SLOUGH BOROUGH COUNCIL

REPORT TO:	Cabinet	**DATE:** 14 February 2012
CONTACT OFFICER:	Jane Wood, Strategic Director of Community and Wellbeing Tracy Luck, Head of Policy and Communications	
(For all enquiries)	(01753) 875518	
WARD(S):	All	
PORTFOLIO:	Health and Wellbeing – Councillor James Walsh	

PART I
NON-KEY DECISION

NATIONAL HEALTH SERVICE AND PUBLIC HEALTH REFORM

1 Purpose of Report

To inform Cabinet of the NHS and public health service changes which form part of the Health and Social Care Bill, currently being considered by Parliament and to seek agreement to the Shadow Health and Wellbeing Board's terms of reference.

2 Recommendations/Proposed Action

The Cabinet is requested to resolve:

(a) To consider and comment on the reforms so far and their implications for Slough.
(b) To consider and agree the Shadow Health and Wellbeing Board's terms of reference (the Health Scrutiny Panel considered a version of this report at their meeting on 1 February 2012 and their views will be reported verbally to the Cabinet).
(c) That officers provide a further report when guidance is received from the government on the relationship between the Health and Wellbeing Board, the Council's Cabinet and Overview and Scrutiny.

3 Sustainable Community Strategy Priorities

The SCS, which was refreshed in 2011, sets out the strategic objectives and priorities for the borough until 2028:

- Economy and Skills
- Health and Wellbeing
- Housing
- Regeneration and Environment
- Safer Communities

All of these priorities form the wider determinants of health and contribute to the wellbeing of the people of Slough. The SCS will in future be monitored by the Health and Wellbeing Board.

4 Other Implications

(a) Financial – it is proposed that a ring-fenced grant (made under section 31 of the Local Government Act 2003) will be allocated to councils to fund public health services. 'Shadow' budget allocations will be made this year before allocations for the 2013/14 financial year.

(b) Risk Management – some aspects of the changes will require the development of a risk plan, particularly in relation to the transfer of staff from the PCT to the local authority, but this will need to be developed when the model of service provision is agreed.

(c) Human Rights Act and Other Legal Implications – the additional statutory requirements placed on local authorities introduced by the Bill are set out in the report. The progress of the Bill, its Royal Assent in due course and the publication of Regulations under the Act , together with any further guidance issued by the Department of Health will need to be reviewed and will continue to direct and shape the further work required by the Local Authority.

(d) Equalities Impact Assessment – an EIA will be required when the public health service delivery model is agreed and when specific proposal such as Local HealthWatch procurement are developed.

(e) Workforce – the public health forms will include the transfer of public health staff, including the Director of Public health to top tier local authorities in April 2013. The implications of this for Slough, which currently shares a Director of Public Health with the other two East Berkshire local authorities is set out in the report.

(f) Sustainability – this report does not have any significant environmental effects.

5 Background Information

5.1 The government published of the White Papers 'Equity and Excellence: Liberating the NHS' and 'Healthy Lives, Healthy People' shortly after the general election. During the past year the Health and Social Care Bill (the Bill) has been published and is currently being considered by Parliament.

5.2 The Bill has major implications for the local health system and the relationship between that system and local government. In particular it provides for the:

- Abolition of PCTs and the establishment of Clinical Commissioning Groups (CCGs), led by GPs, to commission health services locally;
- Transfers responsibility for public health to local government;
- Requires councils to establish Health and Wellbeing Boards.

5.3 The Bill devolves power and responsibility for the commissioning of NHS Services:

- The role of the Secretary of State will change to one of strategic direction setting and holding the NHS to account.

- GPs will get responsibility for commissioning a wide range of healthcare services, with some exceptions. The Bill allows GPs to join together in consortia, and to commission services in the ways that they judge will deliver the best outcomes for patients
- A new National Commissioning Board will support CCGs. The Commissioning Board will set health outcomes, allocate and account for NHS resources, authorise the establishment of consortia, and have powers of direction over consortia in specified areas and circumstances (such as risk of failure). It will also commission specific services (for example, primary medical services and national specialised services) and will oversee the work of consortia.
- Strategic Health Authorities (SHAs) are to be abolished from April 2012 and Primary Care Trusts (PCTs) from April 2013.
- The Foundation Trust model will be reformed with an aim to support all NHS Trusts to become foundation trusts by 2014.

