Health and Wellbeing Boards

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‘The poor have remained beloved by the Gods being

afforded excellent opportunities for dying young’

Generations later R.H.Tawney’s quote retains a resonance today despite the huge improvements in the public’s health and in healthcare. The improvements disproportionately benefit the more advantaged. To narrow the health inequalities gap as part of a broad based approach to sustainable development has to be the priority of a public health focus. Can the proposed Health and Wellbeing Boards deliver on this when so many public health policies of the past have not?

Summary

The overarching priority for health and wellbeing is to enhance social capital, community solidarity and sustainable development for individuals and communities.

Will the Health and Wellbeing Board be another ‘talking shop’ or a significant force for the public’s health and wellbeing? If the latter it will need to be a visible accountable leader and position itself as a strategic commissioner albeit without statutory authority nor budget. That lack of statute could be its weakness and yet its strength being unencumbered by the forces that induce statutory organisations to be so transactional in approach. The Health and Wellbeing Board is not an actual organisation so to deliver on such an ambitious approach it will need to be a commissioner that leads, facilitates, supports and where necessary follows. A model approach for statutory commissioners also but so often unrealised. Consequently a first task for The Board must be to choose their positional leaders who truly possess the attributes to be effective leaders.

There are already complainants saying how can we deliver on public health given the identified budget is too small? A compartmentalised mind-set that fails to recognise the assets that abound in the community - statutory, formal and informal. The initial priority for all with formal public health responsibilities whether statutory or not is to engage in Asset Based Community Development. A joint health and wellbeing needs assessment and strategy must incorporate local community engagement and involvement but ideally needs to go much further by adopting clear community organising principles

There are many areas of public concern that impinge on the public’s health. Most of these priority problems are predominately affected by social class but within that overall frame specific issues and opportunities manifest. The Health and Wellbeing Board must set a small number of its own achievable priorities but also be facilitating, enabling and supporting other organisations and/or individuals who wish to engage and lead on other areas of public concern. Their topics will not necessarily be the overarching priorities for the board itself but nevertheless they should be enabling people or organisations with a particular passion and skill in community involvement to flourish. A commissioner who nurtures, enables and supports to enhance social capital and not simply administers or interprets their role in too reductionist a manner. And to succeed where so many public health policies have underachieved, the Health and Wellbeing Board as for statutory commissioners must be rigorously held to account by their communities.

As a starting point for action and where a population and individual care both clearly conflate and as a national priority is in better support and care for those with long term conditions. Conditions that have a major impact on health inequalities. To achieve a more holistic approach to prevention (and indeed early diagnosis) involvement of local authorities, community based organisations and local leaders is essential

Main paper.

Health and Wellbeing Boards promulgated in the Governments reforming of the NHS White Paper have become the most accepted and arguably the most popular element of the proposals[1]. Further details about the Board were furnished in a more recent development of NHS reform policy [2].

'*We proposed to create statutory health and wellbeing boards in every upper tier local authority to improve health and care services, and the health and wellbeing of local people. Health and wellbeing boards will bring together locally elected councillors with the key commissioners in an area, including representatives of clinical commissioning groups, directors of public health, children's services and adult social services, and a representative of local HealthWatch. Health and wellbeing boards will assess local needs (through the joint strategic needs assessment) and develop a shared strategy (in the form of a new joint health and wellbeing strategy) to address them, providing a strategic framework for commissioners' plans.*

The Future Forum's report supports the idea of health and wellbeing boards, but recommends that we strengthen them, so they are truly the "focal point for decision-making about local health and wellbeing", enabling local authorities to work in partnership with clinical commissioning groups and other community partners to deliver meaningful joint health and wellbeing strategies and maximise opportunities for integrating health and social care. In response to the Forum's recommendations, we will make a number of changes designed to strengthen the role of health and wellbeing boards and increase public and patient involvement.

The boards will provide the vehicle for local government to work in partnership with commissioning groups to develop robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health. The creation of health and wellbeing boards will maximise opportunities for integrating health and social care, and for the NHS and local government to drive improvements in the health and wellbeing of their local population.

Health and wellbeing boards are not just about assessments and strategies. Health and wellbeing boards will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care.'

Will the Health and Wellbeing Board be another 'talking shop' or a significant force for the public's health and wellbeing? If the latter it will need to be a visible accountable leader and position itself as a commissioner albeit with neither statutory authority nor budget. That lack of statute could be its weakness and yet its strength being unencumbered by the forces that induce statutory organisations to be so transactional in approach. The Health and Wellbeing Board is not an organisation in itself so to deliver on such an ambitious approach it will need to be a commissioner that leads, facilitates, supports and where necessary follows. A model approach for statutory commissioners also but so

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[1] Equity and Excellence. Liberating the NHS. DH 2010

[2] Government response to the NHS Future Forum report. ISBN: 9780101811323 Printed in the UK for The Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office. June 011.

often unrealised. Consequently a first task for the Board must be to choose their positional leaders who truly possess the attributes to be effective leaders.

