REPORT TO CABINET

Title:	**Update on Implementation of NHS White Paper 'LIBERATING THE NHS'**
Date:	31 March 2011
Member Reporting:	Councillor Dudley (Lead Member for Adult and Community Services)
Contact Officer:	Christabel Shawcross, Strategic Director of Adult & Community Services – 01628 796258
Wards affected:	All

1. SUMMARY

1.1 The purpose of the report is to update Members on NHS policy changes, and to provide a summary of issues arising from publication of NHS White Paper on Public Health (November 2010) – which sets out public health functions, and to confirm the setting up of a Health & Wellbeing Board chaired by the Lead Member for Adult & Community Services.

1.2 It also provides a summary of NHS changes and timetable set out in 'Liberating the NHS: Legislative framework and next steps' (January 2011). A national and local key issue for RBWM is how to improve democratic legitimacy in health service developments, as set out in options for a Health & Wellbeing Board. The DoH is also inviting LAs to register as 'Early Implementers' of Health & Wellbeing Boards (HWB) to join a national network to contribute to policy development and learn from developments elsewhere.

1.3 The work programme of the RBWM Project Board has taken forward the above issue, and looked at options with the Lead Member of Adult & Community Services. As PCT's will cease April 2013 and transfer most functions to local GP commissioning consortia, the local authority is in an excellent position to early on influence health commissioning and public health improvements with the early implementation through a Health & Wellbeing Board. The recommended option is to confirm becoming an 'Early Implementer' setting up a Health & Wellbeing Board in RBWM to focus on improving health and social care outcomes for local residents.

2. Recommendation:

(1) To agree that the Lead Member for Adult and Community Services and the Director of Adult & Community Services set up a RBWM Health & Wellbeing Board as part of Council structures with democratic services from July 2011.

(2) To agree that a report is brought to Cabinet in November 2011 on progress nationally and locally and timetable for key decisions on public health changes

What will be different for residents as a result of this decision?
Improved health and well being for residents through influencing commissioning of GP consortia and ensuring health and social care services have joined up delivery to vulnerable residents.

3. SUPPORTING INFORMATION

3.1 Background

3.1.1 There has been significant progress nationally and locally since the last Cabinet paper on 20th July 2010. There has been:

- establishment of RBWM Project Programme Board
- establishment of four sub-groups:
  i. Health & Wellbeing Board
  ii. Collaborative Commissioning
  iii. HealthWatch
  iv. Public Health specific changes
- temporary project manager seconded from GOHSE (initially for three months), the post is now vacant and is to be funded short term with development fund budget
- a health and social care facilitated workshop by the DoH on collaborative commissioning – December 13th involved a scrutiny representative and considered the Health & Wellbeing Board structure
- a response was sent to the DoH on increasing democratic legitimacy of the NHS
- Berkshire Chief Executive's commissioned Berkshire Directors of Adult Services (DAS) for options paper on Director of Public Health (DPH) post(s) and options for sharing of posts see para 3.13.1.

3.2 Improving Health Outcomes for local residents through influencing health priorities and developments will be a core responsibility of the Health & Wellbeing Board

3.2.1 Following consultation on the NHS and democratic legitimacy DoH has modified some proposals to significantly strengthen the role of Health & Wellbeing Boards. This is a new requirement to enhance joint working arrangements through a new responsibility to develop a 'joint Health & Well Being Strategy'. Both LA and crucially GP commissioners will be requested to have regard to this. In addition DoH will accelerate introduction of Health & Wellbeing Boards through a new programme of Early Implementers.

3.2.2 The response also confirms that the scrutiny and health and well being roles will be distinct and separate. Scrutiny will be strengthened and this is detailed in para 3.16.

3.2.3 The key statutory function to be taken on by LA's to benefit its residents is the major responsibility for improving health outcomes. Upper tier local authorities will be required to establish a Health and Wellbeing Board by 2013.

