ITEM 14

BRIEFING NOTE

Health and Social Care Bill 2010-11

The Health and Social Care Bill was introduced in the House of Commons on 19 January 2011. Following its second reading on the 31 March 2011, and it had completed its committee stage in the House of Commons, the Health Secretary announced that there would be a break in the passage of the Bill.

The NHS Future Forum was set up by the Government as an independent group to review the Health and Social Care Bill and consisted of 45 members. The group reported it findings and recommendations to the Government and on 14 June 2011 the Health Secretary announced changes to the Health and Social Care Bill based on the recommendations from the Forum.

By 21st December 2011, the H&S Care Bill had reached the House of Commons second reading and is now awaiting the 'report' stage (date as yet to be agreed) at which each line and amendment will be considered in detail. The Bill will then pass to adoption of agreed amendments and achieve Royal Assent later in 2012.

Summary of the Bill

The principles of good quality health care, still available free of charge to patients, remain true. The Health and Social Care Bill proposes to create an independent NHS Commissioning Board, promote patient choice, and to reduce NHS administration costs. It removes a number of the traditional structures of Strategic Health Authorities and Primary Care Trusts, which will continue to work in parallel until the new structures are firmly in place from 2013.

Local authorities are required to establish new health and wellbeing boards. They bring together elected representatives, local HealthWatch (who will represent people who use services) and health and social care commissioners, such as GPs and directors of public health, to plan the right services for their area.

Local authorities will also be responsible for public health, working closely with the NHS, focusing on how to support people to lead healthier lives and ensuring the public are protected from threats to their health such as a flu pandemic.

The main aims of the Bill are to change how NHS care is commissioned through the greater involvement of GPs (into Commissioning consortia) and a new Commissioning Board; to improve accountability and patient voice; to give NHS providers new freedoms to improve quality of care; and to establish an economic regulator to promote efficiency.

In addition, the Bill will underpin the creation of Public Health England, and take forward measures to reform health public bodies. 60 per cent of NHS budget is to be transferred to clinical commissioning groups (formerly named GP commissioning consortia) to commission the majority of local health services.

Key areas

- establish an independent NHS Commissioning Board to allocate resources and provide commissioning guidance
- increase GPs' powers to commission services on behalf of their patients
- strengthen the role of the Care Quality Commission (this will include more recent announcements regarding the review of both residential home standards/payments, and in-home care provision)

BRIEFING NOTE

- develop 'Monitor', the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS
- cut the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.

How the Bill will affect local authorities

The Bill states that 'Each local authority must take such steps as it considers appropriate for improving the health of the people in its area.' (*in the legal advice accompanying the Bill the term 'local authority' means upper tier and unitary local authorities, although there will be elements of local delivery and representation which will affect second tier, i.e. district, authorities too which are identified where applicable.)*

The Bill is divided into 12 parts and part 5 specifically relates to local government.

Part 5 – Public involvement and local government

Currently the responsibility for providing or securing the provision of all health services as set out in the NHS Act, is a function which is largely delegated to Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). However, the new commissioning structure proposed by the Bill means that the Secretary of State would have the duties described above. Direct responsibility for securing the provision of these services would be conferred on the Board and commissioning consortia.

SHAs will remain in place until the end of March 2013. The NHS Commissioning Board and other new national bodies will take up their full accountability and financial responsibilities from 1 April 2013.

Chapter 2 deals with the health scrutiny functions of local authorities and makes provision for the establishment of Health and Wellbeing Boards in each upper tier local authority area.

Health and Wellbeing Boards

It sets out their role in preparing the joint strategic needs assessment, the joint health and wellbeing strategy and in promoting integrated working between NHS, public health and social care commissioners; during the consultation phase, it has been suggested that the role of Health and Well Being Boards be strengthened to

- enable them to promote joint commissioning or act as lead commissioner if necessary
- play a stronger role in the development of commissioning plans and
- be able to refer plans back to the NHS Commissioning Board or commissioning groups if they are not satisfied with them.

Health and wellbeing boards will have a formal role in the authorisation of clinical commissioning groups and will lead on local public involvement.