The Health and Wellbeing Board s will and in particular for the NHS, need a co-operative approach with the providers of care through a strategic partnership built on good relationships. The board not being a statutory commissioner nor a provider will only deliver by ensuring its formal leaders-political or professional- have indeed leadership qualities to engender engagement and partnerships for progress and change. Not least to influence and if necessary challenge the statutory commissioners of the NHS and local government. Thus a first task for the Health and Wellbeing Board must be to choose their positional leaders who possess the technical skills and competencies but also the appropriate behavioural attributes. Identifying the latter attributes not necessarily an intrinsic part of current selection processes. Furthermore a selection approach that would also benefit statutory organisations if their quest is transformational.

The overarching focus to achieve health and wellbeing is for sustainable development. To reduce carbon emissions is hugely important but the guiding principles of sustainable development are much broader; Living within environmental limits; Ensuring a strong, healthy and just society; Achieving a sustainable economy; Promoting good governance; Using sound science responsibly[3].

How could the Health and Wellbeing Board undertake its responsibilities?

'The Big Society'

Political mantras and slogans are much derided by those whom it seems would rather pontificate and commentate. Yet they offer an opportunity to utilise such policy statements and consequent energy for needed action. The current prime minister has set much store in his vision of the 'Big Society' and as so often happens, the concept is presented as radical and new. In fact it follows on from a long history of similar concepts; developing social capital, community solidarity and sustainable development.

If the Health and Wellbeing Board perceives its role narrowly it will set in traditional mode an administrative agenda with two or three key priorities. If it hopefully perceives a wide role, it will need to position itself as an enabling non statutory commissioner. Setting a small number of its own priorities of course but also facilitating, enabling and supporting other organisations and/or individuals who wish to engage and lead on other areas of public concern. Their topics will not necessarily be the overarching priorities for the Board itself but nevertheless they should enable people or organisations with a particular passion and skills in community involvement to flourish. A commissioner who nurtures, enables and supports to enhance social capital and not simply administers or interprets their role in too reductionist a manner. A management mantra I have learnt over many years is 'do not demotivate the motivated'.

Resources.

I already hear many complainants saying how can we deliver on public health given the identified budget is too small. A compartmentalised mind-set that fails to recognise the assets that abound in the community. There are other formal organisations which contribute and indeed some will have the attributes to lead locally or beyond on improving the public's health-for instance schools, the church, population based general practice and voluntary and other third sector organisations. Indeed hospitals and other organisations could also have a community leadership function which would be enhanced if they take on a population responsibility. An inspirational book on such more lateral thinking is by Chief Rabbi Jonathan Sacks 'The Politics of Hope' in which understandably he focuses mainly on the potential of formal faith organisations. And there are also numerous individuals working effectively in the community. All are a significant part of a bigger society.

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[3] *Presidency conclusions of the European Council on Guiding Principles for Sustainable Development (16.-17.06.2005*)

The number one priority for all with formal health and wellbeing responsibilities whether statutory or not is to engage in Asset Based Community Development. This is a methodology that seeks to uncover and utilize the strengths within communities as a means for sustainable development. The first step in the process of community development is to assess the resources of a community through a capacity inventory. This is achieved by involving the residents to determine what types of skills and experience are available. The next step is to support communities to discover what they care enough about to act. The final step is to determine how citizens can act together to achieve those goals.

A joint health and wellbeing needs assessment and strategy must incorporate local community engagement and involvement but ideally needs to go much further by adopting clear community organising principles [4].

NHS Delivery.

The NHS was most commendably set up to be underpinned by the concept of social justice. Its underperformance however underserves those it was most set up to help and enable. The relatively poor clinical outcomes though improving, disproportionately affects the socially disadvantaged. The frail elderly frequently get a bad service whether it was specifically at Mid Staffordshire hospital trust or generally as identified by the Ombudsman and more recently the Care Quality Commission. Social justice has to be about delivery not rhetoric. To ensure an NHS ‘health of the public’ role is a necessary challenge for the Health and Wellbeing Board. The Board as a strategic leader visible to, for and of their communities and where necessary the ‘conscience’ of the public health system.

