

White Paper response – 4th October 2010

Background

Health Action Local Engagement – HALE is a nationally recognized charity (overall winner of the King's Fund / GlaxoSmithKline Impact Award 2010) for having a significant positive health impact on people living in areas of high health inequality. HALE has excellent partnerships and is funded by Bradford and Airedale NHS, Bradford and Airedale GP Alliance, Bradford Adult Services and the local area committee.

HALE was also recently successful in gaining a Social Enterprise Initiative Award, which has been used to enhance our use of financial enterprise to shape how people understand the value of our work.

We demonstrate an innovative and high impact approach, being able to measure outcomes of improved health and wellbeing in our area. The Project Manager is also chair of the local Health and Wellbeing Forum for voluntary groups, ensuring that there is potential for groups to feed into strategic decisions affecting health in the district. Members' views have been sought for this response to this paper.

Putting Patients and the Public First

A truly public-led NHS means that choice is exercised not just by 'patients' at the point of need, but by 'people' at the point of commissioning. The public needs to be able to influence the choice of services available – otherwise they are passive consumers of, rather than active participants in, the health system.

It is extremely difficult to achieve genuine involvement from a diverse cross-section of society. This does not mean we should not try to. The voluntary and community sector is absolutely crucial to ensuring that the voices we don't usually hear are represented in the healthcare planning process. VCS groups should be heavily involved in Healthwatch, in Health and Wellbeing Boards, and in the commissioning cycle. They should be required to demonstrate their user involvement and democratic credentials if they are to do this, and they should be compensated for the staff time involved.

Genuine choice relies on patients having the right information, in the right format, at the right time, and it involves them having the confidence and skills to understand this information and make decisions. For many patients, especially from vulnerable groups, this will require mediation, and the VCS has an important role to play here. VCS groups can understand and engage with people at the community level in a way that the state is not able to. They should be encouraged and supported to bid for this advocacy/support role, and the plurality of the sector should be seen as an advantage rather than a disincentive to contract: a one-size-fits-all approach will not work.

It is critical, therefore, that there is 'real' power given to Healthwatch, and that they are not seen as a tokenistic ticking box, but something that enables people to respond to identified health needs.

Improving Healthcare Outcomes

An outcomes focus is essential, but we must be careful to ensure that public health and wellbeing work is not undervalued by a focus on hard indicators. Attitudinal and behavioural changes towards a healthier lifestyle will save the NHS millions of pounds. Supporting isolated people to become more involved in their community and developing self-sustaining social groups will protect millions from mental ill-health. Promoting better sexual health choices and educating parents about their child's oral health will reduce the strain on our health services. Constraining our understanding of the value of these activities to what can be counted or directly attributed to services provided will threaten a holistic, preventative approach to health.

We also would like to caution on unrealistic outcomes that might not actually change the actual problem. For instance, the outcome set to reducing waiting times in A&E departments resulted in people accessing a triage nurse within the target time, but then being sent to wait in another waiting room for just as long as previously. The outcome was met in that the initial waiting time was reduced, but the solution has not been found for the patient or for reducing costs. The only solution found was for staff, in being able to meet an unrealistic outcome.

Autonomy, Accountability and Democratic Legitimacy

The NHS needs a strong, diverse, sustainable VCS to be able to deliver effective health services across the population. The VCS must be supported to adapt to new commissioning arrangements (and budget cuts), otherwise it will not be there when the NHS needs it.

A great deal of thought needs to be given to how to avoid a Starbucks model of healthcare. GP consortia will understandably want to minimise the administrative burden of commissioning, and will probably prefer universal contracts rather than a range of localized contracts. But the VCS is so good at working with local communities because of the small size and localised nature of VCS organizations. A **one-size-fits-all approach** does not work in a system which is meant to be designed around individuals, or communities. Recent research in Bradford has demonstrated that organisations that have the most impact in improving health are those who work at the local level.

In the field of community health improvement, scaling up is probably not the answer. 'What works' is very often contextual and there is no such thing as best practice, only good practice that may work somewhere else.

Encouraging VCS groups to form alliances, consortia or even to merge may be one solution, but it will be extremely challenging. While many charities work towards similar aims, their methods, culture and values are often different, and expecting charities to work easily in partnership, within a short time frame, is unrealistic. It will require an effective programme of support and investment.

If public health is to shift in its entirety to Local Authorities, Local Authorities will need staff who have the capacity to manage this function and who care about public health. Health and Wellbeing Boards will need to have decision-making powers to effectively coordinate strategies, rather than adding a layer of bureaucracy. GP consortia need a statutory duty to consider the health needs of non-patients, not just the medical needs of patients. A main concern is the consistent use of the word 'patient' in the

document, which suggests that the White paper is wholly using a medical model rather than integrating it with a social one. This would, in our view, be a significant step backwards, as considerable work has gone in towards bringing the two together, but very little work has been done with GPs to ensure that they understand this work.

Cutting Bureaucracy and Improving Efficiency

Cutting bureaucracy is essential when it acts as a barrier that prevents people's health and wellbeing from being seen to properly and there is no doubt that there are significant cuts that can aid this. However, preserving the health of the UK population is an exceptionally complex area and systems and procedures have to be maintained if the service is to stay fair and equitable. The VCS has a vital role to play in ensuring that people do not become patients, or that long term conditions are managed and supported. The VCS is able to adapt and can be responsive to identified need, but understanding this and the impact it can have is essential; it takes time, firstly for organizations to be able to prove and demonstrate their efficiencies, and secondly for relationships and trust to be established.

Cutting bureaucracy would be welcome, but this should not be a smokescreen for cutting important areas that enable the NHS system to function, including support for the VCS.

Additional concerns that have been raised by voluntary groups attending the Health and Wellbeing Forum:

1. Understanding of how GP's will gauge the social determinants of health in a community / individual .
2. The emphasis place on patients. This misses the numerous communities and individuals who are not patients and the role of health prevention.
3. No mention of the role or contribution of VCS in either services or outcomes .
4. A need for clarity around access issues in relation to many community groups – language, cultural, skill levels etc. These do not appear to be accounted for.
5. Role of LINKs in the change over – how will this happen?
6. How will the GP consortia, Health and Wellbeing Boards, Healthwatch be managed to ensure that they will operate cross community/cross area working?
7. The prevention message has been lost – it is a purely reactive message i.e. waiting for people to become patients.
8. Maintaining a dichotomy of health if not enhancing it – preventative / social determinant and clinical.
9. GP Consortia may be operated by large providers – businesses who can offer GP 'easy options' but will not have the skills and local knowledge, and therefore the efficiencies that the VCS can offer
10. GP Consortia will become the PCT in another guise, with local commissioners just changing venue!

11. GP's do not use the VCS now. How will this be addressed and changed?
12. There is concern around regulating providers and the impact that this will have on the VCS, as they may not have the infrastructure to manage some of this.
13. Voluntary sector – Big Society fears – the VCS need paid staff and volunteers need oversight of paid staff.
14. Inequalities – is this the real issue – equity and fairness in provision?
15. How can we ensure that the VCS have a voice at the table and are treated as partners?