14th June 2011	ITEM 7

Health and Well-Being Overview and Scrutiny Committee

HEALTH TRANSITION – NEW RESPONSIBILITIES FOR LOCAL AUTHORITIES

Report of: Councillor Barbara Rice, Portfolio Holder Children's Services and Health

Wards and communities affected:	**Key Decision:**
All	Key

Accountable Head of Service: Roger Harris, Head of Strategic Commissioning and Resources

Accountable Director: Lorna Payne, Corporate Director Community Well-Being

This report is Public

Purpose of Report: With reference to current reform of the health service:

- Communicate key changes;
- Highlight new responsibilities for local government; and
- Identify the steps the Council is taking and has already taken to prepare for the changes and related responsibilities.

EXECUTIVE SUMMARY

This report outlines proposed key changes and new responsibilities for local government contained within the Government's plans for health service reform – **subject to Parliamentary approval of the Health and Social Care Bill 2011**. These include:

- The strengthening of public and patient involvement in health and social care – with the end of Local Involvement Networks (LINks) and the establishment of local HealthWatch with extended responsibilities from July 2012;

- Establishing new GP 'consortia' who will have the commissioning power for most NHS services and in doing so abolishing Primary Care Trusts and Strategic Health Authorities from April 2013;

- Establishing two new national bodies – the NHS Commissioning Board and Public Health England from April 2012;

- Establishing new statutory Health and Well-Being Boards in upper-tier authorities as of April 2013 to lead on improving the strategic co-ordination and integration of commissioning across the NHS, social care, and related children's and public health services;

- Extending the powers of health overview and scrutiny committees from April 2013; and

- Reforming public health so that local authorities have responsibility for health improvement in their local area from April 2013 – including employing a Director of Public Health who will have joint accountability with Public Health England.

Note - the dates above may change due to the 'pause' within the Health and Social Bill 2011.

This report also sets out the transitional steps that the Council is taking to manage the proposed changes and new responsibilities over the next two years.

1. RECOMMENDATIONS:

1.1 That Health and Well-Being Overview and Scrutiny Committee note the proposed changes and actions being taken.

2. INTRODUCTION AND BACKGROUND:

2.1 In recent months the Government has published a number of papers that outline future health service arrangements. These include:

- NHS White Paper – Equity and Excellence: Liberating the NHS;
- The Government's response to the NHS White Paper 'Liberating the NHS: Legislative Framework and Next Steps';
- Public Health White Paper 'Healthy Lives, Healthy People';
- Healthy Lives, Healthy People: Transparency in Outcomes;
- Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health;
- NHS Operating Framework 2011/12; and
- Health and Social Care Bill 2011.

2.2 The papers outline the framework for a radically reformed health service – a health service with increased and strengthened local accountability. Local Government is at the heart of both delivering and influencing this new service.

2.3 This paper highlights the key changes of the new health service – recognising that a number of aspects are still subject to consultation and Parliamentary approval (as part of the Health and Social Care Bill 2011); outlines the proposed new responsibilities for local government; and also outlines the transitional steps that the Council are taking to prepare for those responsibilities.

3. ISSUES AND/OR OPTIONS:

Current arrangements

3.1 The PCT (NHS South West Essex) currently has the responsibility for commissioning healthcare across South West Essex – this includes Thurrock, Basildon, Brentwood, Billericay, and Wickford. NHS South West Essex and NHS South East Essex have recently formed a 'cluster arrangement' under the leadership of one Chief Executive – Andrew Pike. As a result, a number of posts will span both NHS South West Essex and NHS South East Essex. NHS South West Essex and NHS South East Essex will remain as separate organisations, with separate Boards.

3.2 The PCT has recently separated out its provider arm from its commissioning arm and so, following a procurement exercise, community health services in South West Essex (district nursing, therapy services etc.) are now provided by North East London Foundation Trust (NELFT).