There are many facets of improving the public’s heath that the NHS will continue to lead. As a for instance vaccination and immunisation, cervical cytology screening services and improving the health of those who have a long term condition. Services in which population list based general medical practice providers have already achieved much. NHS Commissioners have a system wide role in enabling and ensuring all their providers deliver to both a defined population and individual patients. The responsibility for a population is essential to having an important role in improving the public’s health whilst recognising that a population is made up of individuals and their needs. Population responsibility is often interpreted in an utilitarian collectivist manner rather than a way of enabling individuals within that population to fulfil their health potential. If the NHS commissioner appears to lack a population ambition and direction for its providers, the health and wellbeing board could be a source of inspiration and support. Where population and individual care clearly conflate and as a priority is in better support and care for those with long term conditions. Conditions that have a major impact on health inequalities.

‘Personal health services have a relatively greater impact on severity (including death) than on incidence. As inequities in severity of health problems (including disability, death, and co-morbidity) are even greater than are inequities in incidence of health problems, appropriate health services have a major role to play in reducing inequities in health’ [5]

‘Put succinctly, societies with a sharper distinction between material ‘haves’ and ‘have nots’ have, regardless of average wealth levels, higher rates of harm resulting from broadly defined metabolic syndrome related disorders than more equitable communities. This might be because of as yet not adequately understood physiological factors linking social and economic inequalities to psychological (di)stress and/or an experienced lack of social support. Such findings have global implications regarding the illness prevention and treatment provision. They support the view that in rich and poor

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[4] Ganz, Marshall. "Leading Change: Leadership, Organization, and Social Movements." Handbook of Leadership Theory and Practice. Ed. Nitin Nohria and Rakesh Khurana. Harvard Business School Press, 2010, 509-550)

[5] B.Starfield. Journal of Health Politics, Policy and Law, Vol. 31, No. 1, February 2006)

countries alike the optimal management of metabolic syndrome related disorders is likely to demand political actions and social changes that go beyond those aimed at facilitating the more effective use of medicines and behavioural change programmes aimed just at individuals'[6].

The Institute for Public Policy Research report[7] explores British attitudes to public services. It argues that the better-off receive superior health and education services to the poor and that although the choice agenda has helped improve services for those at the 'bottom', further personalisation of services is needed. The report confirms that the more affluent and better educated a person is, the greater the health benefits they gain from the NHS. It reports that higher socio-economic groups access health care more frequently as elective, planned admissions, while lower socio-economic groups typically enter as emergencies. The report also shows that, across a disparate and wide range of conditions, lower socio-economic groups tend to present to clinicians at more advanced and severe stages of illness.

And to support better long term conditions care; (the following quote from an article was written for an USA journal. Hence the use of the phrase chronic disease which rather than England's 'long term conditions' terminology is still the internationally used description);

'Various policies have been developed since the 1990s to address the needs of people with chronic diseases. These policies include a stronger focus on the prevention of illness, measures to strengthen primary care, and initiatives designed to support people with chronic diseases in managing their own conditions. The NHS Improvement Plan, published in 2004, was important in bringing together these and other initiatives and in signalling the government's commitment to giving explicit priority to chronic care as a policy in its own right. In identifying chronic care as a priority, the government was reflecting international recognition of the need to reorient health systems in response to the changing burden of disease, as well as specific weaknesses in the performance of the NHS in this area.

The chronic care policy promulgated in 2004[8] identified the need for action at three levels: self-management interventions for people able to manage their own conditions; disease management by primary care teams for people with conditions that could be controlled through regular contact with a family physician, nurse, or other team member; and case management for patients whose complex needs meant that they needed more intensive support than that available through self-management and disease management. The NHS and Social Care Long Term Conditions Model was developed to describe the various elements in government policy. The model drew explicitly on the Chronic Care Model developed by Ed Wagner and colleagues. The inclusion of social care in the model was intended to signify that people with chronic conditions required a range of support services that extended beyond the limits of the NHS'.

And in a more prescient quote than I hoped it to be;

'Looking back on the period since the NHS Improvement Plan was introduced, the national director for primary care judges that implementation of the chronic care policy has not been as rapid or as far-reaching as he would have hoped for, although four years may be too short a time in which to offer a considered judgment.'[9]

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In summary, nowhere is the coming together of individual and population needs more important than for serving those patients and individuals with long term conditions. The NHS and social care long term conditions model provides an useful and evidence based framework. Delivery will depend on the NHS providing optimal health care but many facets of the strategy are also for the wider public health eco system and its system wide accountability. NHS commissioners as must all statutory bodies need to exhibit a leadership beyond their own remits and specific responsibilities. The leadership for

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6 Marmot,M., Friel, S., Bell, R., Houweling, T. and Taylor, S. (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Lancet, 372, 1661–1669.).