Creates a new role for Local Authorities in Public Health:

- Public Health England (PHE) will be the national public health service.
- Local authorities will be given responsibility for health improvement currently carried out by Primary Care Trusts (PCTs)
- Directors of Public Health (DsPH), jointly appointed by councils and PHE, will have a leading role in discharging local authorities' public health functions.
- Health and Wellbeing Boards (HWBs) will be statutory in every upper tier local authority and will be required to bring together GP consortia, DsPH, children's services, adult social services and others. The HWBs will have a statutory responsibility to develop a 'joint health and wellbeing strategy' that both local authority and NHS commissioners will be required to have regard to.

Sets up new accountability and scrutiny arrangements:

- Health Watch England will be established as the national voice of patients and the public. Local Involvement Networks (LINks) will be replaced by local Health Watch organisations.
- 'Monitor' will be transformed into the economic regulator for health and adult social care services. Along with the Care Quality Commission, Monitor will licence providers.
- The National Institute for Health and Clinical Excellence (NICE) and the Information Centre will be enshrined in primary legislation for the first time to maintain their independence.

5.4 There was considerable opposition by health professionals following publication of the Bill and this led to the government's "pause" and recommendations by the Future Forum, most of which were incorporated into the 363 amendments to the Bill published at the end of August 2011. There is a developing agenda in relation to public health and therefore some degree of uncertainty about particular aspects. The report attempts to set out what is currently known but that uncertainty means that many questions are still to be answered

5.5 Responsibilities of Clinical Commissioning Groups (CCGs)

5.5.1 The CCGs will:

- Be responsible for managing their combined budget and deciding how best to use these resources to meet the healthcare needs of the patients for whom they are responsible.
- Have the freedom to decide which aspects of commissioning activity they undertake themselves, and which require collaboration across several consortia, for instance through a lead commissioner. In some cases, commissioning will be permitted to take place at a sub-consortium or practice level.
- Decide commissioning priorities to reflect local need, supported by a national framework of quality standards, tariffs and national contracts established by the board. It will be a requirement for priorities to reflect need as set out in the Joint Strategic Needs Assessment (JSNA).
- Become increasingly influential in driving up the quality of general practice and be expected to intervene in the first instance where there are concerns that an individual practice is causing wasteful or ineffective use of NHS resources.
- Be the responsible commissioner for any patients registered within constituent practices – and those in the area who are not registered with a practice.
- Develop arrangements to hold constituent practices to account.

5.5.2 Proposed funding of Consortia

Practice-level budgets will be calculated on the basis of registered patient numbers within the consortia boundary and allocated directly to consortia. Consortia commissioning budgets will include a maximum management allowance to reflect costs associated with commissioning. Consortia may choose to commission services from one or more constituent practice over and above the primary care services they have a duty to provide. Further work will be taken forward to allow this while guarding against conflicts of interest.

5.5.3 What is happening in Slough?

A single CCG has been established, coterminous with the Council's boundaries. The Strategic Director of Community and Wellbeing is a member of the CCG Panel and has a vote. Appointments to the board were made by interview and the chair was selected by the CCG. The CCG has held a number of meetings and has agreed terms of reference. It has also agreed conflict of interest procedures. The CCG has started to review performance and finance issues, for example what Slough is spending e.g. from elective surgery to prescriptions. This has led to some trailblazing work for example controlling the overspending prescriptions budget. It is also working with the PCT to develop new health pathways. The Slough CCG is looking at federation options with others CCGs. It may be that the Health Scrutiny Panel would want to request a presentation by the CCG on their work at a future meeting.

5.6 Health and Wellbeing Boards

5.6.1 The core aim of the Health and Wellbeing Boards (HWBs) is to improve efficiency, secure better care and, ultimately, ensure better health and wellbeing outcomes for the

local population. The Boards are expected to integrate commissioning across NHS, public health and social care services, breaking down divisions between the NHS and local authorities by bringing together those who commission services across the NHS, public health, social care and children's services to plan services for their area, and encouraging them to work in a more integrated way.