3.3 Mental Health, Learning Disability, and other specialist services such as drugs and alcohol, are provided by South Essex Partnership Foundation Trust (SEPT) – often in conjunction with the Council (e.g. the Council has social workers seconded in to SEPT's Adult Mental Health Team).

3.4 Acute Services are provided by Basildon and Thurrock Hospitals University Foundation Trust. Foundation Trusts are not-for-profit public benefit corporations. They are part of the NHS are provide almost half of all NHS hospital and mental health services. They have their own Boards and Governors and are regulated by the independent regulator Monitor. The Government's ambition is that all NHS trusts will become Foundation Trusts within three years.

Strengthening and supporting public and patient involvement – creation of HealthWatch

3.5 The reforms seek to strengthen the voice of patients and seek to 'enhance the role of local authorities in promoting choice and complaints advocacy'. This is to happen through the creation of a Health Watch England – sitting as part of the Care Quality Commission (CQC).

3.6 Upper-tier local authorities are to become responsible for commissioning a 'local' HealthWatch which will replace the existing Local Involvement Networks (LINks) from July 2012. Local HealthWatch will continue LINks' role

of promoting and supporting public involvement in the commissioning, provision and scrutiny of local care services.

3.7 It is proposed that the local HealthWatch has broader powers – including a health and social care advice and information role and also power to escalate concerns about the quality of health and care services to the national Health Watch England for CQC to carry out investigations into health and care services.

3.8 As recommended by the Department of Health, for the purpose of ensuring continuity, the Council has extended LINks' contract (which was due to expire April 2011) until April 2012. It is recognised that 2011 will be a transitional year and due to the 'pause' in the Health and Social Care Bill, the contract expiry date may be extended.

3.9 HealthWatch, like LINks, is to continue to be funded by local authorities, with funding being built in to existing allocations. An additional amount will be provided to support start-up costs. How much this will be is currently unknown.

3.10 It is proposed that Councils will have the additional responsibility for commissioning NHS complaints advocacy from April 2013 – which they will be able to commission to LINks should they wish. They will also have a new responsibility for commissioning mental health advocacy.

3.11 The Council will be expected to commission its local HealthWatch arrangements. It has recently submitted an application to the Department of Health to be a local HealthWatch pathfinder. This will help to scope what local HealthWatch should look like, how it should function, and what it should do.

General Practitioner (GP) Commissioning

3.12 New GP consortia are to be established. They will become responsible for commissioning the majority of NHS services currently commissioning through Primary Care Trusts. Should the reforms proceed as planned; Primary Care Trusts will be abolished by April 2013. All GPs will be required to be a member of a consortium. The PCT will remain statutorily responsible for the planning and delivery of all NHS services until that date.

3.13 Under current proposals, GP consortia will be free to determine their own boundaries – which may or may not be co-terminous with upper-tier local authority boundaries. Consortia boundaries are likely to change and evolve over time. There will be no maximum or minimum size, but the management fee per head of population is likely to help determine size of consortia (the NHS Operating Framework states that this is likely to be between £25 - £35 per head of population). Even though all GPs will be part of a consortium, they can employ staff to undertake functions on their behalf.

3.14 Currently in Thurrock the majority of GPs intend to belong to a consortium which covers Thurrock and a proportion of Basildon. A couple of GP practices are currently intending to belong to a consortium outside Thurrock boundaries. Initial transitional arrangements are that Consortia are in place by April 2011 with those consortia receiving shadow allocations. The Council is working with GPs, The Primary Care Trust and also Essex County Council colleagues to try to encourage a Thurrock-specific GP consortium. It is expected that initial arrangements will be fluid and evolve over time.