7 Public Services at the Crossroads 2007. Richard Brooks. IPPR

8 Raising the profile of Long Term Conditions: A Compendium of Information. Department of Health. 2004

9 [Health Affairs 28,no. 1 (2009): 190–201; 10.1377/hlthaff.28.1.190. Prof Chris Ham].

sustainable development could become the hallmark of Health and Wellbeing Boards. But fine words and rhetoric are easy, it is by their actions the board should be judged by their communities and an holistic approach addressing all aspects of long term conditions must be a priority. A suggested programme will entail;

Prevention;

To achieve a more holistic approach involvement of local authorities, community based organisations and local leaders is essential. Success is important as for instance over half of all cancers could be prevented by changes to lifestyle. [10] and up to 80% of type 2 Diabetes (90% of all Diabetes) could be delayed or prevented. [11]

Multi-agency commitment as in the Department of Health sponsored Change 4 Life programme, community oriented primary care [12] and support for the various initiatives that comprise the Healthy Child Programme[13] are all necessary pre requisites of a prevention programme. Evidenced based approaches to improve the health and wellbeing of children from poor socio economic communities would incorporate Sure Start and Family Nurse Partnership programmes- already many in existence. **My fear is such programmes would be easy prey to arbitrary cuts instead of a focus on the 'cutting' of interventions including clinical interventions which are of proven low value.**

There is an international evidence base to confirm the multi agency approach [14]. However the basic underpinning of a prevention strategy to re-emphasise, must involve local community engagement and involvement but needs to go much further by adopting as described clear community organising principles

Early Diagnosis:

A failure to achieve being one of the most important reasons that we as a country lag behind other equivalent health care systems in clinical outcomes. Late diagnosis is an important and some would argue *the* deleterious influence on outcomes for Cancer in particular, but also for instance Diabetes, Hypertension and Schizophrenia. As with prevention an integral component is an holistic community approach to ensure community awareness of important symptoms. For the NHS clinician awareness of 'red flag' symptoms and for the health care system a better uptake of evidence based screening services.

Treatment and review of care in primary and secondary services;

An interesting potential role for a Health and Wellbeing Board as it must resist the temptation to usurp the statutory commissioner in operational issues and yet maintain a generic strategic leadership role. It will all be about relationships given the NHS Commissioner will be a member of the board.

A role for NHS commissioners and providers alike is the need to question and where the evidence takes us, to challenge the very nature of current clinical practice so as to increase effectiveness, value and challenge unwarranted variation. And concomitantly the public health responsibility to lessen the potential harm to patients from unnecessary and inappropriate interventions. There are abundant clinical evidence bases available to aid this process and describe an optimal care approach. As one manager pointedly told me 'it does not need a clinician to be able to read an evidence base'.

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[10] Cancer Reform Strategy Department of Health 2007

[11] WHO Diabetes Programme Fact sheet N°312. January 2011

[12] Community-oriented primary care: the legacy of Sidney Kark. American Journal of Public Health. 83(7):946-7, 1993 Jul. Gillanders WR)

[13] Healthy Child Programme. Department of Health 2009

[14] North Karelia Project in Finland. Puska P, Tuomilehto J, Nissinen A, Vartiainen E.The North Karelia Project: 20-year results and experiences. National Public Health Institute.Helsinki, 1995 and the SunSmart skin cancer programme in Australia. Health Promot J Austr. 2008 Aug;19(2):86-90..Jones SB, Beckmann K, Rayner J)

The aim and the supporting evidence is to deliver more care in the community with an emphasis on providing significant tranches of the care currently delivered in hospital. Thus enhancing local social capital. This will require effective commissioning of all community based services. Primary Care Trusts generally were/are poor commissioners of community health services hence the Transforming Community Services programme of the NHS Next Stage Review 2008 Primary and Community Strategy. Now and sadly typical in our NHS, Transforming Community Services has become overly focused on structure rather than the intended quality focus of the strategy. Furthermore Practice Based Commissioning a policy since 2004 and attempted to be 're-invigorated' in the Primary and Community Strategy would have engaged General Practitioners in contributing to providing and commissioning system based health care. It never flourished due mainly to a combination of a lack of central (Department of Health and Strategic Health Authority) attention and to quote Norman Warner (former Labour minister) 'I underestimated the capacity of Primary Care Trusts self interest.' [15]

Commissioning for Targets; How to holistically deliver targets whether set nationally or locally has not been an NHS success. Not least as there is a paucity of meaningful locally set targets/indicators. The previous national four hour 'trolley wait' emergency care target provides a salutary lesson. A target generally achieved but since the current Secretary of State has abolished non clinical targets a deterioration in access (as with the 18 weeks elective care target). A deterioration that will disproportionately affect the disadvantaged. It is worth emphasising that when Secretary of State was the opposition spokesman on Health he was encouraged by clinicians and managers alike to remove targets.

