Report for Information to the Health & Wellbeing Board for RBWM

Contains Confidential or Exempt Information	**NO – Part I**
Title	Update on the NHS Changes
Responsible Officer(s)	Christabel Shawcross, Strategic Director of Adult & Community Services
Contact officer, job title and phone number	Catherine Mullins, NHS Changes Project Manager 01628 68 3664
Member reporting	Cllr Simon Dudley
For Consideration By	RBWM Shadow Health & Wellbeing Board (SHWB)
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1. Report Background

1.1 This report is a continuation of the updates for the SHWB regarding the NHS changes that are currently still going through the parliamentary process. This has been reported to the SHWB previously on the 4th November 2011 as an information update.

2. Report Summary

2.1 This report will give the latest information on the progress of the Health and Social Care Bill status and the national guidance that has been issued to support the process.

2.2 Included with this report is an update on the latest information for the transition of the public health function to councils, both on a national and local basis.

2.3 In addition to the progress of the Bill and the transfer of the public health function, there have been changes to the local implementation of Healthwatch.

3. Details of Update / Information

Health and Social Care Bill

3.1 Since the last meeting of the SHWB the Health and Social Care Bill is still going through the House of Lords, it is now at the Reporting stage, where a line by line examination of the Bill takes place, key issues are voted on and every member of the House of Lords can take part in this stage. There are still a couple of stages for the H&SC Bill to go through in the House of Lords and then back to the Commons before Royal Assent is reached. There is no specified timeframe for the next stages of the Bill and no official announcements on when Royal Assent is expected to be reached.

3.2 Parallel to the parliamentary process the NHS Future Forum has completed the second stage of the examination of the Health and Social Care Bill and has made a series of recommendations based on their findings.

3.3 The recommendations from the Future Forum have been accepted by the Government and will be incorporated into the Bill and associated guidance through the parliamentary process. The recommendations are associated with Integration of Care, Information (with engagement), NHS Role in Public Health and Education & Training.

3.4 Further guidance on the full implications of the Health and Social Care Bill and the national changes for both Health and Local Authority is due in the Spring.

Public Health Transfer

3.5 There has been a selection of guidance from the Department of Health regarding the roles and responsibilities of Public Health England (PHE) and public health in local government.

3.6 PHE will be established from April 2013 and will be the authoritative national voice and expert service provider for public health. The core purpose of PHE is described as

- To deliver, support and enable improvements in health and wellbeing in the areas set out in the PHOF
- Lead on the design, delivery and maintenance of systems to protect the population against existing and future threats to health

3.7 PHE three main functions will be

1. Delivering services to national and local government, the NHS and the public
2. Leading for public health
3. Support the development if the specialist and wider public health workforce

3.8 Factsheets have been issued that cover the local government new public health function, including the role to monitor or commissioning responsibilities for:

- Tobacco control
- Drug and Alcohol misuse services
- Public health services for children aged 5-19 (including Healthy Child Programme)

- The National Childhood Measurement Programme
- Obesity – to include lifestyle and weight management solutions
- Nutrition initiatives
- Physical activity
- 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 changes to prevent cancer
- Local initiatives on workplace health
- Support, review and challenge delivery of key public health functions such as immunisation and screening programmes
- Sexual health services, including STI's contraception outside of the GP contact and sexual health promotion
- Reduce excess details due to seasonal mortality
- A role in health protection incidents, outbreaks and emergencies
- Public health aspect of promotion of community safety, violence prevention and responses
- Public health aspects of social exclusion
- Reduction of environmental risks to health

3.9 In addition to the above there is a requirement for local authorities to be able to act as the public health advisors to NHS commissioners

3.10 Nationally the Public Health Outcomes Framework has not been finalised and is due imminently from the Department of Health. The way that the PHOF will work with the NHS and the Adult Social Care Outcome Frameworks are subject to another report for the HWB to consider.

3.11 The staffing aspects of the transfer are being addressed through central government guidance including a *Public Health Human Resources Concordat* (issued November 2011) and *Public Health Workforce Issues, Local Government Guidance* (issued January 2012) and guidance on the appointments of the Director of Public Health role.

3.12 There is a timeline for the transition which details that the agreement on the formal transfer of HR and finance processes will take place through the "shadow" year of 2012 / 2013. There is an expectation that each area will have a transition plan for the shadow year that covers the formal management of the transfer of public health functions.