3.2.4 Health & Wellbeing Outcomes

3.2.4.1 It is expected the Board will provide a key forum for public accountability of the NHS, Public Health, Adult Social Care, Children's Services and other commissioned services that the Board considers relevant. Whilst the emphasis is on influencing NHS plans, GP consortia will be required to have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health & Wellbeing Strategy (JHWS) and to inform NHS Commissioning Board that the H&WB agrees their plans are adequate in this regard. This a key and new area of influence for the local authority.

3.2.4.2 The leadership role of the local authority in improving health outcomes will be evidenced through the success and achievements of the Health & Wellbeing Board strategy and should become the 'place to do business' and join up service health and social care integration across Adults and Children's Services. This should incorporate wider determinants of health such as housing, education and employment.

3.2.5 Proposed Statutory Functions

These are:

- Developing Health & Wellbeing Strategy (new statutory)
- Joint Strategic Needs Assessment (existing statutory)
- Action plan and monitoring (new statutory)
- Agreeing priorities and how to spend public health budget (from 2013)
- Influencing GP Commissioning
- Ensuring health and social care are integrated to benefit residents

- Patient and resident influence on commissioning through HealthWatch having place on board (statutory).

- Patient and resident experience of quality of service. (It is unclear how this will fit between Health and Wellbeing Boards, setting direction and commissioning for quality, and scrutiny role in scrutinising the what and how and qualitative aspects.)

- Monitoring and delivering Public Health Outcomes Framework.- Health and Wellbeing Boards will be responsible for delivering some of the outcomes measures set out in the proposed Public Health outcomes framework. In particular, those measures will relate to the wider determinants of health e.g. Children in poverty, overcrowded households and access to green space. The 'health premium' will act as a financial incentive depending on the progress made to reduce health inequalities.

- Agreeing priorities for Health Improvement budget (2013) whilst building on current arrangements will be necessary in the short term, as they were set up to deliver LAAs and is proposed to fundamentally reshape the current partnership groupings, so they are fit for purpose and can deliver on the new Health & Wellbeing agenda.

3.2.6 The local NHS Changes Board and Lead Member for Adult & Community Services and Children's Services consider this is a significant opportunity to grasp early, to shape and influence strategic changes, in what is and will be a very fluid NHS environment. The local authority as the constant throughout the implementation has significant support to offer the local NHS, to ensure better services for residents. Discussions between the Strategic Health Authority Chairman and Lead Member for Adult & Community Services confirmed their support for the LA taking this lead.

3.2.6.1 Proposed local agendas could be based on current and new commissioning priorities.

1. Joint Strategic Needs Assessment – agreement on priorities and developments (currently led with PCT)
2. Development of Health and Wellbeing Strategy (new statutory requirement)
3. Oversight, monitoring, sign off of Adult Social Care Planning for Growth
4. Integration of Mental Health Community Team with Berkshire Healthcare Trust
5. Dementia Strategy
6. Integration of Intermediate Care and Social Care reablement provision with Berkshire Healthcare Trust. Formal S.75 to be agreed
7. Children's Plan

3.2.7 How will the Health & Wellbeing Board work effectively?

3.2.7.1 Core Membership (minimum required)

- Mayor (directly elected) or Executive Lead Member
- Director of Adult Social Care
- Director of Children's Services
- Director of Public Health
- Health Watch
- Local DoH Commissioning Board (for specific topics)
- GP Commissioning representative
- Other reps to be locally agreed from partnerships / stakeholders.

It is up to local areas to determine membership, the above is minimum and the Lead Member as part of the executive is expected to be on the Board.

There is a need to separate out those who are commissioners from providers. So health provider trusts are not expected to be core members.

There may be representatives of regional Public Health and regional NHS commissioning on an issues basis.

3.2.7.2 A key function of the project manager will be to develop the detail, terms of reference and governance arrangements and agree through the project board with the Lead Sponsor the Lead Member for Adult & Community Services. It is proposed that the board is chaired by the Lead Member of Adult & Community Services with the Lead Member for Children's Services as deputy.

