6th September 2011	ITEM 6
Health and Well-Being Overview and Scrutiny Committee	
Health Service Reform – Update Report	
Report of: Ceri Armstrong, Directorate Strategy Officer, Community Well-Being	
Wards and communities affected: All	**Key Decision:** Non-key
Accountable Head of Service: Janice Forbes-Burford, Project Director Health Transition, Community Well-Being	
Accountable Director: Lorna Payne, Corporate Director Community Well-Being	
This report is Public	
Purpose of Report: To update the Health and Well-Being Overview and Scrutiny Committee on the latest developments concerning health service reforms and how they impact upon the Council.	

EXECUTIVE SUMMARY

Health Service Reforms are evolving at speed. This report details the key changes that have been announced since the Health and Well-Being Overview and Scrutiny Committee last met and include:

- How the reforms have altered since the Government announced a 'pause' in the legislative journey of the Health and Social Care Bill – which includes GP consortia now being known as clinical commissioning groups (CCGs) and a stronger promotion of integrated care;
- How GP commissioning is developing in Thurrock with two CCGs and how arrangements have been broadened to include a wider range of clinicians and multi-agency professionals in clinical commissioning decisions;
- The latest structural changes and timescales for change including contraction of the number of SHA across the country; changes to the PCT structure and how the PCT is supporting the development of clinical commissioning;
- Detail about the authorisation process for Clinical Commissioning Groups (previously GP Consortia) and the Council's involvement;

- The latest news regarding HealthWatch development; and
- The key changes to be announced by the Government in response to the Public Health White Paper 'Healthy Lives, Healthy People'.

1. RECOMMENDATIONS:

1.1 That Health and Well-Being Overview and Scrutiny Committee note the contents of this latest update report.

2. INTRODUCTION AND BACKGROUND:

2.1 An overview of the planned health service reforms, how they were likely to impact upon the Council, and how the Council was preparing for the changes the reforms would bring about, was presented to the Committee at its June meeting. It had been previously agreed by the Committee that regular updates would be brought to each of its meetings as a standing agenda item. This report is the latest update.

2.2 Since June, a number of changes have occurred. These include:

- NHS Listening Forum recommendations and the Government's response – indicating how the proposed health service reforms were likely to alter, if at all;
- The confirmation of Clinical Commissioning Group pilots;
- Structural changes – such as Strategic Health Authority and PCT reorganisation and consolidation;
- Confirmation of the Clinical Commissioning Group authorisation process;
- Government announcement of HealthWatch pathfinders; and
- Government response to the Public Health White Paper consultation.

2.3 This paper summarises key points from the above changes – including how they impact upon the Council and what the Council is doing to prepare for the impact of the changes.

3. ISSUES AND/OR OPTIONS:

NHS Listening Forum Recommendations and Government Response

3.1 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'. The NHS Future Forum was established to consider submitted views and to make recommendations. The Council made its own response. The Future Forum made its recommendations

in June and the Government responded shortly after. The Government's response outlined how the reforms were likely to be amended – if at all.

3.2 Key proposed changes announced by the Government are:

- GP Consortia are now known as Clinical Commissioning Groups (CCGs) – to reflect wider clinical involvement;
- CCGs will be established by April 2013 – but some will not be fully authorised and will exist in 'shadow' form only;
- The NHS Commissioning Board will be responsible for 'authorising' CCGs – with key input from Health and Well-Being Boards;
- CCGs will have governing bodies – with at least two lay members and at least one nurse and one specialist doctor;
- Clinical Senates (multi-professional including social care) and Clinical Networks will provide advice to CCGs – ensuring that decisions made are clinically robust;
- Health and Well-Being Boards will have a stronger role in promoting joint commissioning and integrated provision – they will not have the right to 'veto' CCG plans, but can refer CCG commissioning plans back to the NHS Commissioning Board should they not reflect Health and Well-Being Strategies;
- CCGs will have stronger duties to promote care integrated around the needs of the user – there will be a 'duty to promote integrated health and social care around the needs of service users'; and
- The Government has confirmed that CCGs should not normally cross upper-tier local authority boundaries – unless they can demonstrate that this would be in the best interest of the community they serve.

Clinical Commissioning Group Pilots

3.3 The NHS Operating Framework 2011/12 announced plans to accelerate GP commissioning. This included the development of pathfinder GP consortia through which some budgetary responsibility would follow. The approval of the pathfinders would be managed by Strategic Health Authorities in a number of 'waves'. The process has continued now that GP consortia are to be Clinical Commissioning Groups.