3.15 As part of the plans, Consortia will be able to buy-in support and collaborate with local authorities. This is a potential opportunity for the Council should GPs wish to work with the Council on commissioning. This includes consortia exploring joint and lead commissioning arrangements with local authorities as well as other council services such as payroll and procurement. The Council is currently discussing these commissioning opportunities with Thurrock GPs, the PCT, and also Essex County Council and Southend Council colleagues– e.g. to look at the Council taking the lead for the commissioning of health and care services for groups such as learning disabilities; older people; mental health; and children. It is anticipated that commissioning will take place at a number of different geographical levels, some at local authority (e.g. Unitary) level and others which would be a group of local authority geographical areas (e.g. Thurrock, Southend and Essex). This is more likely to be the case for specialist services that cover a broad geographical area (for example Mental Health).

3.16 The Bill states that each consortium will have to produce a commissioning plan before the start of each year. In preparing the plan, the consortium must consult with each relevant Health and Well-Being Board about its views on whether the plan takes proper account of the most recent joint health and well-being strategy. Also as part of the Bill, Health and Well-Being Boards and Joint Health and Well-Being Strategies will be statutory and exist in each upper-tier authority area with the Council being the lead authority. Current proposals are that consortia must include a statement of the Health and Well-Being Board's opinion in their plan.

3.17 GP consortia and local authorities will be expected to collaborate – with joint obligations to prepare Joint Strategic Needs Assessments and Joint Health and Well-Being Strategies. The new national NHS Commissioning Board, to be in shadow form during 2011/12, will have a duty to promote collaboration between GP consortia and local authorities, and also to reinforce the importance of Health and Well-Being Boards. The NHS Commissioning Board is to be responsible for holding consortia to account in relation to achievement of outcomes and financial responsibilities.

3.18 One of the risks to the success of the new arrangements is the current lack of relationship between the Council and Thurrock GPs. To date, the Council's relationship with health has been with South West Essex Primary Care Trust. This is also the same for GPs. The Council recognises that a good relationship with Thurrock GPs is critical to the success of the new arrangements. The Council has established a joint steering group with

representatives of Thurrock's GPs through which key issues are being discussed, and also has a Health Transition Project Director seconded from the PCT to focus on building key relationships.

Health and Well-Being Boards (H&WB)

3.19 The establishment of H&WB Boards in upper-tier authorities will be statutory as part of the anticipated Health and Social Care Act. The purpose of the H&WB Board will be to lead on improving the strategic coordination of commissioning across NHS, social care, and related children's and public health services. Councils are expected to establish Shadow Boards by the end of the year. Thurrock is an 'early implementer' and has already established its Shadow Health and Well-Being Board – the first meeting of which took place in April. A key purpose of the Board will be to help steer the Council's transitional arrangements but also to maintain relationships with the PCT whilst still in existence.

3.20 The Bill confirms membership of the Board as: a representative of each relevant GP commissioning consortium; a least one local councillor; the Director of Adult Social Services; the Director of Children's Services; the Director of Public Health; and a local HealthWatch representative. It will be the Leader of the Council's responsibility to nominate a councillor(s) to be on the Board. It was agreed by Cabinet in March that the Leader of the Council would chair the Health and Well-Being Board, and that initial membership would also include the portfolio holder responsible for health, and an opposition elected member. Other elected members would be invited to attend meetings as appropriate. A representative of the NHS Commissioning Board will also join the H&WB Board for certain purposes – e.g. to participate in the preparation of the Joint Strategic Needs Assessment and Health and Well-Being Strategy. It is expected that membership of the shadow Board will need to be flexible depending upon the agenda and, until 2013, will include the PCT's Chief Executive and a Non-Executive Director.

3.21 Local authorities will be able to choose to delegate additional functions to H&WB Boards and as such, it is expected that the functions and responsibilities of the Board will evolve over time. The reason for this is that the Board's remit will span those factors that influence health – i.e. the wider determinants, rather than just traditional health and social care services.

3.22 The Bill places a statutory duty on the Council and GPs to prepare together a Joint Strategic Needs Assessment and Joint Health and Well-Being Strategy via the H&WB Board. Both documents are critical in so much as they provide the overarching framework for commissioning plans and incorporate wider-determinants of health – e.g. environment, earnings and employment.