3.2.7.3 Given the huge overarching agendas, and with the transition of the NHS, there is a risk that it becomes a 'talking shop' as opposed to 'action oriented' to do business. The Board ideally should be small in number to set the overall strategic vision of commissioning, and well supported by an executive officers group chaired by the DASS with small highly focused delegates work to key standing partnership sub-groups with some decision-making. Key decisions required to be made by Cabinet and Health Boards to be signed off by Health and Wellbeing Board. The frequency could be the Board to meet quarterly and task:

- sub-groups with managing timescaled projects;
- partnership boards – to oversee performance monitoring and identifying issues to influence commissioning strategies. Report back to Health & Wellbeing Board as part of 1) annual cycle 2) as and when required for specific areas of work.

3.2.8 The DoH has requested LA's expressions of interest in becoming an 'Early Implementer' of Health & Wellbeing Boards by March 1st and a letter has been sent with Lead Member approval. The DOH responded on march 10th confirming acceptance of RBWM as an early implementer and thanking us for the approach. The letter sets out the details of the programme and how best practise will be developed with local areas to influence national guidelines.

3.2.9 Geographical Scope

This can be flexible as some GP consortia boundaries may not be coterminous with local authorities. In RBWM there is likely to be a small part of Ascot with Bracknell, reflecting current commissioning patterns. Berks unitaries could join for strategic issues and consideration will be given to this. However given the key need for a local focus to improve health and well being for RBWM residents a local Health & Wellbeing Board is best place to achieve this.

3.2.10 Discussions have also been held with the Local Community Partnership for whom improving health outcomes are important for the overall community strategy.

3.2.11 It is proposed that Cabinet endorse RBWM becoming an 'Early Implementer' (applications had to be in by March 1st) and agree to setting up a Health & Wellbeing Board from July 2011. This will be subject to agreed terms of reference and legal advice on accountabilities. This will give sufficient time to set up governance and other arrangements for statutory requirement from April 2013.

3.3 **Further National NHS Developments:**

The Coalition Government issued the DoH new vision for Adult Social Care - October 2010 (subject of a separate February Cabinet report) confirming the importance of integrated health and social care.

3.4 A White Paper on Public Health 'Healthy Lives Healthy People' Our strategy for Public Health for England – November 2011, sets out the proposed separation of public health functions between, local authorities, Public Health England and the Health Protection Agency. All these changes require legislative changes and the

Health and Social Care Bill (January 2011) is working its way through the Parliamentary process. It could take 12 months for agreement, so there can be no formal transfer of powers and legal accountabilities until after the Bill is accepted.

3.5 **The key points of public health changes in the new guidance are:**

- confirms each relevant local authority to have DPH function;
- to have Health and Wellbeing Board.
- funding only to be transferred from April 2013 – with allocated amount to be known April 2012. PCT continues to carry out public health functions until then.

3.6 **PCT Changes**

As part of the NHS strategy for change, to achieve management savings and ensuring stability of governance arrangements, the SHA has confirmed PCT's will cluster. For RBWM that means Berkshire East and West joint as one PCT. This has started already and will be completed by July 2011. The PCT's will cease from April 2013. Their functions will be transferred to the new GP consortia formally by then, but some budgets will be managed on a shadow basis from 2011.

3.7 **Public Health Functions**

3.7.1 There has been clarification of public health range of functions:

These have to fit with new national bodies set up:

- a new National Public Health Service will work with NHS Commissioning Board (NHSCB);
- National Public Health Service will have regional and local presence, as will NHS National Commissioning Board.
- ring fenced budget and new health premium to reward progress on outcomes;
- takes on Health Protection Agency and National Treatment Agency for Substance Misuse (transfers funds to PCT);
- local health improvement functions transfer to local government April 2013, with budget 2014;
- local government to be given new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health (through HWBs);

3.8 What needs to be achieved with local authority Public Health Strategy and how?

The White Paper states it 'sets out a radical new approach to empower local communities, enable professional freedoms and unleash new evidence based on what works, whilst ensuring the country remains resilient to current and future health threats'. Details are attached at Appendix 1.

