**Meeting:** **Social Care, Health and Housing Overview and Scrutiny Committee**

**Date:** **24th October 2011**

## Subject: Implications of Health Reforms for Central Bedfordshire

**Report of:** **Cllr Hegley, Executive Member for Social Care, Health and Housing**

**Summary:** The report outlines the major implications of recent health reforms for Central Bedfordshire Council

| | |
|---|---|
| Advising Officer: | Julie Ogley, Director of Social Care, Health and Housing |
| Contact Officer: | Celia Shohet, AD Public Health and John Rooke, Managing Director, Bedfordshire Clinical Commissioning Group |
| Public/Exempt: | Public |
| Wards Affected: | All |
| Function of: | Council |

**CORPORATE IMPLICATIONS**

**Council Priorities:**

1. The health reforms will see the council taking a leading role in improving, promoting and protecting the health of their communities. In addition the health and social care system will be brought together at a local level through the health and wellbeing boards. These will directly contribute towards the following council priorities:

- Supporting and caring for an ageing population
- Educating, protecting and providing opportunities for children and young people
- Creating safer communities
- Promoting healthier lifestyles.

**Financial:**

2. The council will be funded to carry out their new public health responsibilities through a ring-fenced grant. The size of the grant and the conditions on its use will be established nationally but work has taken base locally to determine current baseline spending. Shadow budgets are expected to be identified for 2012-13 by the end of this year with the grant being allocated for the first time in 2013-14.

3. There is an expectation that the health and wellbeing board will promote the pooling of budgets between the Clinical Commissioning Group and the Council to maximise benefits of joint commissioning

**Legal:**

4. None currently

**Risk Management:**

5. Not applicable

**Staffing (including Trades Unions):**

6. Discussions are taking place regarding the transition of public health staff to the Council in 2013 and an HR 'concordat' is being developed nationally between the NHS and local government employers.

**Equalities/Human Rights:**

7. An equalities impact assessment has not yet been conducted locally regarding the impact of the changes. This could be established once agreements have been reached nationally regarding the budgets, transition arrangements and responsibilities have been finalised.

**Community Safety:**

8. Not applicable.

**Sustainability:**

9. Not applicable.

**Procurement:**

10. Not applicable.

**RECOMMENDATION(S):**

**The Committee is asked to:-**

**1.** Note the new responsibilities of the council with regards to public health, the health and wellbeing board and the establishment of local healthwatch.

**2.** Note the proposed configuration and arrangements for the Bedfordshire Clinical Commissioning Group

**Introduction**

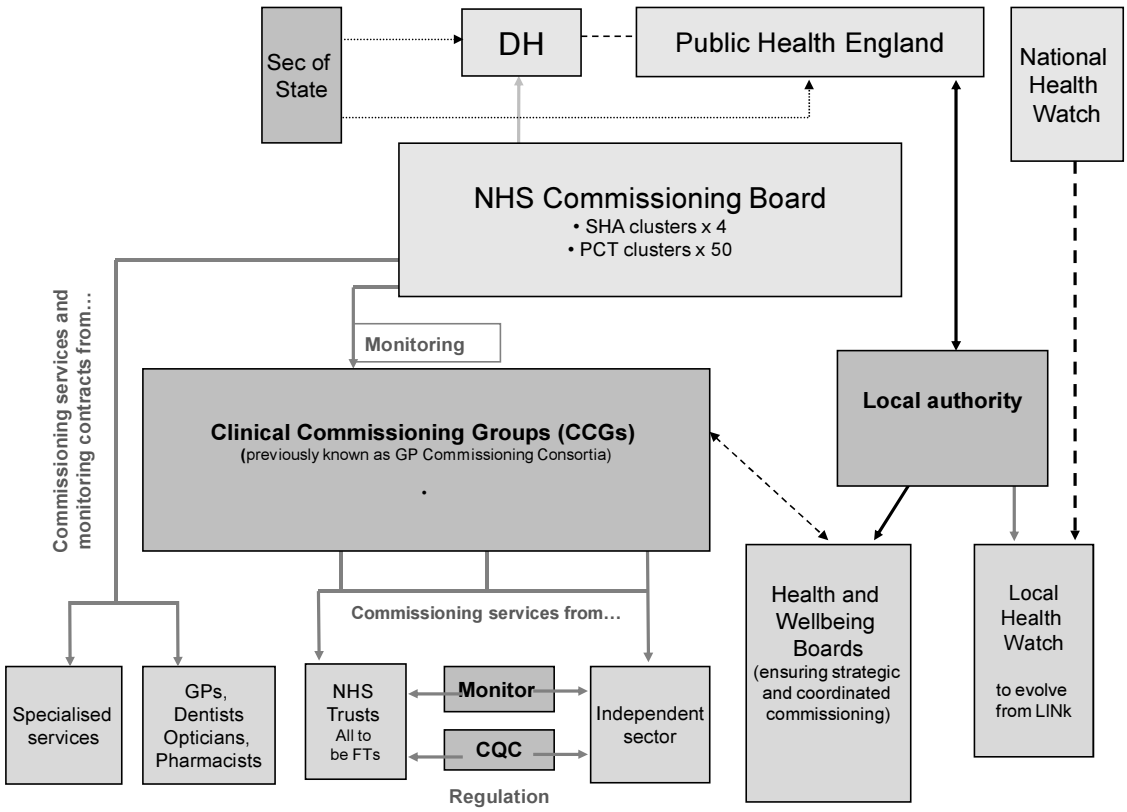
11. The Health and Social Care Bill represents a major restructuring, not just of health care services, but also of council's responsibilities in relation to health improvement and the coordination of health and social care.