3.4 In Thurrock, two prospective CCGs have had their pathfinder applications approved by the East of England SHA. These are: Thurrock Managed Care (17 practices, 96,000 population) and Multi-Consortium Commissioning Group (22 practices, 68,664 population). Some practices in Thurrock are still, at this moment in time, aligned with CCGs outside the Council's boundaries.

3.5 Representatives from both Thurrock pilot CCGs sit on Thurrock's shadow Health and Well-Being Board. In addition, Council officers (Head of Strategic Commissioning and Resources, and Project Director Health Transition) attend the management meetings of both CC groups.

3.6 Since Health and Well-Being Overview and Scrutiny Committee last met, the Primary Care Trust has undergone a major restructure. This has resulted in the

establishment of a Clinical Commissioning Transition Directorate under which sit four separate units aligned to CCGs. One of the units is aligned to Thurrock and will support the two current CCGs move towards authorisation. The Council will be working closely with the Chief Operating Officer (COO) of the Thurrock Clinical Commissioning Transition unit. It is recommended that the COO attends the Health and Well-Being Overview and Scrutiny Committee on occasion to provide a progress report – including how the work with the CCGs is helping to develop and promote integration between health and social care.

3.7 The Council is clear that Thurrock should have one Clinical Commissioning Group representing the needs of the population, and that the CCG should be co-terminous. It, and the Health and Well-Being Board, will want to see evidence as to why in particular having a CCG crossing Thurrock's boundaries is in the best interest of Thurrock's residents. The Portfolio holder for Health, Councillor Rice, recently wrote to the CCG to re-iterate that this is the Council's position. Currently this is not the case and the Council will continue to encourage alignment. It will continue to work both with the CCGs and the PCT to move towards the goal of one Thurrock CCG.

Structural Change

3.8 A number of structural changes and timescales for those changes to be implemented have been announced since the last report on Health Transition was made to the Committee. Key changes are summarised below.

3.9 **Strategic Health Authorities** – have been condensed to four 'clusters' and will now be abolished at the same time as Primary Care Trusts (end of March 2013).

3.10 **NHS Commissioning Board** – The NHS Commissioning Board will have full responsibilities as of April 2013. In the interim, areas covered by PCT clusters will act as 'local' arms of the Board and may carry out commissioning on behalf of those CCGs who are not fully authorised by April 2013. A 'shadow' NHS Commissioning Board will be in place as of October 2011 and will be able to authorise CCGs by October 2012.

3.11 **Clinical Commissioning Groups** – the expectation is that all CCGs will be established by April 2013, but that not all CCGs will necessarily be authorised to carry out the full range of responsibilities by that date. For example, those CCGs who are not ready or who cannot demonstrate they are ready to take on their commissioning responsibilities will not be authorised to do so. In this instance, the NHS Commissioning Board will undertake commissioning on their behalf.

3.12 **Primary Care Trust** – Primary Care Trusts have clustered and have recently undergone a complete restructure. Interviews are in the process of taking place for posts under the new structure. The restructure has included the development of the Clinical Commissioning Transition Directorate as discussed within paragraph 3.6. The restructure taking place across South Essex PCT Cluster has resulted in a South East and South West Public

Health Directorate being maintained. The rationale behind this is that the South East Public Health Directorate will align itself to Southend Council, and the South West Public Health Directorate will align itself to Thurrock Council. Both will need to continue to support parts of Essex County Council until final arrangements are developed and upper-tier local authorities take responsibility for elements of Public Health. The Council is continuing to work closely with the PCT – including the South West Essex Public Health Directorate.

Clinical Commissioning Group Authorisation Process

3.13 The Department of Health has recently issued guidance about the authorisation of CCGs – 'Developing clinical commissioning groups: towards authorisation'.

3.14 The guidance identifies six domains that CCGs will need to demonstrate competencies against. These are:

- A strong clinical and professional focus which brings real added value;
- Meaningful engagement with patients, carers and their communities;
- Clear and credible plans which continue to deliver the QIPP (Quality, Innovation, Productivity, and Prevention) challenge within financial resource in line with national outcome standards and local joint health and well-being strategies;
- Proper constitutional and governance arrangements with the capacity and capability to deliver all their duties and responsibilities, including financial control, as well as effectively commission all the services for which they are responsible;
- Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and
- Great leaders who individually and collectively can make a real difference.