5.6.2 The Boards will have responsibilities for ensuring that the current and future needs of the local population are understood and best served by health and social care commissioners and providers. They will assess local needs and develop a shared strategy for how best to address them, providing a strategic framework for local commissioning plans. They will be expected to facilitate democratic patient and carer input into the commissioning of local services and give communities more say in health and social care services for local people. They will do this by including elected representatives and patient representatives (via the local HealthWatch once it is in place) in shaping the strategic direction of health and social services in their area, and by acting as the forum for holding those responsible for commissioning decisions to account.

5.6.3 The role envisaged for HWBs has been strengthened as a result of the Government's 'listening exercise' as part of its 'pause' earlier in the year. In response to Future Forum recommendations, the Boards will have a stronger role in addressing wider health determinants, promoting joint commissioning and integrated provision between health, public health and social care. There will also be a new duty on the Boards to involve users and the public, and a requirement for CCGs to involve HWBs as they develop their commissioning plans, with HWBs having the authority to refer commissioning plans back to the Clinical Commissioning Consortium or the NHS Commissioning Board if they are not satisfied that the plans are in line with the JSNA or Joint Health and Wellbeing Strategy (JHWS) (although HWBs will have no veto rights).

5.6.4 Specifically, the Boards will:

- Produce the JSNA and JHWS;
- Be responsible for ensuring that the CCGs commissioning plans align with the joint strategy;
- Play a role in the annual assessment of CCGs and in the initial authorisation process;
- Be required to involve users and the public in the JSNA and JHWS.

5.6.5 Statutory requirements

HWBs are a statutory requirement; every upper-tier local authority is required to lead on developing a HWB in their locality and to establish a Shadow HWB by April 2012. These will become fully constituted bodies under forthcoming legislation in April 2013.

There are a number of specific statutory requirements that relate to the governance, membership and functions of HWBs:

- The legislation will require the Boards to be established as a committee of the council, with local government legislation being amended to reflect the proposed membership of them;

- The minimum core membership will be prescribed, namely:
    - At least one councillor;
    - The directors of adult services, children's services and public health;
    - A representative of the local HealthWatch organisation;
    - A representative of each relevant CCG;
    - And, for some purposes, a representative of the NHS Commissioning Board;
- They will have a duty to involve users and the public in the commissioning of local health and social care services;
- They will have a duty to promote joint commissioning and integrated working between the NHS and local government;
- The legislation sets expectations that HWBs are involved throughout the NHS commissioning process, so commissioning plans (CCGs and others) are in line with the JHWS;
- The JHWS, which the HWB are expected to produce, will be a statutory requirement for both local authorities and CCG;
- The JSNA, which the HWBs are expected to produce, will be a statutory requirement for both local authorities and the CCG, and the HWB will be required to demonstrate that due regard has been given to the findings of the JSNA;
- NHS and local authority will be required to consult with HWB and have regard to the JSNA and JHWS when drawing up their annual commissioning plans;
- Legislation gives HWBs a role in the annual assessment of CCGs (and a non-statutory role in their initial authorisation).

5.6.6 **What is happening in Slough?**

Last summer the council commissioned the consultancy Shared Intelligence (Si) to assist in developing the Council's response to the public health reforms. Specifically in relation to the formation of a Health and Wellbeing Board, Si developed draft terms of reference, suggested membership and an outline work programme.

Building on the Si work a Shadow HWB has been formed and has held a planning meeting and a first working meeting. Si's work emphasised the particular circumstances of Slough, where the wider determinants of health, including housing, skills and crime are of importance (as clearly evidenced in the refresh of the JSNA). It was therefore agreed that the Shadow HWB would replace the former Local Strategic Partnership as it will act as the umbrella partnership for the borough and retaining the LSP would have led to duplication. The terms of reference of the Shadow HWB are attached as **Appendix 'A'**. These are submitted to the Cabinet for approval. The Shadow HWB will be considering a name for the board which reflects its wider responsibilities. Until the HWB is constituted as a council committee from April 2013 formal decisions will need to be referred to the Cabinet for approval.

Also attached as **Appendix 'B'** is a document called "Operating principles for health and wellbeing board" prepared jointly by the Department of Health and Local Government Association, amongst others, which sets out some useful information, including success criteria for boards.

The Shadow HWB has been developing a sub structure and has agreed that the Children's, Safer Slough, Skills, Employment and Enterprise, Community Cohesion, and

Climate Change Partnerships will sit below the Board and report into it. A reformed Health and Wellbeing Sub Group will also be set up to deal with the detailed specific health work which the HWB will need to delegate to a delivery group.