A frequent 'breacher' of the four hour wait target (some 40%) were elderly often frail patients. Achieving the target focused particularly on Accident & Emergency services when the system response should have also included a high quality community based long term conditions programme with a particular focus on the elderly frail involving the NHS, social care and often the third sector. A necessary prerequisite for better care is for the whole local system to be held to account through locally engendered performance indicators. Local and often specifically for individual patients/clients is where indicators for complex care are most appropriately set.

Self Care;

A further and central aspect of the long term conditions policy that needs to be delivered on is a support for self-care. A key aspect is for people with long term conditions to feel they have the power, influence and internal locus of control to feel confident to self care. People with long term conditions are an under-utilised resource as experts in their own selves as individuals and how their condition affects them and their lives. This is not just about a change in service provision, but about a cultural change, allowing patients to be partners in their care, letting them decide what support they need, when they need it and how. The NHS will need to think differently to be able to be responsive to those needs, respecting and valuing the contribution people can make to improve health'. [16] Programmes such as the 'Expert Patient Programme' not only aid the individual with one or several long term conditions by aiding their skills, confidence and locus of control but concomitantly add to social capital. Again a leadership role for Health and Wellbeing Boards to influence healthcare culture and community confidence. Patient determined outcomes has to be *the* key outcome.

Social Care;

Social services are an essential part of a long term conditions programme and unlike the NHS will be subject to absolute budgetary reductions. Some 70% of expenditure of both the NHS and social services are for long term condition care so there are major opportunities to avoid duplication and to identify synergies. The NHS given its relatively more secure future funding will need to cross fund social care where the evidence shows such investment will support more 'care closer to home'. The

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[15] A Suitable Case for Treatment, by Lord [Norman] Warner, is published by Grosvenor House 2011

[16] Supporting people with long term conditions to self care. Department of Health. 2006

bringing together of the NHS, local authorities with other stakeholders on the Health and Wellbeing Board will hopefully and necessarily realise those synergies

Summary of Commissioning for Long Term Conditions;

It is clear that the major short term focus and priority is on meeting better the needs of the vulnerable and frail with complex needs. A group whom as already described, many parts of the NHS and social services are significantly underserving.[17]

All facets of the long term conditions framework need to be deployed for optimal care of this client group from prevention to long term support. With a culture of partnership with the patient/client as the defining principle. The concept that the clinical consultation is the 'meeting between two experts'. [18] must also be manifest at the organisation level through a partnerships with communities. For patients within those communities this can be achieved by systematically instituting patient/client centred care planning and care plans rather the linear approach of many hospital focused care pathways. The concept of the 'year of care' [19] has been employed in pilot studies of diabetes care in England with notable success. A year of care describes the on-going care a person with a long term condition should expect to receive in a year including support for self management, all of which ideally can be costed and then commissioned. The approach involves shared decision-making between patients and healthcare professionals in the design of a package that meets the patient's individual needs. A time frame was seen to be essential hence the 'year' was perceived as optimal.

The World Health Organisation (WHO) highlighted in 2008 in their report of primary health care, that increasing the number of primary care clinicians in areas with the greatest health need is one of the most effective ways of improving the population's health. All community based services need to contribute to and for many patients deliver the whole clinical or 'year of care' pathway from prevention, screening, early diagnosis through to co-ordination and review of care.

In summary more emphasis on the empowerment of those with long term conditions coupled with investment in effective primary and community based service has to be the short term aim. Lessening the effects of long term conditions will improve the health and wellbeing of individuals, have the quickest impact on reducing health inequalities and release significant resources to fund other and wider approaches to improving the public's health.

Other NHS opportunities for a leadership and implementation approach to improve the public's health by taking an age span approach are described in the table below. Together with the focus on long term conditions, the Health and Wellbeing Board is there to encourage, support and ensure full NHS engagement in their health of the public responsibilities.

