce resource (both money and people), looking at opportunities to share where it makes sense to do so. At the same time, we must avoid a bureaucratic structure of joint meetings simply for the sake of it. We suggest that ANEC should give further consideration as to how the 12 HWBs can work together most effectively and how it might help in this process.
49. Another issue that HWBs will need to consider is how they are going to work with those providers who operate on a wider base than a single local authority? Should they each have an individual relationship with the provider body in question, or should this be through some collective mechanism?

50. Those who submitted evidence to us noted that political leadership provided through ANEC is probably the only opportunity left to ensure that the area as a whole is able to take a strategic approach where required (and where economies of scale are helpful at that spatial level); for example, on issues such as aspects of health promotion and marketing, and other work. We pointed out that ANEC is a body of, and owned by, the local authorities. ANEC's political advocacy work is considered to be very valuable.

51. We recommend that:

- **each HWB should take some time to consider its approach - how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact;**
- **HWBs should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans;**
- **HWBs should ensure that they develop working relationships with national bodies including NHS Commissioning Board, Public Health England and their outposts, and with provider bodies that operate on a wider base than a single local authority;**
- **HWBs should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy;**
- **each HWB should consider how it will engage with voluntary and community sector across the various roles that the VCS plays;**
- **as part of this, HWBs should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established;**
- **each local authority should ensure that the provider perspective is available to its HWB; and**
- **ANEC should be asked to further consider how the 12 HWBs can work together most effectively and its role in this agenda, going forward.**

Question 3: Are there any 'must dos' (or must don'ts) that apply to every authority?

52. In the previous sections we have set out a number of issues which we believe authorities should be addressing. It is worth re-emphasising here some key principles:

- local authorities should take a 'whole systems' approach to health, ensuring that the widest possible range of local authority functions contribute to improving health functions (this is the rationale for returning public health to local authority control);
- it is vital for local authorities and clinical commissioning groups in particular to develop strong, constructive relationships;
- local authorities should play a key role in facilitating relationships between NHS Trusts and CCGs;
- HWBs, CCGs and other partners should consider data and intelligence requirements and aim if possible to create a 'hub' or single point for partners to utilise so all are working to the same evidence base (where appropriate making use of existing resources, such as the North East Public Health Observatory);
- while recognising that health services and issues inevitably have a strong political dimension, authorities should as far as possible avoid allowing issues about structure to dominate their focus;
- acknowledging the important role of HealthWatch as a forum for local people to express their views on health issues, it is essential to engage local councillors, as the democratically elected representatives of local people, in identifying local health needs and drawing up strategies to meet them. Local councillors are ideally placed in this respect as they represent their communities on the breadth of issues which make up the determinants of health (see question 4);
- member development and capacity building will need to be an important priority – it will be essential to invest in developing members' capacity to deal with health issues; and
- local authorities should review where the HWB sits in relation to the Executive/Cabinet, with the aim of ensuring that it does not operate in isolation but is seen as fully part of the corporate decision-making processes of the authority.

Question 4: What are the opportunities for political leadership in improving health?

53. Local government is an equal partner in addressing health inequalities. Democratic accountability and political leadership are critical elements of the health reforms. We would see the role of political leadership as encompassing:
- providing leadership and vision;
 - advocacy and challenge;
 - working together, facilitating, developing relationships – including with CCGs – and between CCGs, Foundation Trusts and other partners;
 - ensuring that structural inequalities are addressed;
 - bringing the authority's mainstream services to bear on health;
 - ensuring community engagement;
 - ensuring that key issues are embedded into strategies, not just the health and wellbeing strategy but other relevant local authority strategies – and are followed up; and
 - ensuring cross-boundary working where appropriate.
54. Under the Health and Social Care Bill as it currently stands, it is formally the responsibility of the Leader or Elected Mayor to nominate the local authority member(s) of the Health and Wellbeing Board. In addition, or instead, he/she may choose to be a member of the HWB. It goes without saying that this is an opportunity to secure appropriate high-level political representation on the HWB – if not by the Leader/Elected Mayor then through the Health and other portfolio holders (adults, children's services).
55. In any event the Leader/Elected Mayor will want to ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships – including the Local Strategic Partnership, if the local authority chooses to continue with it.
56. Local authorities will also want to consider the whole Council role in the health agenda. All areas of the council have a contribution to make. Again, the Leader/Elected Mayor will want to ensure that this consideration takes place.

Conclusions

57. We repeat our belief that health is a critically important agenda for the North East, and that the NHS reforms present local authorities with real opportunities to bring about improvements in health outcomes for the people and communities of the North East, provided the right conditions are in place: finance, resources and freedom from central control. Our role has been to consider how to make this happen. We feel that the important thing is to start by trying to understand where we want to be and to work back from there, looking at how we might achieve our goals and objectives. We have tried not to focus on structures for their own sake but to think about how the new structures – Health and Wellbeing Boards in particular – can work effectively, building strong partnerships, working at the appropriate spatial level and focusing on the key public health issues.