These proposed amendments are still subject to agreement in the final paper.

ITEM 14

BRIEFING NOTE

The Herts Health and Wellbeing Board was established in 2011, with representatives from the health and social care sector, the Links/Healthwatch, Herts County Council, Director of Public Health and, for local authorities, two Herts districts, one of which is NHDC. The member representative is Cllr Lynda Needham, Leader of the Council and NHDC officer representative on the HWB strategy group is Liz Green, Head of Policy and Community Services.

Health Scrutiny

The responsibility for Health Scrutiny remains with upper tier/unitary authorities, with districts/boroughs playing their part by participation in the process, identifying local issues etc. The original Bill proposed restrictions being imposed on health scrutiny with the ability to use power of referral to the Secretary of State for significant changes to designated services only – however, the feedback from the consultation now appears to suggest that these restrictions will be lifted and some degree of citizens 'right to challenge' poor services and lack of choice may be granted as an option in due course. Following amendment being approved, this will follow in formal guidance supporting the H&S Care Act in due course and be relayed via the Herts Health Scrutiny network.

Commissioning Consortia

The Bill would create a comprehensive system of commissioning consortia – following reaction to the consultation which proposed solely GP focussed commissioning bodies, the Government 'stall' in proposals allowed the development of wider, multi agency commissioning proposals which will include nursing and other clinical staff, as well as practice management and associated professionals delivering community services. Their purpose would be to commission most NHS services, supported by and accountable to the NHS Commissioning Board.

There are three commissioning consortia now established in Hertfordshire – east and north herts, a southern/western consortia and one single practice consortia at Red House in the south west of the county.

DofH: Public Health in Local Government update - December 2011

Local government leading for public health

Throughout this briefing paper, the use of the term 'local government' refers to upper tier (county) or unitary authorities – requirements devolved to districts and boroughs are restricted to those areas within their scope of operation/responsibilities.

Local government has a long and proud history of promoting and protecting the public's health dating back to Victorian times. It was only in 1974 that the NHS took over most public health functions. The Government is returning responsibility for improving public health to local government for several reasons, namely their:

- population focus and engagement with members of the local community
- ability to shape services to meet local needs
- ability to influence wider social determinants of health
- ability to tackle health inequalities.

ITEM 14

BRIEFING NOTE

Population focus

Local authorities are democratically accountable stewards of their local populations' wellbeing, previously captured within the general 'powers of well being' afforded to them. They understand the crucial importance of "place"; that the environment within which people live, work and play, their housing, the green spaces around them, opportunities for work and leisure, are all crucial to their health and wellbeing.

Taking a population perspective, which is at the heart of public health, is a natural part of the role of local government. The intention is that an integrated public health function in local government at both strategic and delivery levels offers exciting opportunities to make every contact count for health and wellbeing. Local authorities have considerable expertise in building and sustaining strong relationships with local citizens and service users through community and public involvement arrangements, which will help extend the engagement of local people in the broader health improvement agenda.

Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live work and age, including the health system. The strength of the evidence linking social determinants to good and poor health has been clearly demonstrated in the Marmot Review (2010) (*Fair Society, Healthy Lives*). Social determinants are one of the main mechanisms driving health inequalities.

Tackling health inequalities

Local authorities have ample experience of the reality of health inequalities; many of the social determinants fall within their ambit, so they can assist in the prevention of inequalities across a number of functions, such as housing, economic and environmental regeneration, strategic planning, education, children and young people's services, fire and road safety.
The Director of Public Health, located within the upper tier local authority, will be well placed to bring health inequalities considerations to bear across the whole of the authority's business, and to think strategically about how to drive reductions in health inequalities, working closely with the NHS and other partners.

However, they will also need to look more widely at issues such as crime reduction, violence prevention and reducing reoffending, which may also prevent health inequalities. They can do this through links to existing partnership working and through new relationships, for example with incoming Police and Crime Commissioners.

Looking forward

In one sense the Health and Social Care Bill can be seen to be returning public health home. But at the same time local government has changed hugely since 1974, as have the issues for people's health. In particular, there have been major gains from the close integration of public health with clinical services, not least a greater focus on prevention, on prioritisation and on reaching the whole population.