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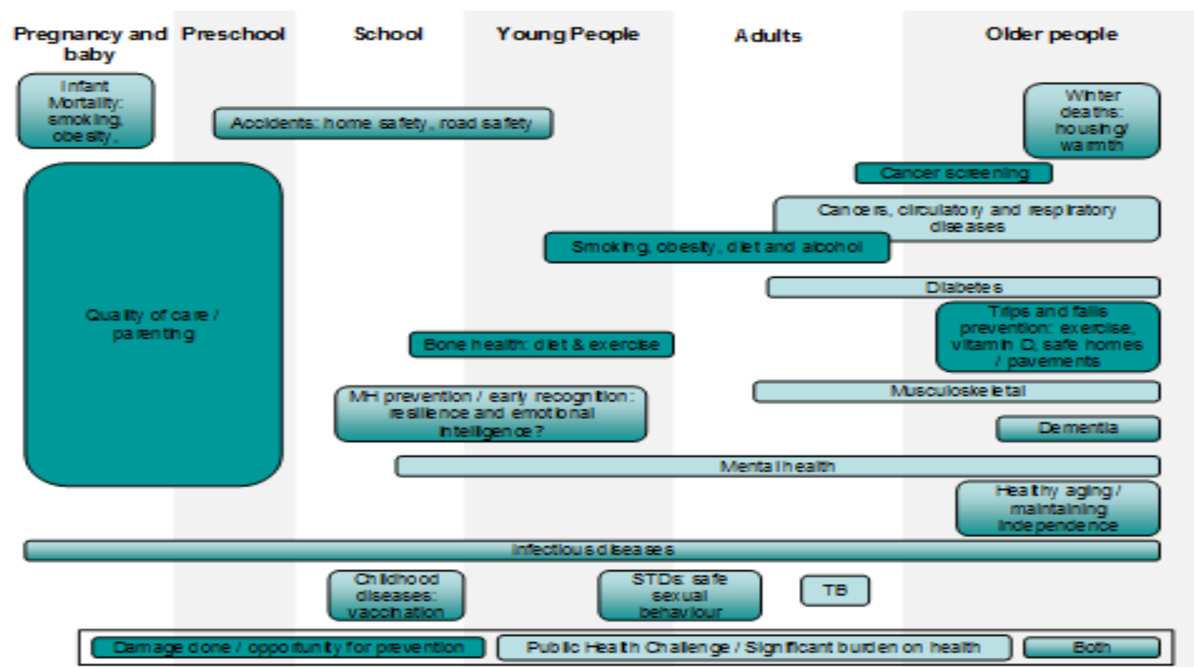
[17] Parliamentary and Health Service Ombudsman (2011) *Care and Compassion. Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. http://www.ombudsman.org.uk/care-and-compassion/home accessed: 26/8/2011)

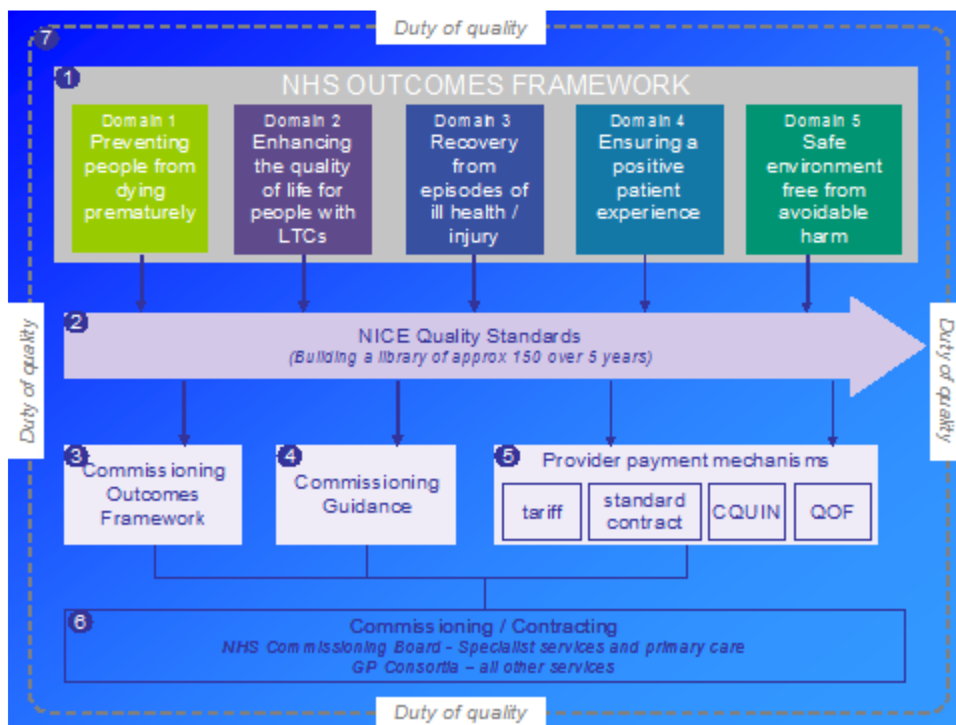
[18] Meetings between experts. David Tuckett, Mary Boulton, Coral Olson and Anthony Williams. Tavistock Publications, London and New York, 1985

[19] Degeling, P, Close, H & Degeling, D. (2006) Re-Thinking Long Term Conditions: A Report on the Development and Implementation of Co-Produced, Year-Based Integrated Care Pathways to Improve Service Provision to People with Long Term Conditions. Centre for Clinical Management Development. Durham University



Other important areas of high impact on the health of the public.