3.12.1 Locally there is a Public Health Transition Plan being developed through the CEO Programme Board, which is looking at all aspects of the transfer of public health into local authorities. The Transition Plan is due to be agreed in the next couple of weeks and will inform the actions needed on a local, East Berkshire and Berkshire level to successfully meet the outcomes of the population

3.13 Further information on all of the process of the public health changes can be found at this link http://healthandcare.dh.gov.uk/public-health-system/

3.14 The financial aspects of the public health transfer have not yet been announced but are due at any time. Local financial information has been submitted to the Department of Health for East Berkshire and the results that inform of the

expected spend for the shadow year is still unknown.

3.15 Locally the transfer of the public health function is the subject of a workshop hosted by NHS Berkshire and regarding public health commissioning, contracts and financial information at the end of January. The Berkshire CEO's have formed a Programme Board to look at the most effective ways of managing / commissioning the public health functions once the key information is issued in regard to finances available and the priorities of each locality stemming from the JSNA.

Development of the Health and Wellbeing Board (HWB)

3.16 There has been some best practice information published regarding operating principles for HWB to comply with. These are general principles that are intended to help HWB members consider how to create effective partnerships across local government and the NHS, the link to the principles is below:

http://www.nhsconfed.org/Publications/Documents/Operating_principles_101011.pdf

3.17 There are seven Action Learning Sets that are being hosted by the Department of Health until the end of March 2012 which are each expected to provide further clarity the different aspects of the HWB on the roles and responsibilities of the HW

3.18 It is still currently a core function of the HWB to ensure that the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) are produced. Locally the JSNA is being led by the NHS Public Health Team with the support of RBWM and other key partners. The HWB is receiving a report on the JSNA in February 2012.

3.19 The local development of the JHWS has been delegated to the Strategic Director of Adult & Community Services by the shadow HWB in July 2012. Preliminary guidance on the JHWS was issued by the Department of Health in December, in advance of the Action Learning Set producing further information on the JHWS in the spring of 2012 and also the finalisation of the Health and Social Care Bill.

3.20 This first guidance regarding the JHWS has identified that initial work on the format and content should commence in April 2012 based on the priorities evidenced in the JSNA. Strategy development feeds into the commissioning cycle and plans throughout the summer months ready for the business and financial planning during the autumn for the next financial year.

3.21 In advance of the official guidance, RBWM and partners hosted an Engagement Event on the 28th November to work with key stakeholders and community groups to establish how the local JSNA and JHWS should work together to reflect the local needs, inequalities and priorities. Feedback from the event is attached as an appendix to this report, and will be used to formulate the local JHWS in line with the national requirements and expectations.

3.22 The next steps for the Joint Health and Wellbeing Strategy are going to be determined by national guidance, however preliminary thoughts have been discussed on the development of the local JHWS. This includes a joint working group to interpret the guidance and formulate the structure and priorities in the JHWS and diarising consultation events throughout the planning months for public engagement in setting the priorities. This way the commissioning plans of the Local

Authority, CCG(s) and stakeholders can effectively reflect the needs and priorities of the Borough.

Healthwatch

3.23 The start date for the functions Healthwatch has been pushed back from October 2012 to April 2013. The function of Healthwatch as the voice for the consumer of health and social care services is specifically one of the seven action learning sets as referred to above and is being lead nationally by John Wilderspin, who is also the national lead for the development of the Health and Wellbeing Boards.

3.24 There has been a consultation regarding the formula by which Healthwatch will be funded by central government, the results of which have not yet been released. There are two options that are available, one based on the working age population and the second based on the adult social care relative needs formula. Locally there is a significant difference in funding between the two options (Option A circ £112,000 and Option B circ £62,000) it may be that aspects of the functions of Healthwatch have to be jointly commissioned to ensure economies of scale or to fully meet the expectations on HealthWatch in regard to the Health and Social Care Bill

GP Clinical Commissioning Group(s)

3.25 Due to the geographical nature of RBWM there are two GP Clinical Commissioning Groups (CCG) who will be commissioning health care services for residents of RBWM. Primarily the issue is that 3 Ascot GP practices are geographically located in RBWM, covering 20,000 patients, whose GPs are part of the Bracknell and Ascot CCG.