The role of Health and Well-Being Overview and Scrutiny

3.23 The NHS White Paper suggested that the functions exercised by the health overview and scrutiny committee would be subsumed within the H&WB Board. The response to the White Paper and subsequent Health and Social

Care Bill has clarified that this will not be the case and has in fact confirmed that health overview and scrutiny committees are to have significantly extended powers and be a separate committee from the Health and Well Being Board. The Committee's new powers will become statutory through the Health and Social Care Act.

3.24 The primary focus of the Health and Well-Being Board will be the improvement and co-ordination of commissioning – related to the NHS, social care, and related children's and public health services. As such, the Health Overview and Scrutiny Committee will have a key role in holding the Health and Well-Being Board to account. A Health O&S separate to the Health and Well-Being Board is key to it retaining its independence and to being able to effectively scrutinise the Board. For this reason, members of Health O&S should not also sit on the Health and Well-Being Board.

3.25 The new powers include any NHS-funded provider or commissioner being required to attend scrutiny meetings or provide information as requested; and local public health services being scrutinised along with any provider of a NHS-funded services – e.g. primary medical dental or pharmacy services and independent treatment centres, as well as any NHS commissioner.

Public Health Responsibilities

3.26 As of April 2013, it is proposed that upper-tier local authorities will become responsible for health improvement in their area. This will be via a ring-fenced budget (amount currently unknown) distributed by a new national body called Public Health England. Public Health England is to be established in shadow form as of 2011/12 and is expected to become a statutory body from April 2013. The health improvement responsibilities (currently being consulted on) that are expected to transfer to the local authority are attached.

3.27 As part of the new arrangements, the Council is to be responsible for employing a Director of Public Health – who will be a joint appointment with and jointly accountable to Public Health England.

3.28 Although sitting within the local authority, the Director of Public Health will also be expected to work closely with GP consortia, and have other roles and responsibilities as determined by Public Health England.

3.29 Although funding is to be confirmed, the Public Health White Paper is clear that it expects the majority of services to be commissioned and with a wide range of providers – e.g. voluntary, community, and social enterprise organisations. In the interim and whilst NHS South West Essex PCT retain responsibility, health improvement services will be provided by North East London Foundation Trust (NELFT). The Council is working with the PCT to ensure that NELFT's contract reflects the needs of Thurrock and is outcome-driven.

3.30 The Council is working closely with PCT colleagues and other local authority colleagues to organise transitional arrangements that reflect 'end state' as

quickly as possible. This will include putting shadow arrangements in place by April 2012 – including shadow public health ring-fenced allocations. The Council is also starting to develop what its own internal arrangements might look like for public health and also what Thurrock's health improvement priorities are.

3.31 To help manage the transition towards and scope its new public health responsibilities, the Council has agreed with NHS South West Essex that their Director of Public Health be seconded to work at Thurrock Council on a part-time basis until final arrangements have been confirmed. This is at no cost to the Council. The end state discussed with each PCT and the three upper-tier local authorities in Essex, is that each of those authorities will have their own Director of Public Health. The clarification of funding will allow local authorities to identify what they can afford both in terms of posts and services. Thurrock's interim Director of Public Health has already taken the lead for refreshing Thurrock's Joint Strategic Needs Assessment, and is leading on the development of a Tobacco Control Strategy.

3.32 Much of the final detail for public health reform is contained within three consultation documents:

- Public Health White Paper 'Healthy Lives, Healthy People';
- Healthy Lives, Healthy People: consultation on funding and commissioning routes for public health; and
- Healthy Lives, Healthy People: transparency in outcomes.

In addition, the Health Committee is conducting an inquiry in to Public Health and has issued an invitation to submit written evidence. This new inquiry will review major changes being proposed by Government to the organisation of public health services, as part of its wider plans for reform of the NHS. The Government's final response to these documents and the inquiry will allow the Council to fully develop and finalise its internal arrangements.