12. The main aims of the Bill are to change how NHS care is commissioned through the greater involvement of clinicians and a new NHS Commissioning Board; to improve accountability and patient voice; to give NHS providers new freedoms to improve quality of care; and to establish a provider regulator to promote efficiency. In

addition, the Bill will allow the creation of Public Health England, and take forward measures to reform health public bodies.

**Overview of the structure**

13. The figure below shows how the landscape is expected to look in 2013.




14. In brief Local Authorities will have responsibilities across all three domains of public health and will be required to deliver certain public health services. They will also be required to commission local health watch organisations which will replace the current Local Involvement Networks (LINk). The whole system will be brought together locally through the health and wellbeing boards.

**Devolution of power and responsibilities for the commissioning of NHS services**

15. The Secretary of State will continue to be under a duty to promote a comprehensive health service and will also have direct responsibility (with local authorities) to protect and improve public health.

16. The NHS Commissioning Board (NCB) will have broad overarching duties to promote the comprehensive health service (other than in relation to public health) The four newly clustered SHAs (Central Bedfordshire is within the NHS Midlands

and East cluster) are to become part of the sub-national structure known as 'commissioning sectors'. The recently clustered Primary Care Trusts (Central Bedfordshire is within the Bedfordshire and Luton Cluster) are to become 'local branches' of the NCB initially.

17. The expectation that the majority of NHS provider trusts will have become foundation trusts (FT) by April 2014 remains. There is an expectation that trusts not having achieved FT status by this point may be subject to a streamlined process for mergers and acquisitions. The Luton and Dunstable Hospital is already an FT with Bedford NHS Hospital Trust having applied but not yet gained FT status. There is an 'Acute Services Review' covering Bedfordshire, Milton Keynes, Northampton, Kettering and Luton that may have a significant impact on future acute care.

**Establishment of Clinical Commissioning Groups**

18. Clinical Commissioning Groups will be responsible for commissioning the majority of health services. Locally it is proposed that the Bedfordshire Clinical Commissioning Group (BCCG) will be established covering the geographical area of Central Bedfordshire and Bedford Borough. The Local Government Group, in its response to the listening exercise, recommended that coterminosity with local authorities was a requirement of the CCGs. However the health and social care bill currently in the House of Lords allows for boundaries to be crossed when this can be justified in terms of benefits to patients and integration of health and social care services. The national guidance and criteria recently issued to CCGs for authorisation supports the proposed configuration in Bedfordshire. The proposed governance and management structures of the consortium have been developed to directly support and engage with the two Unitary authorities. Two senior Clinical Director posts have been created, and are currently being recruited to. These will provide dedicated focus at each LA area in delivering change projects, supporting the work of H&WB Boards and leading the better integration of health and social care. The localities within the consortium will also provide the critical links operationally with the authorities. The Director of Public Health is a joint appointment to the PCT and both Local Authorities and a CCG Board member.