3.26 This means that people who are resident of Ascot within the RBWM boundaries will have their health services commissioned by B&A CCG. However the Public Health Function and Healthwatch are the responsibility of RBWM, as the local authority which would be accountable. This means the RBWM Health & Wellbeing Board will want to assure itself that Bracknell is appropriately commissioning for the needs of the RBWM residents in Ascot, and based on the JSNA.

3.27 There have been a couple of meetings with the leads of the Bracknell and Ascot CCG and the Windsor, Ascot and Maidenhead CCG together with RBWM to determine the most effective way to work together to achieve the best outcomes for the residents who are effected by the CCG's working across the geographical boarders. The idea of a formal protocol that reflects a common understanding and supports the governance arrangements of both areas has been accepted and is being discussed.

4. Risks and Implications

4.1 Due to the delay of the Health and Social Care Bill through the parliamentary process the risks and implications are the same as per the report on the NHS changes to the HWB in November 2011.

4.2 The key main risks for RBWM with the NHS changes that have been identified so far are monitored through the project board with mitigations:

1. Further delay to the Health and Social Care Bill – this would have the consequence of shortening the time available to implement the contents of the Bill and / or delaying the start-time for some of the key changes
   Mitigation: The Programme Board will ensure that the national and local plans are monitored and adapted accordingly and represent to the HWB and Cabinet as appropriate
2. The Public Health Ring-Fenced Grant Amount – this amount is unknown until December and there is a risk that the allocation may not cover all of the functions associated with the transfer. This may include staffing / TUPE, commissioning and contractual commitments, service provider relations and internal RBWM structures.
   Mitigation: This will be managed through the Berkshire Chief Executives Group and is recognised as being a national concern.
3. HealthWatch role is complex – if guidance is not sufficient there is a concern that roles and legal requirements of the organisation is vague leading to not meeting requirements and proposed activity.
   Mitigation: These will be scoped with the Healthwatch partners and the HealthWatch Project Manager to keep updated with the national information as it becomes available.
4. Partnership working and collaboration – full scope of the roles and responsibilities on partners still being established.
   Mitigation: The Programme Board and HWB provide the opportunity to reach agreement as to how to best work together within the national framework to improve the health of RBWM residents.

Table Discussions – RBWM Partnerships Event
28th November 2011

Question 1 - What do you think the local priorities should be from the JSNA?

Before JSNA consider;

- that it properly reflects health and social care,
- that there are drilled down abilities,
- how a lay person will be able to understand it.

Needs to include;

- prevention,
- transport,
- education,
- housing,
- signposting

enabling activities for each / how to access them

- Needs to be a clear understanding of the current drivers behind the JSNA findings and have a mechanism that reduces the risk that specific requirements that are important, but not necessarily large volume are overlooked.

- Some underlying health factors need to be better targeted to ensure effective use of large budgets e.g. Smoking Cessation – in the main RBWM does not have the same problems as national, but there are groups e.g. Teenage Girls who do need to be targeted to have the desired effect, rather than being restricted to national targets alone.

- JSNA needs to adopt a Health and Wellbeing focus, not just disease and illness approach.

- JSNA seeking to achieve better population profiling – combining social care information with NHS information to look at the triangle of care – focusing on prevention for those who have no intervention need to stay that way.

- Consultation process has to allow proper input to be effective

- Possible problem – people looking at the JSNA may not have the necessary knowledge to input in an educated / fair way.

- How can the JSNA be influenced as it is an evidence bank?

- Issues around – does it include all that attendees here would expect – any gaps? Does it appropriately pull out the priorities?

- When do alarm bells start ringing – not just facts and figures, but what and when triggers action levels and hence intervention, especially for preventative action

- Addressing hidden pockets – what are the gaps - how collect – how address.

Housing

- Noted that housing did not feature in the presentations but it is essential and has a huge impact in RBWM. In particular, the availability of affordable housing.

- Also noted that in order to attract a local workforce e.g. Homecare staff, and then there needs to be more affordable local housing so people can live and work in the Borough.
- Also important to make links between traffic and housing – if people are just commuting into the Borough because they can't afford to live here then they may not spend their money in the Borough. Our roads can't sustain a continued increase in commuting traffic.