3.9 **Health and Wellbeing Through Life**

This means:

3.9.1 Empowering local government and communities, who will have new resources, rights and powers to shape their environments and tackle local problems. This fits with objectives in the Local Communities Bill 2011.

- Taking a coherent approach to different stages of life and key transitions, instead of tackling individual risk factors in isolation.
- Giving every child in every community the best start in life.
- Making it pay to work.
- Designing communities for active ageing and sustainability.
- Working collaboratively with business and the voluntary sector through the Public Health Responsibility Deal.

3.10 **Health improvement and inequalities**

3.10.1 The DPH will be responsible for health improvement, addressing local inequalities in health outcomes, and addressing the wider determinants of health such as housing and education. This may also include working with other DsPH and Public Health England across a wider geographical area as appropriate, including issues relating to personal public health services such as smoking cessation, alcohol brief interventions, weight management and work to address the wider determinants of health.

3.11 **Funding**

3.11.1 The funding is complex and frustrating in so far as no local authority will know what its budget will be until 2013, yet is asked to agree to taking on functions before that. The reason for this, according to the SHA, is that all PCT's have allocated different amounts to public health. DoH needs to know the full spend in England, to allocate between the three bodies and ensure equity between local authorities.

3.11.2 Public Health England budget could be over £4bn.

3.11.3 It will allocate ring-fenced budgets, weighted for inequalities. The ring-fenced budgets will fund both improving population health and wellbeing, and some non-discretionary services, such as open-access sexual health services and certain immunisations. There will be scope, as now, to pool budgets locally in order to support public health work. It will be a grant under 5.31 of 2003 Local Government Act – with some conditions on use.

3.11.4 There will be a health premium funded from overall public health budget to incentivise reduction in health inequalities. The more progress evidenced, the higher the premium. It is expected the Health & Wellbeing Boards will oversee priorities of spend.

3.12 **'Shadow' allocations for 2012/13**

3.12.1 In the 2011/12 transitional year the NHS operating framework will set out arrangements and running cost reductions and efficiency across health system.

3.12.2 The first step in determining budgets for public health will be to establish the baseline health spend on those services for which Public Health England will take responsibility in the future. Local PCT spending on such services during 2009/10 will be used as the baseline to reflect recent historic spending rather than spending during a transition year.

3.13 **What does taking on public health function mean for RBWM?**

3.13.1 DPH post and functions:

Whilst each upper tier local authority is expected to have one DPH, Berkshire unitaries are unique, as not being coterminous with one PCT, and having one DPH to three unitaries, due to small populations. There are currently two posts for East and West Berkshire. There are options to consider the viability of one or two DPHs', as there is only funding for two. One DPH per six unitaries would require additional funding from each local authority and not considered necessary. There is also a 'critical mass' of population size that relates to DPH's and one unitary would be too small. There are a range of issues such as how can one DPH across Berkshire have a local leadership and role with six Health and Wellbeing Boards (HWBs)?

- how will cross-cutting commissioning functions be secured? E.g. mental health and all provider foundation trust services which cover East and West PCTs
- how will one DPH relate to potentially six or more GP commissioning consortia?
- How will this fit with strong emphasis on local decision making?

3.13.2 The options on these questions were outlined in a paper by Directors of Adult Services with DsPH and considered by Berkshire Chief Executives for decision after final guidance issued early January 2011. The decision was because of lack of clarity on funding until April 2012, more work was to be done on the options, to consider the most cost effective way to reduce health inequalities for Berkshire residents. The Health & Wellbeing Boards may also consider working across geographical boundaries on issues of common interest.

3.14 **GP Commissioning Consortia**

3.14.1 The fundamental change in NHS commissioning is the transfer of responsibility and budgets to local GP Consortia from PCTs. The RBWM position is about to be confirmed. Windsor & Maidenhead clusters will join with two Ascot practices, the rest will join Bracknell social enterprise pathfinder. They will have representation on the Health and Wellbeing Board.