3.15 The DoH has announced that there will be a phased approach – with the first phase being a 'risk assessment' of the proposed configuration of a CCG. This will take place from October 2011 and no later than December 2011. The risk assessment will look at issues such as geography, and any CCGs with boundaries not co-terminous with the Council needing to provide clear justification – e.g. demonstrating how this is in the best interest of both registered and unregistered patients. The risk assessment will also look at the viability of the CCG relating to its size. With two relatively small pilot CCGs and one non-coterminous CCG, the Council will want to watch the risk assessment process very carefully as there are currently issues concerning co-terminosity and size.

3.16 The Council will have a key role in the authorisation process and this has been confirmed in the guidance. For example, part of the process will use a

360 degree assessment where the views of partners will be taken in to the consideration. The Health and Well-Being Board will also have a key role as described earlier – e.g. they can refer commissioning plans back to the NHS Commissioning Board should they not reflect Health and Well-Being Strategies.

3.17 The Health and Well-Being Board will want to consider their part in the authorisation process, including locally discussing whether the Health and Well-Being Board should have an even stronger role.

HealthWatch Pathfinders

3.18 In May, the Council submitted an expression of interest in becoming one of the HealthWatch pathfinders. The Department of Health formally announced that Thurrock would be one of the HealthWatch pathfinders in August.

3.19 The Council has already established a working group jointly with Thurrock Local Involvement Network through which the pilot will be developed. An initial stakeholder event is being held on the 29th September to help to identify what a Thurrock HealthWatch's focus should be.

3.20 HealthWatch will become statutory as of October 2012 and the Council is developing the best commissioning model.

Government Response to Public Health White Paper

3.21 The Government published its response to the Public Health White Paper 'Healthy Lives, Healthy People' in July. Key points from the report 'Healthy Lives, Healthy People: update and way forward' include:

- Local authorities will have responsibilities across all three domains of public health reflecting that they are well placed to deal with the wider determinants of health (health improvement, health protection, and population healthcare) although some functions are still to be confirmed;
- The role of the Director of Public Health has been confirmed – including being the principal advisor on health to elected members and officials; being the officer responsible for delivering key new public health functions; being directly employed by Councils as a senior officer of the council; producing an annual report on the health of the local population; and leading on investing the ring-fenced grant;
- Local authorities will receive a ring-fenced grant (shadow grants are to be announced later this year) with the Government announcing that it will place 'only a limited number of conditions on the use of the grant' in order to maximise flexibility;
- Health and Well-Being Boards will be key to bringing the 'whole system together at a local level; and
- Public Health England will be established to bring together expertise from a number of different bodies.

3.22 The Council is working closely with the South West Essex Primary Care Trust Public Health Directorate, in particular the Interim Director of Public Health, to develop its plans. More solid plans can be developed once the size of grant to transfer to the Council is known later this year.

Next Steps

3.23 As the Committee will see, the Health Service Reforms are constantly evolving. The Council is continuing to take the necessary steps to both plan for and embed the changes. In summary, this includes:

- Continuing to build the relationship with the Clinical Commissioning Group pilots – e.g. through attendance at their management group meetings;
- Working alongside the PCT to develop plans – including the newly formed Thurrock Clinical Commissioning Transition Unit and the Unit's Chief Operating Officer;
- Being a pilot authority for both the Health and Well-Being Board and HealthWatch;
- Undertaking benchmarking and networking with other areas – mostly via being a pilot authority; and
- Further developing the shadow Health and Well-Being Board and its work plan.

4. CONSULTATION (including Overview and Scrutiny, if applicable)

4.1 Not applicable

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

5.1 The changes brought about by Health Service Reform will impact in particular on Priority 4 - Provide and commission high quality and accessible services that meet, wherever possible, individual needs.

6. IMPLICATIONS

6.1 **Financial**

Additional grant will be received by the Council for HealthWatch; NHS Complaints Advocacy; and Public Health responsibilities. Allocation options for HealthWatch are currently being consulted on and the shadow ring-fenced Public Health grant is due to be announced by the end of the year.

6.2 **Legal**

To be confirmed – but will include the standing of the Health and Well-Being Board as a 'committee of the Council'.

6.3 **Diversity and Equality**

A number of the changes are linked to the Joint Strategic Needs Assessment and the Health and Well-Being Strategy. Both will ensure that commissioning meets the needs of both the individual and the population – including recognising differences that may exist within the Borough.

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

N/A

BACKGROUND PAPERS USED IN PREPARING THIS REPORT:

- Government response to the NHS Future Forum Report
- Healthy Lives, Healthy People – Update and Way Forward
- Developing clinical commissioning groups – towards authorisation
- The Month (Department of Health) Special Edition June 2011

APPENDICES TO THIS REPORT:

- None

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