Local government for its part has also moved on having taken on a key role in promoting economic, social and environmental wellbeing at local level, and it is considered ideally placed to adopt a wider wellbeing role.

ITEM 14

BRIEFING NOTE

Government vision for local government leadership of public health

The vision is for local authorities to use their new responsibilities and resources to put health and wellbeing at the heart of everything they do, thereby helping people to lead healthier lives, both mentally and physically.

This means:

- including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- investing the new ring-fenced grant (at county level) in high-quality public health services;
- encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will show what a healthy population can do for their local community
- tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, or provide an end to end service i.e. GP visit and referral, to hospital treatment, to rehabilitation and home care/support.
- making effective and sustainable use of all resources, using evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent the best possible value for money for local citizens.

Public Health England will have a key role in sharing and signposting evidence on the most effective, including cost-effective interventions to improve and protect public health.

This will mean working with a wide range of partners, not least the third sector, including through the shared leadership of health and wellbeing boards. They will be supported in this by HealthWatch, which will better enable people to help shape and improve health and social care services at both a national and, through its seat on the local health and wellbeing board, the local level; this work is already happening, but with the new powers and new resources proposed it will be possible to take this joint work further.

Local government's new public health functions

Subject to Parliament, each upper tier and unitary local authority in England will take on a new duty to take such steps as it considers appropriate for improving the health of the people in its area.

An obvious way in which local authorities will fulfil this duty will be commissioning a range of services from a range of providers from different sectors, working with clinical commissioning groups and representatives of the NHS Commissioning Board to create as integrated a set of services as possible.

However, local authorities can fulfil this duty in a wide range of ways, including

- the way they operate the planning system,
- policies on leisure,
- provision of open spaces and promoting their use

- key partnerships with other agencies for example on children's and young people's services,
- promoting cessation of smoking for their population and workforce

In all they do, local authorities will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues.

The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

The role of the Cabinet lead for health within a council is critical, but there needs to be a much broader engagement in this agenda among all local politicians.

It will be vital that district councils are closely involved in the development and implementation of local strategies, and that existing health and wellbeing partnerships in two-tier areas are built on in the creation of the new system.

Commissioning

In *Healthy Lives, Healthy People: Update and way forward* we published a provisional list of what should be funded from the public health budget, and who the principal commissioner for each activity should be.

The aim is to create a set of responsibilities which clearly demonstrate local authorities' leadership role in:

• tackling the causes of ill-health, and reducing health inequalities
• promoting and protecting health
• promoting social justice and safer communities.

The list of new local authority responsibilities is set out in the Public Health in Local Government: Commissioning responsibilities factsheet.

Local authorities will also wish to work with clinical commissioning groups to provide as much integration across clinical pathways as possible, maximising the scope for upstream interventions. The health and wellbeing board will be critical to driving this agenda.

The synergies and implications arising from the Open public services white paper proposals

The recent Open Public Services White Paper outlines how modernising public services, ensuring high quality and accessibility, requires increased choice, wherever possible, and public services that are open to a range of providers.

It highlights the role that staff-led enterprises have to play in meeting the Government's commitment to improving choice and quality in the delivery of healthcare services. This right to provide enables staff to consider a wide range of options, including social enterprise, staff-led mutuals, joint ventures and partnerships, putting them in a strong position to deliver improvement in health outcomes. It will also provide a vehicle to improve access, address gaps and inequalities and improve quality of services where users may have identified variable quality in the past.

ITEM 14

BRIEFING NOTE

Increasing the number of service providers, maximising user choice, will allow providers to compete for services within the market – a process which is less bureaucratic than traditional procurement by competitive tender, although changes will be required to local authority procurement rules under new guidance to be issued.

Local authorities are also in an excellent position to test out new and joint approaches to payment by outcomes, such as reducing drug dependency and to extend such approaches with external investment, such as the proposals being developed on social impact bonds to improve services and outcomes.