Appendix A

Membership of the Task & Finish Group

Members:

Councillor Nick Forbes (Chair)	Newcastle City Council
Councillor Florence Anderson	Sunderland City Council
Mayor Linda Arkley	North Tyneside Council
Councillor Jim Beall	Stockton on Tees Borough Council
Councillor Barry Coppinger	Middlesbrough Council
Councillor Kevin Dodds	Gateshead Council
Councillor Mary Foy	Gateshead Council
Councillor Pamela Hargreaves	Hartlepool Council
Councillor Eunice Huntington	Durham County Council
Councillor Liz Langfield	Newcastle City Council
Councillor Tristan Learoyd	Redcar & Cleveland Borough Council
Councillor Ian Lindley	Northumberland County Council
Councillor John McCabe	South Tyneside Council
Councillor Charles Rooney	Middlesbrough Council
Councillor Andrew Scott	Darlington Borough Council
Councillor Mel Speding	Sunderland City Council

Advisors:

Ian Parker	Chief Executive, Middlesbrough Council
Chris Willis	Regional Director – White Paper Transition, NHS North East
Melanie Laws	Chief Executive, Association of North East Councils
Andy Robinson	Head of Local Government Policy, Association of North East Councils
Jonathan Rew	Specialist Support Officer, Association of North East Councils

Participants in panel discussion:

Wendy Balmain	Deputy Regional Director Social Care and Partnerships, Public Health North East
Richard Barker	Director of Commissioning Development, NHS North East
Ken Bremner	Chief Executive, City Hospitals Sunderland NHS Foundation
Paul Hanson	Strategic Director of Community Services, North Tyneside Council
Professor Peter Kelly	Acting Regional Director of Public Health
Guy Pilkington	Chair, Newcastle Bridges Consortium (Pathfinder)
Colin Shevills	Director, Balance North East

Appendix B

Proposed public health responsibilities of local authorities

Subject to further engagement, the new responsibilities of local authorities will include local activity on:

- tobacco control;
- alcohol and drug misuse services;
- obesity and community nutrition initiatives;
- increasing levels of physical activity in the local population;
- assessment and lifestyle interventions as part of the NHS Health Check Programme;
- public mental health services;
- dental public health services;
- accidental injury prevention;
- population level interventions to reduce and prevent birth defects;
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions;
- local initiatives on workplace health;
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes;
- comprehensive sexual health services;
- local initiatives to reduce excess deaths as a result of seasonal mortality;
- having a role in dealing with health protection incidents and emergencies, alongside Government departments and NHS bodies;
- promotion of community safety, violence prevention and response; and
- local initiatives to tackle social exclusion.

Appendix C

Summary of recommendations

Key public health challenges

1. Local authorities should recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions.
2. ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively.
3. Consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda.
4. A declaration should be developed and agreed by the 12 authorities of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being.
5. There should be further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts').
6. As part of this discussion, we would seek the retention by Primary Care Trusts of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (and for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward).
7. Where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.
8. Local authorities should work with health partners to bring about a shift in the balance of resources between acute services, community services and public health.
9. Local authorities should ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships.
10. Local authorities should use their role as major employers to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.
11. Government's attention should be drawn to concerns about (a) the allocation of the ring-fenced public health budget between Public Health England and local government, and between individual local authorities, and (b) the need to avoid 'top down' approaches by national bodies including the NHS Commissioning Board, Public Health England and Monitor.

Making the new structures work effectively

12. Each Health and Wellbeing Board should take some time to consider its approach – to think about how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact, and to set out, at an early stage, its values, goals and tasks.
13. Health and Wellbeing Boards should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans.
14. Health and Wellbeing Boards should ensure that they develop working relationships with national bodies including the NHS Commissioning Board, Public Health England and their outposts, and wider base than a single local authority.

15. Health and Wellbeing Boards should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy.
16. As part of this, Health and Wellbeing Boards should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established.
17. Each Health and Wellbeing Board should consider how it will engage with the voluntary and community sector across the various roles that the VCS plays.
18. Member development and capacity building will be an important priority.
19. Each local authority should ensure that the provider perspective is available to its HWB.
20. ANEC should be asked to further consider how the 12 Health and Wellbeing Boards can work together most effectively and its role in this agenda, going forward.

‘Must dos’ (and must don’ts)

21. In addition to the other recommendations in this report, local authorities should keep in mind:
 - the need to take a ‘whole systems’ approach to health, ensuring that the widest possible range of local authority functions contribute to improving health outcomes;
 - the need to develop strong, constructive relationships with clinical commissioning groups in particular;
 - their key role in facilitating relationships between NHS Trusts and CCGs;
 - the need to consider, with partners, their data and intelligence requirements, with the aim of creating, if possible, a ‘hub’ or common evidence base for all partners to use, making use of existing resources where appropriate;

- the need to avoid allowing issues about structure to dominate their focus; and
- the importance of engaging local councillors in identifying local health needs and drawing up strategies to meet them.

Opportunities for political leadership

22. Local authority political leaders should recognise their key role in ensuring that their authority maximises the opportunities to improve health outcomes, through exercising the political leadership roles identified in paragraph 53.
23. In particular the Leader/Elected Mayor should ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships.
24. The Leader/Elected Mayor should also ensure that the authority considers the arrangements by which all areas of the Council can contribute to the health agenda.

Association of North East Councils

Guildhall
Quayside
Newcastle upon Tyne
NE1 3AF

Tel: 0845 076 0080

Fax: 0191 232 4558

Email: enquire@northeastcouncils.gov.uk

www.northeastcouncils.gov.uk

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