The membership of the Shadow HWB has been agreed to reflect the need to ensure work is coordinated on the wider determinants of health and is chaired by Councillor Robert Anderson, Leader of SBC. In addition to the statutorily required members includes representatives from Thames Valley Police, the business and voluntary sectors and the Royal Berkshire Fire and Rescue Service. It will be important for this range of partners to play an active part in delivering the aims of the HWB, for example domestic violence is known to have a significant impact on both the health and wellbeing of adults and children in Slough and a number of partners will be able to contribute to a response and prevention.

It will be important for the Health Scrutiny Panel to establish how it will work with and scrutinise the HWB. The Panel will scrutinise the Board's strategic policy development and performance outcomes. This relationship should be developed during the Shadow HWB stage. To facilitate this the minutes of Shadow HWB meetings will be made available to Health Scrutiny Panel Members.

6. Public Health

6.1. From April 2013 top tier local authorities will have a statutory responsibility to employ a DPH jointly with PHE. DsPH will lead local public health efforts: this role can be shared with other councils if agreed locally. In this joint arrangement DsPH will be professionally accountable to the Chief Medical Officer (CMO) and part of the Public Health England professional network. They will also be accountable to the council and HWB for local delivery and outcomes.

6.2 The DPH as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the DPH to produce an annual report on the health of the local population, and for the local authority to publish it. DsPH will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services. There is an expectation, though not a requirement that the DPH will report to the Chief Executive and be seen as the lead officer for Members to contact on health matters. Specifically the DPH will:

- Be the principal adviser on health matters including needs assessment and priority setting
- Be responsible for the reduction of health inequalities and disease prevention including interventions, commissioning, and provision
- Ensure evidence based commissioning: GP, primary care, secondary , specialist - care and pathways
- Ensure the provision of health protection and emergency preparedness/response, including infections/control
- Be responsible for workforce development – whole system.

6.3 DsPH tasks will include:

- Developing an approach to improving health and wellbeing locally, identifying need, promoting equality and tackling health inequalities and monitoring outcomes
- Providing and using evidence relating to health and wellbeing informing the role, functions and outcomes of the HWBs
- Advising and supporting GP consortia on the population aspects of NHS services and evidence based commissioning including integrated pathways
- Collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

6..4 The proposed division of responsibilities for the commissioning of public health functions is set out in **Appendix 'C'**.

6.5 **What is happening in Slough?**

6.5.1 The transfer of the DPH and their staff to local authorities is relatively straightforward in areas where the DPH's remit is coterminous with the upper tier authority (e.g. county councils and London boroughs). However, currently Slough shares a DPH with the other East Berkshire councils (Bracknell Forest and Windsor and Maidenhead). A further complicating factor is that prior to abolition of the PCTs in April 2013, the East and West Berkshire PCTs have been clustered together with a joint management structure (although currently retaining two DsPH).

6.5.2 The Council has been examining different models of managing public health in consultation with partners, including the PCT and with other Berkshire local authorities. As mentioned in paragraph 5.6.6 the Shared Intelligence consultancy has been providing advice to the council about the public health transition and this has included development of workforce options. The three options developed are to have a public health function dedicated to Slough, to share a function with the East Berkshire councils or all of the Berkshire councils or a hybrid model with a shared DPH and some other functions with some dedicated Slough staff.

6.5.3 A cross-Berkshire group convened to progress the transition but decisions will depend on the value of the grant to local authorities. Guidance was issued to PCTs at the end of 2011 and outline transition plans need to be produced by 27 January.

7. **Local HealthWatch**

7.1 Local HealthWatch will become operational in April 2013 (this is a recent postponement from October 2012). Local authorities will be responsible for facilitating the development of an effective local HealthWatch which provides opportunities for people to have their say about the quality and development of their local health and adult social care services, particularly to influence the commissioning of services and to scrutinise them.

7.2 The functions of local HealthWatch will include:- signposting, advice and information giving, assisting with complaints, community networking, intelligence work on national and local statistics in order to inform the commissioning overview functions and assist patients in their choices, enter and view, and possibly advocacy. Local HealthWatch will need the resources to support all of these functions and to support the training of

volunteer members carrying out monitoring visits, inspections, enter and view and participating in Health and Wellbeing Board and a wide range of influencing activities in relation to commissioning.