19. The Bedfordshire CCG has a clear vision signed up to by its constituent members.

*The shadow Bedfordshire Clinical Commissioning Consortium, working with its partners and stakeholders, aims to deliver the best possible outcomes to its patient population through innovative, responsive and effective clinical commissioning.*
The CCG is committed to the delivery of specific goals for the population of Bedfordshire. These include:

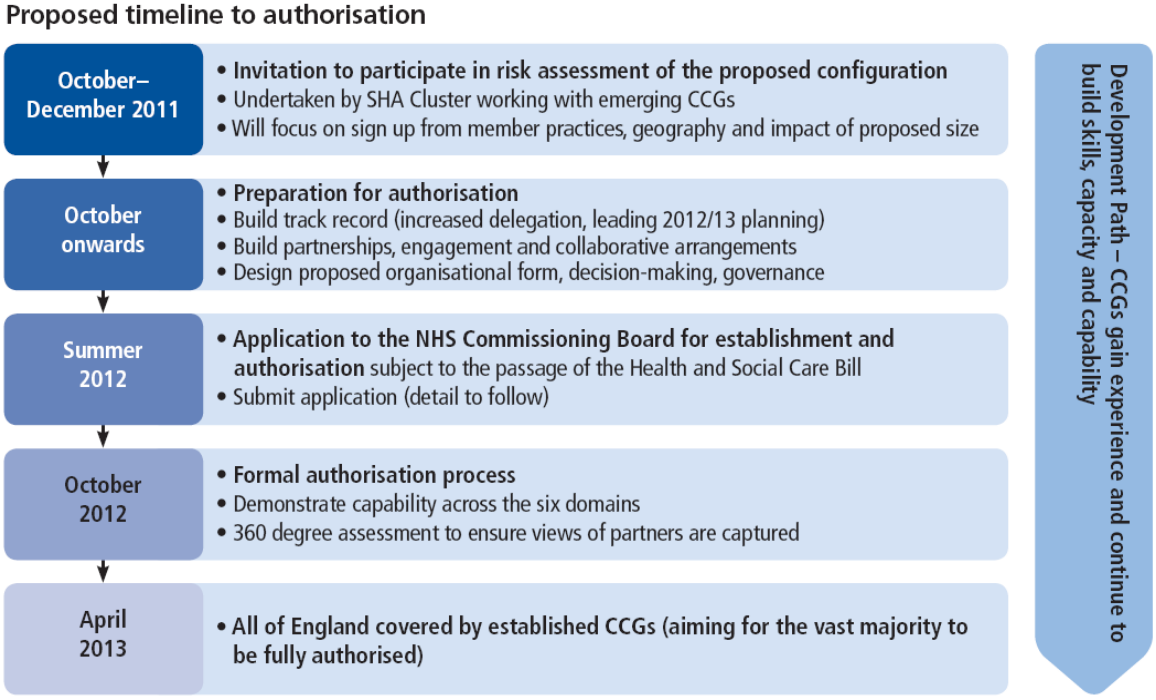
- To improve the health and wellbeing of the population in Bedfordshire and its local communities in a fair and transparent way
- To reduce unfairness in health and reduce health inequalities
- To ensure a better healthcare experience for the population of Bedfordshire
- To ensure that the people of Bedfordshire have more choice and access to high quality, safe, clinically and cost effective local health services
- To provide patients with a greater say and choice

20. The process by which CCGs will be authorised has recently been published by the Department of Health. The chart below shows the overall framework. 6 'domains' have been identified against which each CCG will be assessed. These are;

    1. Clinical Focus and Added Value
    2. Clear and credible plans which continue to deliver QIPP and local joint health & wellbeing strategies
    3. Meaningful engagement with patients, carers and their communities
    4. Capacity and capability including constitutional and governance arrangements
    5. Collaborative arrangements with other CCGs and local authorities
    6. Leadership capacity and capability

21. Local Authorities and Health and Wellbeing Boards will play an important role in the authorisation process and in informing the final decision of the National Commissioning Board

22. The national timetable is shown in the chart over page. The earliest a CCG could be authorised is expected to be October 2012 depending on the establishment of the NCB. The Bedfordshire CCG is aiming to be in the 1st wave of authorised CCGs.




**A new role for Local Authorities**

23. A new national body, Healthwatch England, will be established as a statutory committee within the Care Quality Commission. In addition local Healthwatch organisations will be established within in each local authority area. The Government's health and social care reforms are centred on the fundamental principle that patients and the public must be at the heart of everything health and care services do. Health Watch will be the independent consumer champion for

the public to promote better outcomes in health for all and in social care for adults.

24. A steering group has already been established to commission the councils local health watch in 2012.

25. The establishment of health and wellbeing boards provide an opportunity to strengthen democratic legitimacy and join up commissioning across the NHS, social care and public health. They will have a strong role in the development of local commissioning plans, responsibilities to promote joint commissioning and integration, and a lead role in local public involvement. In addition the board will be able to refer commissioning plans back to BCCG if it felt that it took insufficient account of the local health and wellbeing strategy, which should be based on the needs identified within the joint strategic needs assessment.