I have chosen a varied set of areas of concern by no means exhaustive but all demonstrating the sheer diversity of need and opportunity. The following high impact areas of concern are predominately affected by social class but within that overall frame specific issues and opportunities manifest. The generic question is whether the Health and Wellbeing Board identifies these or any other areas as their priority? Or if not, can at least identify and support the community leaders who can improve outcomes. Outcomes defined by the NHS outcomes framework, the proposed public health outcomes and any that are locally engendered.



The proposed public health outcomes with much synergy with the NHS Outcomes Framework;

- Protect the population's health from major emergencies and remain resilient to harm
- Tackling the wider determinants of health
- Health improvement
- Prevention of ill health
- Healthy life expectancy and preventable mortality

Education

The WHO evidence is clear. The health of the population is best improved if a nation can improve the educational attainments of their population and in particular for women. The success of local statutory and indeed non statutory educational services and other educational opportunities could deliver more for health gain and sustainable development than for instance the NHS. I appreciate that policies being discussed relate to England but the UK has some of the poorest functional literacy and numeracy compared with equivalent Organisation for Economic Co-operation and Development countries. *(22% of 16- to 19-year-olds in England are functionally innumerate – meaning their maths skills are limited to little more than basic arithmetic, researchers from Sheffield University (2010) discovered. This means their numeracy levels are at or below an 11-yearold's. This is a higher rate of innumeracy than many other industrialised countries, the study of literacy and numeracy rates over the past 60 years found. Meanwhile, 17% of 16- to 19-year-olds are functionally illiterate – meaning they cannot handle much more than straightforward questions. It is unlikely, or even impossible, that they will understand allusion and irony, the researchers found. Their reading standard is at or below an 11-year-old's.*
The government-funded study of the levels of attainment in literacy and numeracy of 13- to 19-year-olds in England, from 1948 to 2009 found rates of innumeracy and illiteracy had remained at the same level for at least 20 years. By 2007 the evidence was that a large proportion of the adult population could not read, write and count adequately. According to the most recent figures, the UK is ranked 14th in the international league tables of literacy and numeracy. (Public Accounts Committee2009)

Local educational service leadership offering opportunities in formal and informal education and in particular for those many who did not enjoy and had little benefit from their schooling has to be a priority. Large organisations private or public can be an excellent vehicle for staff

educational offers. International organisations such as Ford, BT and so on have in the past led the way. The problem is sustainability in particular when senior leadership moves on. And the big employers in many areas are the NHS and local authorities many of whose workforce have had little opportunity for further education. Can the Health and Wellbeing Board focus on and influence education service quality and general educational opportunities for all generations?

Gender

Men have generally poorer health outcomes than women and also are less frequent NHS primary care attendees and in particular for preventive services. Alternative ways of reaching out to men are well established. The UK wide Men's Health Forum is a significant source of information and ideas. To quote their web site *'Many men are reluctant users of traditional health services, such as GPs andpharmacies, and do not always respond to mainstream health awareness campaigns. However, most men care about their health and do respond to messages when the information is presented in formats that appeal to them. We know that men are enthusiastic users of wide range of new technologies – online systems, mobile phone applications, social networking, gaming, etc. We want to harness this interest in new technologies to develop health services, information and products that engage men so they take action to improve their health'*
Women from poorer socio economic background have been less likely to be appropriately referred for cardiology services than even men from an equivalent social class. This fact alone emphasizes the important but often underemphasized public health component of the individual consultation with a health care professional. Incidentally a 'brief intervention' on smoking cessation within a consultation with their general medical practitioner has been shown to have an increased effect on cessation.

Breast cancer is uncommon a disease in that it has a higher prevalence amongst the middle classes but then disproportional worst outcomes in women of disadvantaged back ground. NHS Cancer Screening reports 'The outcomes for women with screen-detected cancers are better than for non-screen detected cancers even amongst deprived or Black and Minority Ethnic communities. Breast cancer patients from deprived or black and ethnic minority communities will do just as well as white breast cancer patients if they are diagnosed by a routine mammogram.' The recent evidence casting some doubt on the validity of screening for cancer has to be investigated and future national policy made clear.

