Draft Review of Draft Health and Well-Being Strategy
South Reading Patient Voice
5 December 2012

Scope

We have reviewed draft 2A (November 2012) of the Reading Health and Well-Being Strategy. The contents of this document were discussed and agreed at a meeting of the South Reading Patient Voice on 28th November 2012.

Welcome

South Reading Patient Voice welcomes the creation of the Health and Well-Being board led by Reading Borough Council. The opportunity to understand, assess and act on local needs and to review change across Health and Social Care under local authority leadership and with the involvement of the public could energise our local services and lead to a real and successful attack on some of our long-standing problems, particularly in health awareness and health inequalities. We are particularly gratified that the Board has a high degree of democratic responsibility due to the dominance within it of elected Councillor members. This is in contrast to all other parts of the Health Service.

Powers and Duties

The powers of Health and Well-Being boards are primarily to require information from clinical commissioning groups, the local authority and Healthwatch, and to require the CCGs to consult on commissioning plans and have regard to the JHWS.

Their duties are to involve CCGs, Healthwatch and the public and to prepare the JSNA and JHWS (with public involvement), to consider pooled budgets and coordination between health care and social care (NHS Flexibilities). They also have duties to secure continuous improvement in outcomes, and quality of services, public involvement, health equalities and integration across health and social care, and also to promote innovation. They must review the contributions of CCGs to the achievement of the JHWS. Informally (NHS Confederation guidelines) Health and Well-Being boards should provide local leadership, steer pooling of budgets and local co-working, oversee best use of resources and monitor outcomes.

It is on the basis of these powers and duties that South Reading Patient Voice offers the comments that follow. Our ambitions should be high and we should work towards the highest quality in our strategy.

- The present draft does a fair job of summarising the JSNA, describing key social and health needs in Reading and it sets out four goals with three sub-objectives for local health care to aim at. The focus on health inequalities and adaptation for diversity, the main principles of the strategy, is welcome.
- When JSNA repetition and contextual material is removed the content is slender and sometimes vague. The strategy is low on specific and practical measures, saying little about what its objectives mean or how they should be realised. There is not much left after the opening diagram – less than a page of rather general material on Goal One, less than half a page of more specific proposals for Goal Two, a useful diagram and less than a page on long term conditions for Goal Three and about half a page on Goal Four. The rest is context. More specific and practical measures would give the reader confidence that goals are understood.
- There is nothing about robustness of provision, GP services, costs, continuous improvement, service coordination and innovation. Failure to include these will risk events sidelining the Health and Well-Being board. There are numerous examples that could be cited here and a selection is given below:

Selected Examples of Topics on which the Strategy has little to say

- The strategy has nothing to say on cost or value for money – which is, however, a big constraint and concern in healthcare. The healthcare and social care sectors are under severe financial constraint with healthcare having to find 4% efficiency savings per year for five years,
  A large proportion of the commissioning budget is spent in the acute sector, much with the Royal Berkshire Hospital Foundation Trust. All acknowledge that the profile of acute care is changing, with an ageing population, continuous medical innovation and new expectations of care by patients and carers. Ed Donald, chief executive of the RBHFT has talked of the "decade of integration" in the National Health Service, while Elizabeth Johnston, lead GP of the South Reading Clinical Commissioning Group has used the "pyramid of care" concept to emphasize how prevention and community services can reduce emergency admissions and crises for patients with long term conditions, and deliver savings.
- Stability in the provision of acute and emergency services is important to the people of Reading. The strategy has nothing to say about this strategic issue, for example on the importance of the local 24/7 services for cardiac and stroke emergency care – would 60-90 extra minutes of ambulance travel be acceptable for these cases?
- Keeping patients with long-term conditions out of hospital using community services and new technology is very welcome, but it places demands on community nursing, social care and the out-of-hours medical and nursing services. These need to be brought out at the Health and Well-Being board where health and social care leaders meet.
- In relation to lifestyle, safe outdoor play opportunities, safe cycling and walking, swimming pools and gyms are involved in some of the lifestyle changes. These matters are mentioned briefly, but specifics on coordination with the relevant areas of local authority competence are lacking.
- The Health and Well-Being board has a duty to secure a continuous improvement in quality and outcome of services. The strategy does not bring this out nor offer proposals as to how it is to be done.
- The Health and Well-Being board has a duty to promote innovation but the strategy does not contribute to that.
- As the local authority is now responsible for public health, the strategy should have something to say about how the local authority can increase awareness of health and local health problems, the JSNA and the JHWS and how public health can cooperate with social, primary and secondary care.
- This strategy should make clear whether services are to be provided for the homeless, hostel dwellers, travellers etc. Reading has a significant refugee problem including people who have suffered abuse. The strategy should quantify this and suggest appropriate measures. There is in addition a significant population in Reading of people who cannot use English well enough to make themselves understood in health care. A strategic statement regarding this issue would seem essential.
- Good access to GP services is the basis of British Healthcare. The people of Reading have an interest in the access, quality and provision of GP services. While it is not clear what formal role the Health and Well-Being board might have, as a local leader in health care its interest is very clear. Its strategy should cover this.

Voluntary Organisations

Voluntary organisations can be very cost-effective in strengthening the benefits of

community to groups and families with specific needs. *Home Start Reading* was specifically cited by one member of SRPV. Such groups must figure – if proper economically effective integration of services is to be achieved – in the Board's remit.

The Imprecise Use of the Word "Community" in the Strategy

We wish finally to make a serious point about the use of the work "community" which is used freely in the Draft Strategy. The word is used imprecisely and this means that the strategy conveys much less than it might.

A community is a group of people with particular characteristics and having mutual support and networking communication. This may be because they live in a long-established, thriving well-defined area ("local community"), because they share beliefs or religious practices ("faith community") or because they have common origin or ancestry in a different country and/or culture ("ethnic community").

Just because people share characteristics does not make them a community. The unemployed, those with learning difficulties, those with hearing difficulties, NEETS, the lonely, the poor, are identifiable groups but they are not communities in any real sense.

The present strategy claims to aim to reach the disadvantaged. One disadvantage, even cited by the strategy, is *not belonging to a thriving community*. A strategy which is couched in terms of reaching communities, as this strategy is, cannot reach the lonely, NEETS, those with learning difficulties etc. effectively. They have special requirements but do not form a community. The strategy as it is phrased is self-defeating and contradictory.

Those who do take part in a thriving community do sometimes have special needs or are hard to reach and their community, with its mutual support and networking, makes it easier to reach them. It makes sense to take advantage of these mechanisms to reach those people. But it is a nonsense to suppose that all people in need can be reached by such mechanisms. The socially isolated are not going to be reached through their community – precisely because of course they are isolated.

The strategy should be rephrased to use the word community in a more careful sense. It may well propose using established and recognised communities for delivery of healthcare and health promotion. The strategy, or a follow-up document, should name the relevant thriving communities in Reading so that appropriate delivery mechanisms can be formulated for the members of those communities. *But it should also indicate how people who do not have the good fortune to be part of a thriving community are to be reached*.