26. The council's health and wellbeing board has already met in shadow form and has started to identify it's priorities for improving the health and wellbeing of the residents of Central Bedfordshire.

27. Central Bedfordshire Council will have responsibilities across all three domains of public health – health improvement, health protection and population healthcare and will be required to deliver certain services. Directors of Public Health (DsPH) will be a senior officer of the council reporting to the Chief Executive. The Council and their DsPH will be required to provide advice and clinical support to BCCG.

28. The public health responsibilities of the council are likely to include tobacco control, alcohol and drug misuse, obesity and community nutrition, physical activity, public mental health, dental public health, workplace health and supporting/reviewing NHS delivered public health services such as immunisation programmes.

29. There is currently a lack of detail regarding size of the public health ring-fenced budget or the nature of restrictions which may be placed on its use. Further clarity is awaited about the role of Public Health England, its relationship with local government and its budget.

**Conclusion and Next Steps**

X

30. The scale of change to the health system is significant and at the same time as the NHS needs to deliver huge productivity savings, which will be challenging. The productivity savings required and the actions to deliver these are outlined within the QIPP (Quality, Innovation, Productivity and Prevention) programme. Summaries of the QIPP plan for Bedfordshire can be found at www.bedfordshire.nhs.uk and for Luton at www.luton.nhs.uk

31. The council will have new responsibilities around public health and as a result to further improve public health outcomes. The Public Health outcome framework (summary attached as an appendix) is currently in draft form with the final version expected by the end of 2011.

32. The transition arrangements for public health to the council are being agreed as far as possible given the current lack of clarity around the public health budget and the HR framework for public health staff.

33. The establishment of the health and wellbeing board will provide welcome opportunities to promote joint commissioning and integration.

34. The BCCG was established formally as a sub-committee of the PCT on 7 September. A clinical Chair and Chief Operating Officer have been appointed, with further appointments underway. It is now in the process of building an Organisational Development Plan that will enable the new organisation to be fit for purpose.

35. The local Health Watch will be commissioned and funded via the council by April 2012. Health Watch will be accountable for operating effectively and providing value for money.

## 1 Health protection and resilience

**Objective**

Protect the population's health from major emergencies and remain resilient to harm

**Improvement areas**

- Organisational plans and preparations are in place to enable a coordinated, proportionate, timely and effective response to major emergencies.
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.
- Life years lost from air pollution as measured by fine particulate matter
- Population vaccination coverage (for each of the national vaccination programmes across the life course)
- Treatment completion rates for TB
- Proportion of public sector organisations with a board approved sustainable development management plan.

| *Key* | |
|---|---|
| | Measure is replicated in DH's proposed contribution to the cross-Government Transparency Framework |
| | Consistent with indicators in the NHS Outcomes Framework for 2011/12 |
| | Consistent with the proposed adult social care outcome measures |

# DRAFT Public Health Outcomes Framework

Overview of outcomes and indicators

## 2 Tackling the wider determinants of ill health

**Objective**

Tackling the wider determinants of health

**Improvement areas**

- Children in poverty
- Housing overcrowding rates
- Rates of adolescents not in education, employment or training at 16 and 18 years of age
- Truancy rate
- New entrants to Youth Justice System by 18 years of age
- Proportion of people with serious mental illness in accommodation
- Proportion of people with serious mental illness in employment
- Proportion of people in long-term unemployment
- Repeat incidents of domestic abuse
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise
- Older people's perception of community safety
- *Social connectedness*
- Rates of violent crime, including sexual violence
- *Cycling participation*

## 3 Health improvement

**Objective**

Helping people to live healthy lifestyles and make healthy choices

**Improvement areas**

- Prevalence of healthy weight in 4-5 and 10-11 year olds
- *Prevalence of healthy weight in adults*
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)
- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds
- Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)
- *Self reported wellbeing*

## 4 Prevention of ill-health

**Objective**

Reducing the number of people living with preventable ill health

**Improvement areas**

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breast feeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- *Child development at 2 - 2.5 years*
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge
- Health-related quality of life for older people
- Acute admissions as a result of falls or fall injuries for over 65s
- *Indicator based on the 'NHS Health Check'*
- *Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed*

## 5 Healthy life-expectancy and preventable mortality

**Objective**

Preventing people from dying prematurely

**Improvement areas**

- Infant mortality rate
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all circulatory disease (including heart disease and stroke) in persons less than 75 years of age
- Mortality rate from cancer in persons less than 75 years of age
- Mortality rate from chronic liver disease in persons less than 75 years of age
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age
- Mortality rate of people with serious mental illness
- Excess seasonal mortality