3.14.2 The overall implementation timetable for public health functions changing is set out in Appendix 3.

3.15 **Opportunities of Health & Wellbeing Boards**

3.15.1 Local areas with Health & Wellbeing Boards will have opportunities to influence NHSCB with for example production of pharmaceutical needs assessments. It is

therefore envisaged responsibilities could change but essentially Public Health England will have three principal routes for funding services:

- granting the public health ring-fenced budget to local government;
- asking the NHSCB to commission services, such as screening services, and the relevant elements of the GP contract; and
- commissioning or providing services directly, for example national purchasing of vaccines, national communication campaigns, or health protection functions currently conducted by the Health Protection Agency (HPA).

3.16 **LA Scrutiny Role and Functions**

3.16.1 The current scrutiny functions will be retained and will not be the function of Health & Wellbeing Boards but of a separate committee as now. DoH had an overwhelming response that it should not merge strategic executive functions with separate roles of scrutiny.

3.16.2 However the way in which health and overview scrutiny functions are carried out will be down to local determination as to how best to discharge these powers. The Bill will confer the scrutiny function directly on the LA itself.

3.16.3 As part of the desire to increase local democratic legitimacy and scrutiny the Government will significantly extend the powers. This means scrutiny will be able to scrutiny any provider of NHS funded services, e.g. independent sector treatment centres and any NHS commissioner, including GP commissioning consortia. The latter is seen as a very important way of ensuring local public accountability.

3.16.4 There will also be changes on the right of referral on any significant changes to any designated services to the Secretary of State increasing the remit to cover any NHS provider and GP commissioners. Details of this are in Appendix 4. However these will not occur until legislation is confirmed. It is proposed a further report on this for decision by Cabinet will be made when guidance is clearer.

3.17 **HealthWatch**

3.17.1 The Local Implementation Network (LINKS) will have a transfer year from April 2011-12 to become formally constituted as HealthWatch by 2012. DoH funding has been reduced but will allow for funding of a local service. The arrangements for this have changed, away from a Berkshire commissioned host body, which was not effective, to a local host service through a voluntary sector provider. This has been consulted on and agreed with the local LINKS.

3.18 **HealthWatch Role**

3.18.1 The HealthWatch role is considerably strengthened to represent the resident voice of people who use health and care services. They will also link into the new HealthWatch section of the Care Quality Commission and have role in raising issues of service quality. Further functions such as patient advocacy are being considered by DoH.

3.19 **Funding for Project Implementation**

3.19.1 There is no government funding for implementation. As there are significant changes which require effective project management to implement and deliver the outcomes, a development fund bid of a maximum of £90,000 has been agreed by the Corporate Management Team for 2011/12. It is hoped to offer an internal secondment opportunity for the project manager.

3.20 **The costs are broken down as follows**:

- Project Manager for 12 months approx £60k
- External consultant expertise for Health & Wellbeing Board functions and collaborative GP commissioning options consultant £15k (as required)
- Project events and set up costs £5k (as required)
- HR and legal and finance costs £10k (as required)

Total = £90k

3.20.1 The HR costs are for involvement in the transfer of Public Health functions and associated staff, but may not be required until after 2012, when higher costs are likely. This will depend on the Berkshire-wide agreement on the configuration of Public Health staff and whether there is a host authority or each authority employs staff. Estimated cost of £35,000 with ICT, legal and finance costs on top of this.

3.21 **Further Guidance**

In addition the DoH has publicised a range of key public health documents in 2011.

Winter 2010/11

- health visitors;
- mental health; and
- tobacco control.

Spring 2011

- Public Health Responsibility Deal;
- obesity;
- physical activity;
- social marketing;
- sexual health and teenage pregnancy; and
- pandemic flu.