Criminal justice.

Members of the public who have appeared before the criminal justice system together with their families are a population who present multiple problems and disadvantage often 'passed on' to subsequent generations. I was impressed on visiting in 2010 the successes and potential of the Stoke-on-Trent Safer City Partnership which was officially launched in October 2007. It is responsible for implementing the national crime, disorder, drug and alcohol strategies at a local level. Its aim is to work in active partnership; "creating a safer, stronger and healthier city by reducing crime, disorder, substance misuse and associated problems".

Each year the Partnership undertakes a needs assessment to determine the priorities for the coming year. The following priorities were identified for 2011/12: Antisocial behaviour; Violent crime; Drugs and alcohol; Offending behaviour and re-offending, Acquisitive crime including, personal robbery, shoplifting, home burglary *'Each year the Partnership undertakes a needs assessment to determine the priorities for the coming year. The following priorities were identified for 2011/12: antisocial behaviour, violent crime, drugs and alcohol abuse, offending behaviour and re-offending, acquisitive crime including, personal robbery, shoplifting, home burglary and bogus callers.*

The successful implementation of these strategies depends on a partnership approach being adopted. These associated issues are complex and require a range of agencies to be responsible for delivering the agenda. Therefore, membership includes a wide range of stakeholders from: Public sector, private sector, voluntary sector and community (much as the best of health and wellbeing boards)'.

Of course the police remain valued for their role in community safety, Tough on crime, tough on the causes of crime indeed and victims of crime disproportionally live in the poorer socio economic areas.

Fire Services

Another of our emergency services who contribute hugely to community safety are the Fire Brigade whose preventive role has led to a significant decrease in the occurrence of serious large fires

Race

Race related problems still abound despite a sea change in attitudes over the years. A particular contentious area which combines race, faith and gender issues relates to our Muslim community within which women's issues manifest. *'We suggest that Muslim women are tired of being the subject of analysis and critique, to whom motives are often ascribed without their opinion being sought. Scott-Baumann demonstrates that this often constitutes a form of what Achcar calls "Orientalism in reverse", whereby it is prevalent in media and other forms of public discourse to believe that Muslims seek solutions that are alien to those of the secular West; thus the hijab is seen as a sign of repression and as a form of identification with extremism (Scott-Baumann 2011). British Muslim women contest this view and seek to be heard: instead of being those on whom research is done, they want work to be done with, by and for them (Contractor 2010).So, for example, when asked, many Muslim women in Britain talk about the hijab as empowering and as positioning them as ambassadors of their faith in pluralist British communities (Contractor 2011). The headscarf, which is the subject of much popular rhetoric, also makes them visible flag-bearers of their faith (Tarlo 2010) and their standpoints. Simultaneously, these same Muslim women also play diverse 'secular' roles – as students, professionals, social workers – they are also 'Western' women. Thus through visible practice of both their Islamic and Western selves and their syncretic Western Muslim or British Muslim identities (Dwyer 1997), these women and their life stories can facilitate an as yet underutilised opportunity to discuss difficult questions such as cohesion, identity, pluralism and diversity.'*[20] (
There is a particular responsibility to engage and support women leaders in all faiths and races

Faith

Faith based approaches are often perceived as narrowly focused and inward looking to be a true community resource and many are the subject of negative rhetoric. In my experience as someone who is not of a faith, many faith based organisations perceive their role and deliver services well beyond their own faith and must be seen as an important part of a bigger society.

Conclusion

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[20] Perspectives. Teaching Islamic Studies in higher education Issue 2 June 2011. Enhancing the visibility of Muslim women in Islamic Studies Sariya Contractor and Alison Scott-Baumann)

Can we now further and faster advance our progress on the Alma Ata Declaration?

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector

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Post Script
Operating Framework 2012-13

Health and Wellbeing Boards

3.9 Health and Wellbeing Boards will operate in shadow form from April 2012 and will be statutorily operational from April 2013. Health and Wellbeing Boards will act as the local system leader through work on Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS), and NHS organisations need to be active leaders within this process. The JHWS sets shared priorities and a plan for what the NHS and local authorities can do individually and collectively to deliver seamless care, improved outcomes and reduced health inequalities. The JSNA and JHWS inform CCGs' commissioning plans and support integration of delivery.

3.10 SHA and PCT clusters should support shadow Health and Wellbeing Boards and encourage CCGs to play an active part in their formation, including participation in the programme of accelerated learning sets. Health and Wellbeing Boards will contribute to the authorisation process and will play a part in supporting the NHS Commissioning Board in holding CCGs to account.