Mandatory steps

The Health and Social Care Bill includes a power for the Secretary of State for Health to prescribe that local authorities take certain steps in the exercise of public health functions, including that certain services should be commissioned or provided.
The purpose of this power is not to prioritise some services over others, but to ensure greater uniformity of provision. In others the Secretary of State for Health is currently under a legal duty and needs to ensure that that obligation is effectively delivered when a function is delegated to local government (the provision of contraception is an example).

The mandatory services and steps that were identified in *Healthy Lives, Healthy People: update and way forward* included:
• appropriate access to sexual health services
• steps to be taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
• ensuring NHS commissioners receive the public health advice they need
• the National Child Measurement Programme
• NHS Health Check assessment.

Government previously signalled that it would be mandating elements of the Healthy Child Programme 5-19. More work is still required to model the impact of making any elements of the programme mandatory to ensure value for money. We do not intend to mandate any elements of the programme for 2013.

The role of the Director of Public Health

In taking forward their leadership role for public health local authorities will rely heavily on the Director of Public Health and the specialist public health resources he or she has at their command. Indeed the Health and Social Care Bill makes clear that the Director of Public Health is responsible for exercising the local authority's new public health functions.

Responsibilities

The Director of Public Health 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 Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. Directors of Public Health 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.

ITEM 14

BRIEFING NOTE

The Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality.

With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

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Way forward

The Director of Public Health's new role offers a great opportunity to build healthier communities. But to make the most of this Directors of Public Health will need to:

• be fully engaged in the redesign of services that address the coming challenges
• influence and support colleagues who have a key role in creating better health, such as planning officers and housing officers
• facilitate innovation and new approaches to promoting and protecting health, while bringing a rigorous approach to evaluating what works, using the resources of Public Health England
• contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

Commissioning responsibilities

Local authorities will be responsible for:

• tobacco control and smoking cessation services
• alcohol and drug misuse services
• public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
• the National Child Measurement Programme
• interventions to tackle obesity such as community lifestyle and weight management services
• locally-led nutrition initiatives
• increasing levels of physical activity in the local population
• NHS Health Check assessments
• public mental health services
• dental public health services
• accidental injury prevention
• population level interventions to reduce and prevent birth defects
• behavioural and lifestyle campaigns to prevent cancer and long-term conditions
• local initiatives on workplace health
• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
• comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
• local initiatives to reduce excess deaths as a result of seasonal mortality
• the local authority role in dealing with health protection incidents, outbreaks and emergencies
• public health aspects of promotion of community safety, violence prevention and response

public health aspects of local initiatives to tackle social exclusion
• local initiatives that reduce public health impacts of environmental risks.

Abortion Services proposal and consultation

Given the highly clinical, and in most cases surgical, nature of abortion provision we have reconsidered our earlier decision to place these services with local authorities. We have provisionally concluded that abortion should remain within the NHS and be commissioned by clinical commissioning groups. However, we are keen to seek a range of views on this revised commissioning route. A consultation on this revised recommendation will begin in due course.

Health protection plans

At present Directors of Public Health in primary care trusts play a key leadership role in planning for, and responding to, health protection incidents, supported by local Health Protection Agency health protection units. Subject to Parliamentary approval, the Health and Social Care Bill will provide that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population.

Under this duty, local authorities (and Directors of Public Health on their behalf) would be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services including, for instance, coordination of outbreak control, and access to national expert infrastructure as and when necessary.

With regard to emergencies, the following will apply. At the Local Resilience Forum (LRF) level, a lead Director of Public Health from a local authority within the LRF area will be agreed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.
The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.
Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

ITEM 14

BRIEFING NOTE

LHRPs are a formalisation of existing health subgroups found in the majority of LRF areas. They will enable all health partners to input to the LRF and in turn provide the LRF with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats. Further work will be done over the coming months to pilot and plan the resourcing and operation of LHRPs.

More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model.

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Population healthcare advice to the NHS

We will also mandate local authorities to provide population healthcare advice to the NHS. Good population health outcomes, including reducing health inequalities, rely not just on health protection and health improvement, but on the quality of healthcare services provided by the NHS. That is why we are preserving a key role for local authority public health teams in providing public health expertise for the NHS commissioners of these services.