3.22 **Conclusion**

3.22.1 The project board will oversee implementation of the Health & Wellbeing Board and report for decisions by Cabinet as necessary, subject to the national timetable, on other NHS changes reporting to the project board. The Project Manager will take forward all the actions.

3.22.2 There are opportunities to set up local structures that work best for RBWM, as guidance is unlikely to be prescriptive, in order for the Health & Wellbeing Board to achieve agreed health and social care outcomes for residents.

3.22.3 Once GP consortia are agreed, in shadow form from April 2012, it will be easier to develop structures as there will be a formal body to agree proposals with.

3.22.4 Further workshops will be set up to scope options and recommendations in line with overall timetable.

3.22.5 The scrutiny role will need to be formally enhanced once the legislation and guidance is confirmed, probably by 2012.

4. OPTIONS AVAILABLE AND RISK ASSESSMENT

4.1 Options

	Option	Comments	Financial Implications
1.	Do nothing	Not feasible as will be statutory duty to take on Public Health functions, and have Health & Wellbeing Board.	No need for project management costs until 2012.
2.	Implement proposals in line with statutory timetable	Gives more time to consider options and governance arrangements for Health & Wellbeing Board but disadvantages local population with no local leadership to influence changes.	Need for project management costs £90k.
3.	Accelerate developments of Health & Wellbeing Board prior to statutory timetable **Recommended Option**	Opportunity to put improving residents health and well being at the heart of Council business. To influence and learn from 'Early Implementers' programme with DoH on Health & Wellbeing Board.	As above.

4.2 Risk assessment

4.2.1 Whilst some local authorities applied in 2010 to have Health & Wellbeing Boards in shadow form they also have GP commissioning consortia agreed. DoH awarded in December 100 first wave pilots. In RBWM due to the issues concerning the number of DPH posts and GP Consortia, there was no benefit in being a shadow board, and with no clear guidance on functions.

4.2.2 As the functions have been set out, and local GP Commissioning Consortia are about to be set up, there is now the opportunity to be innovative and creative to improve and influence health and social care outcomes locally through setting up a Health and Wellbeing Board as part of Council structure, and fundamentally review and streamline existing arrangements.

4.2.3 Whilst Option 1 would delay the need for project management costs, it would disadvantage local residents as no Health & Wellbeing Board would be established to oversee health improvements and influence GP commissioning plans. Option 3 is recommended.

5. CONSULTATIONS CARRIED OUT

5.1 An internal workshop was held involving the Project Board, Senior PCT, Adults & Children's Services staff. The chair of Health Scrutiny and the Lead Liberal Democrat Member, as agreed by Cabinet, were invited. The overall agreement was the need to consider carefully the implications and make best use of existing structures, with a focus on clear governance and decision-making functions for the Health & Wellbeing Board.

5.2 Informal discussions were held with stakeholders and partners at an Adult Social Care Strategy and Partnership Workshop on 8 March 2011, and views fed back to shape structures reporting into the Health & Wellbeing Board. Overall there was positive support for the setting up of the board and need to ensure all the key issues of the various partnership boards were recognised. It was confirmed that the intention was to build on all the work these partnerships do to deliver better outcomes for residents.

6. COMMENTS FROM THE OVERVIEW AND SCRUTINY PANEL

To be confirmed.

7. IMPLICATIONS

The following implications have been addressed where indicated below.

Financial	Legal	Human Rights Act	Planning	Sustainable Development	Diversity & Equality
✓	✓	✓	N/A	N/A	✓

Background Papers:
NHS White Paper – Liberating the NHS: 'Equity & Excellence' – July 2010
Healthy Lives Healthy People Our strategy for Public Health for England – November 2010
Liberating the NHS: Legislative framework and next steps – January 2011
2003 Local Government Act

Authorisation:

	Legal	Finance	Planning	Property	Procurement	DMT
Name:	Maria Lucas	Alan Abrahamson	NA	NA	NA	DMT
Date Approved:	02 03 11	10 02 11				24 02 11

	Directors Group	Lead Member	Ward Cllrs (if Appropriate)	Leader's Office	Scrutiny Panel
Name:	Christabel Shawcross	Cllr Dudley	NA		
Date Approved:	02 03 11	02 03 11			

Appendix 1

PUBLIC HEALTH STRATEGY

Reaching across and reaching out – addressing the root causes of ill health.