7.3 Local HealthWatch will provide a single point of contact, by connecting people to the right NHS and social care advice and advocacy services, and by helping people to find information that will enable them to choose the services they need and require. It will support people to speak out and give those who want it, an opportunity to get more involved in a range of different ways.

7.4 Local HealthWatch will not be a 'network' like the LINk. It will be a "body corporate", so at some point, Local HealthWatch may need to be set up as a charity, company or similar body, which means that it:

- will be an organisation in its own right, and no longer 'just' a network overseen by volunteer groups
- may appoint its own staff
- will have to produce its own annual accounts
- will have standards provided by a national HealthWatch organisation, HealthWatch England, against which Local HealthWatch organisations can be measured.
- will be subject to the Equality Act 2010. (It is not yet clear what the implications of this will mean, but it may be that Local HealthWatch will have to demonstrate how it is meeting its obligations under the Equality Act, by engaging with all the different sections of the community.)

7.5 It appears that Local HealthWatch will be led by local members or volunteers, and that paid staff will be there to support volunteers, as is the current situation with LINks. The Health and Social Care Bill talks about Local HealthWatch 'members'. It is not clear exactly how HealthWatch will define 'members', but it is possible that the Department of Health considers that Local HealthWatch organisations will be run and 'owned' by a board of members, similar to charity trustees or health board non-executive directors. Some parts of the Bill suggest that Local HealthWatch members might be paid. The Bill it also states that Local HealthWatch members must be "representative of local communities" and this will be challenge for a diverse area like Slough.

7.6 There continues to be considerable uncertainty about the formations of LHW. Local authorities are expected to set up an organisation to meet local needs but there is no recommended procurement route or recommended specification, although there will be consultation on what a 'good' LHW looks like.

7.7 Local Authorities must make arrangements to establish a Local HealthWatch a contract. Local authorities will fund Local HealthWatch in the same way that they fund the LINks: i.e. they will put together specifications for Local HealthWatch and put this out for organisations to bid for. They will then performance manage the contracts, and can terminate them if they think the performance of the Local HealthWatch is unsatisfactory. The Health and Social Care Bill says that local authorities may possibly make HealthWatch arrangements 'directly with the Local HealthWatch'. There is debate about what this means, as how can local authorities make arrangements with a body that does not yet exist? In theory, what could happen is that groups of local volunteers might get together and form an organisation (such as a social enterprise or charity) and then bid

for the Local HealthWatch contract. However, as such groups would have no experience of tendering then it is hard to see how this could work.

7.8 Local HealthWatch will be funded from money from central government. The amount for each local authority will be different based on need and is not ring-fenced and will roughly equate to the current LINk budget plus 65% of the Patient Advisory Liaison Service (PALS) local budget. There will also be additional funding in 2013 if Local HealthWatch is successful in bidding for the complaints advocacy (currently Independent Complaints Advisory Service or ICAS) work that local authorities will have to commission.

7.9 The following functions will transfer from PALS to Local HealthWatch:

- Providing information about the NHS and help with health related enquiries
- Helping resolve concerns or problems patients have when using the NHS
- Providing information about the NHS complaints procedure and how to get independent help to make a complaint
- Signposting patients to agencies and support groups outside the NHS
- Informing people about how to get more involved in their own healthcare and the NHS locally
- Improving the NHS by gathering feedback about services and experiences for people who design and manage services
- Identifying problems or gaps in services and reporting them to NHS Trusts.

It is not yet clear what will happen to PCT PALS staff contracts.

7.10 **What is happening in Slough?**

Work has now started to develop a Local HealthWatch model that will meet the needs of local people. There will be close working with the Slough LINk to learn from their experience. We will be reviewing our consultation and engagement arrangements, what has worked well, looking at gaps and involving GPs.

8. **Next stages**

The current Department of Health timetable is:

Early 2012
PCT outline transition plans prepared
Letter about Directors of Public Health appointments
Public Health outcomes framework published
Building the PHE People Transition Policy document published
Public health workforce strategy consultation launched
Shadow local authority allocations for 2012/13 announced
LGG HR Guidance
Sender’s HR guidance

March
Local transition plans agreed

April
Chief Executive PHE designate starts

Early summer
PHE People Transition Policy including terms and conditions

2013

April
Public Health England established

9. Background Papers

None other than statutory publications