Pause and next steps

3.33 At the beginning of April this year, the Government announced that there would be a 'pause' in plans for health reform. This would be to 'listen and reflect on people's views on the NHS modernisation agenda'.

3.34 The Government has been inviting people to provide views on different themes and also generally. The closing date for 'listening and reflecting' was 31st May. The Council submitted its own response and has used this as an opportunity to emphasise a number of key points – e.g. the role of the Health and Well-Being Board in holding GP Consortia to account etc. It is unclear as to when the outcomes of the pause and how they will affect current reform plans will be announced. The Council will need to review how any changes affect its transition plans and amend them accordingly.

3.35 The Council has been keen not to lose momentum whilst the pause has been in place and has continued with its plans and preparations. This has included the continuation of the shadow Health and Well-Being Board, making a submission to become a local HealthWatch pathfinder (of which the Council is

awaiting the outcome), and regular joint meetings with the PCT executive. The Council is also continuing to work with Thurrock GPs and regularly attends the Thurrock Managed Care committee meetings – as well as GP representatives attending the shadow Health and Well-Being Board.

4. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

4.1 In particular, the new responsibilities for local authorities will impact upon the priority of 'provide and commission high quality and accessible services that meet, wherever possible, individual needs' (priority 4).

4.2 In terms of the Council's new responsibilities for health improvement, all priorities will be affected. This is in recognition of 'health improvement' and 'health inequalities' being linked to a number of wider determinants – e.g. employment, skills, education, housing etc.

4.3 The impact on the community is potentially great, as the changes provide a greater emphasis on community leadership in health, and ensuring that the commissioning of 'health' services is driven by the needs of the local population.

5. IMPLICATIONS

5.1 Financial

Implications verified by: **Funké Nana**
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Financial implications are:

- Allocations for the Council's new responsibilities are currently unknown – e.g. local HealthWatch, health improvement, advocacy for mental health
- It is unclear as to whether the funding will be sufficient to provide the new responsibilities – e.g. whether the health improvement responsibilities to transfer will match the funding available

5.2 Legal

Implications verified by: **Lee Bartlett**
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Legal implications are:

- The changes contained within this report are statutory – e.g. Health and Social Care Bill contains most of the statutory responsibilities brought about by the NHS and Public Health White Papers.

- It is unclear what status the Health and Well-Being Board will have as part of the Council's constitution, if at all, as the Health and Social Care Bill states that 'a Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972'.
- Subject only to the intended provisions contained in this report being statutorily compliant no other Legal Implications arise.

5.3 **Diversity and Equality**

Implications verified by: **Samson DeAlyn**
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One of the key responsibilities of the Health and Well-Being Board will be to ensure that the commissioning of services is driven by community priority and need. To do this effectively, the Board will need to ensure that priorities are correctly informed. This will help to ensure that individuals and groups are not unfairly disadvantaged. The establishment of a local HealthWatch as a consumer champion will assist in reducing the risk of disadvantage as will the continued engagement with different service user and patient groups such as mental health and learning disabilities.

The Council is responsible for leading on the Joint Strategic Needs Assessments. Ensuring that the JSNA is accurate and based upon robust data will help to ensure that the correct priorities are developed and that these priorities then influence where resource is placed and most needed.

5.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

None.

BACKGROUND PAPERS USED IN PREPARING THIS REPORT:

- NHS White Paper 'Equity and Excellence: Liberating the NHS'
- Liberating the NHS: Legislative Framework and Next Steps
- Public Health White Paper 'Healthy Lives, Healthy People'
- Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health
- Healthy Lives, Healthy People: Transparency in Outcomes
- Health and Social Care Bill 2011

- NHS Operating Framework 2011/12

APPENDICES TO THIS REPORT:

- Appendix 1 – Shadow Health and Well-Being Board Terms of Reference
- Appendix 2 – Proposed Public Health Responsibilities

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