A new approach is needed, which gets to the root causes of people's circumstances and behaviour, and integrates mental and physical health.

Wider factors that shape the health and wellbeing of individuals, families and local communities – such as education, employment and the environment – also need to be addressed in order to tackle health inequalities.

Responsibility needs to be shared right across society

Local government is best placed to influence many of the wider factors that affect health and wellbeing.

Responsive – owned by communities, shaped to meet their needs

We will end this top-down government. It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre.

This will be supported by a proposed public health outcomes framework and a **'health premium'**, which will incentivise local government and communities to improve health and reduce inequalities, while leaving them free to decide how best to do this, in line with local needs. Data will be published to make it easier for local communities to compare themselves with others across the country and to incentivise improvements.

Will shortly consult on details proposals for a public health outcomes framework, so that local communities, local government, the NHS and other key partners have an opportunity to shape it.

Resourced – based on ring-fenced funding, with incentives to improve

It is time to prioritise public health. The government will ring-fence public health funds from within the overall NHS budget to ensure that it is prioritised, although it will still be subject to the running-cost reductions and efficiency gains that will be required across the system.

Rigorous – professionally-led and focused on evidence; efficient and effective

Public health professionals have been disempowered and their skills not sufficiently valued when compared with their counterparts in NHS acute services.

Public Health England. This will be a uniting force for the wider family of professionals who also spend time on improving people's lives and tackling inequalities.

Resilient – strengthening protection against current and future threats to health

The current system for health protection is fragmented.

Making accountabilities in the system clearer and creating a new streamlined public health service to lead health protection and public health efforts across the country.

Appendix 2

DPH FUNCTIONS

1. Provision and use of evidence

. The DPH will be responsible for ensuring that the local authority, and its key partners, have access to the high-quality analysis and evidence needed to inform the JSNA, the Annual Health Report, emergency preparation and response, and all public health services for which they are responsible.

2. Population healthcare

Although the DPH will be employed by local authorities, it will be vital to ensure a high-quality public health input into NHS services. DsPH will need to work closely with GP consortia to help identify, prevent and manage a range of conditions, such as mental ill health, cardiovascular disease, diabetes and cancer, across the population, to support people to take care of their own health. DsPH will also need to have input into commissioning services for people with established diseases and long-term conditions.

3. Vision of the role of Director of Public Health.

The DPH is seen to have a critical leadership role in the new system – at the centre of improving the health and wellbeing of local communities across England. The DoH vision for the post and key points relating to functions and accountabilities are in the White Paper.

It envisages that the DPH will be the principal adviser on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population, including identifying health inequalities and developing and implementing local strategies to reduce them.

He or she will play a key role in the proposed new functions of local authorities in promoting integrated working; contribute to the development of the local Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy which is a new statutory requirement; be an advocate for the public's health within the community; and produce an authoritative independent annual report on the health of their local population. Further detail on the functions are attached at Appendix 2.

4. Health protection and emergency preparedness and response

Where the Secretary of State enters into arrangements with local authorities in relation to health protection and emergency preparedness, DoH envisages that the DPH will play an important role in local emergency planning and response to public health threats that affect their communities.

5. Accountability

DsPH will have a professional duty to keep their skills up to date and to ensure their staff are similarly well trained. This is to ensure there is a competent local multi-disciplinary public health workforce, with strong professional leadership at its heart.

6. The primary accountability for local government will be to their local populations through transparency of progress against outcomes and their local strategy. There will also be a relationship between Public Health England and local councils through the allocation of the ring-fenced budget, for which the Chief Executive will be the Accountable Officer.

DsPH will be jointly appointed by the relevant local authority and Public Health England. They will be accountable to the Secretary of State for Health and professionally accountable to the Chief Medical Officer.

Appendix 3

Public Health Changes Timetable

Summary timetable (subject to Parliamentary approval of legislation)	Date
Consultation on: • specific questions set out in this White Paper; • the public health outcomes framework; and • the funding and commissioning of public health.	Dec 2010 – March 2011
Set up a shadow-form Public Health England within the Department of Health Start to set up working arrangements with local authorities, including the matching of PCT Directors of Public Health to local authority areas	During 2011
Develop the public health professional workforce strategy	Autumn 2011
Public Health England will take on full responsibilities, including the functions of the Health Protection Agency and the National Treatment Agency Publish shadow public health ring-fenced allocations to local authorities	April 2012
Grant ring-fenced allocations to local authorities	April 2013

Appendix 4

New Scrutiny Functions
Right to Refer to Secretary of State
(excerpt from DoH – Legislative Framework & Next Steps)

1. In addition to being consulted on the designation of what services are subject to additional regulation, the local authority will be able to refer decisions about significant changes to any designated services to the Secretary of State. In this way we will retain the "right to refer", the importance of which was emphasised by a number of NHS, local government and third sector organisations. In the words of Norfolk Community Health and Care, there should be a *"principle of referring to the NHS Commissioning Board and then, by exception, to the Secretary of State for Health".* The Department agrees.

2. There was support for the idea that, as Telford and Wrekin Council argued, *"proposals that are referred nationally should be on an exceptional basis and resolution of disputes should be addressed locally where possible"*, with commissioners and local authorities working to discuss proposals and reach consensus from an early stage. University Hospitals Bristol NHS Foundation Trust suggested that there should be *"clear thresholds that must be met before a referral is accepted that specifies what should have been undertaken locally first and by whom, what level of evidence is required to support a referral and specify the level of consensus that must surround any referral".*

3. To ensure that the health scrutiny model is consistent with other forms of scrutiny in local authorities, and as democratic as possible, we propose that any decision to refer a substantial service change proposal should be triggered by a meeting of the full council. This is in line with the views expressed by the Association of Directors of Adult Social Services and many councils that *"flexibility"* and *"local determination"* are crucial, combined with a recognition that the strengthened role of local authorities in relation to health should be reflected in a new approach to scrutiny and referral.

4. The exception to this will be if a number of councils choose to establish a joint scrutiny arrangement, in which case the joint OSC will hold the referral power. To support joint working and to provide the clarity and consistency asked for by many respondents such as Somerset PCT, Ealing NHS Trust, Liverpool and Lewisham PCTs, we propose that when local authorities establish joint OSCs, they do soon the basis that at an early stage they agree for the decisions of the joint OSCs to be binding on all contributing councils. The Department is also considering revisions to the regulations governing referrals, so when deciding to make a referral, local authorities are obliged to publish a timescale for the decision-making process and take account of a wider range of considerations including the duties on NHS commissioners to improve the safety, effectiveness and patient experience of services, and the need for services to be financially sustainable. We will consult on these proposed changes to the scrutiny regulations.

5. In future, the local authority's right of referral described in paragraph 1 will apply in relation to any type of provider of NHS-funded services, whatever their

governance arrangements and ownership structure. Given the importance the Government places on local authority referral, the Bill will include a regulation making power that can enable the Secretary of State to direct NHS commissioners (either directly in the case of the NHS Commissioning Board, directly or via the NHS Commissioning Board in the case of GP consortia) to stop reconfigurations of those services subject to additional regulation, when they are referred to him. This is one of the few occasions, other than in an emergency, or possibly in complying with EU law, when we envisage the Secretary of State will have any ability to interfere with an individual commissioner or provider. In making decisions, the Secretary of State will, as now, be guided by the Independent Reconfiguration Panel, and additionally be required to take account of the safety, effectiveness and patient experience of services and the need for services to be financially sustainable.