Routes to employment

- In particular for older people. Example of 'Age Works' initiative from Age Concern that supports older people into employment or voluntary work. Needs to be investment to continue to support these types of initiatives.
- NEET – need to invest in services to support young people into employment. Example from Wokingham that it costs £64k a year to support a young person who is NEET. Would it not be more cost effective to spend money on preventing that person becoming 'NEET' in the first place?
- Essential that we invest to save
- Point also made that central government funding is available once an individual reaches 16+ hours per week employment, but there is no funding for the journey an individual has to go on to get there, e.g. people may have to start at a lower number of hours. Need to find ways to remove this barrier to employment.

Transport

- A key priority to ensure that people have access to services.
- A joint health and social care/LA transport plan would be helpful to look at some of these issues.
- Need to look at the affordability, as well as availability of local transport

Other Areas

- Increasing life expectancy and a need to keep people well for as long as possible through prevention
- Improving joined up working e.g. between GPs, hospitals and social care. But that joined up working is also about other partners e.g. Police
- Alcohol – in particular preventing hospital admissions due to alcohol and preventing premature deaths due to alcohol

Learning Disability

- Applies to small volume of people, but high cost e.g. a placement can be £150k per year
- Need to develop local provision to avoid moving service users away from their families, sometimes this can be long distances. Keeping service users local and with their families and friends has wider health and wellbeing benefits

Mental Health

- Provision of local services needs to be improved e.g. Prospect Park
- Recognition that the current economic climate has an impact on mental health issues
- Really important to find the balance between cost and demand, and decisions must be evidence based

Procurement

- Need to improve negotiation of terms and conditions in contracts e.g. if entering into a contract with the private sector then include a requirement for the company to provide some employment opportunities e.g. for LD clients, or apprenticeships for young people. Has been done in Hampshire and Reading.
- Need to make better use of our negotiating position.

Question 2 - Considering the Marmot Themes, what do you think the JHWS should include and how should it look?

- Strategy must balance the differences between high level priorities and the more specific requirement to meet overall needs, how do you ensure nothing falls through the gaps.

- Partners must be effectively engaged as the changing and emerging priorities are developed, not just today's event but as themes and priories become clearer for the strategy, partners will need to have the opportunity to comment and contribute.

- What are the timescales for the development of the strategy and over what period will it aim to set strategic direction. Needs to be clear to all.

- How will expertise from within LA and NHS be retained given the high level of change in hand, part of the Strategy needs to secure the local knowledge is not lost.

- Housing issues are critical and there are a number of aspects that the Strategy will need to address

    - How can access be provided to key knowledge about how to help people stay at home longer e.g. OTs, Adaptations available, enable the public who need to know access to what is in place but they may not be aware of. This would help people stay at home longer etc.
    - How could the LA help assist / enable older persons move form very large inappropriate housing to smaller more appropriate housing that would enable them to stay at home longer? Could the LA take a brokerage role on via the local plan process?
    - Can the Strategy ensure the LA as Planning Authority ensures all new homes and adaptations are age future proofed etc? Wheelchair friendly and basic OT needs e.g. 240v sockets are appropriate levels.

- Transport – various aspects including
    - Car Services to support older persons need to be universally available.
    - Appointments by providers need to be patient friendly, not at the convenience of the service provider which may be at a venue difficult to get to/access.

- Local needs should rule over national initiatives, how will this be covered in the strategy?

- Local priorities matched effectively, local targets need to reflect local needs and not just the National expectations, and how this will be done. This must be embedded in the JHWS.

- Justifying prevention is known to be hard, but how will the JHWS recognise that prevention investment has a longer than one political administration timescale to be able to demonstrate pay back, how will our strategy address this well know problem.

- Joint working – the strategy must include clarity on how the populations health and social care based needs will be addressed.

- Learn from others – are there examples of conditions that are not yet a very high priority for RBWM but are on the increase, but have been effectively addressed elsewhere (e.g. TB in Slough) where they are at a different stage to us.

- Strategy needs to address the multiple numbers of carers supporting old people if it is to help efficiency some old people have 16 different support workers in a week. Why not rationalised into just three of four who could cover all care needs social and health etc. All sorts of efficiency gains potential.

- GPs view of the health of the nation is heavily driven by their expertise in disease and ill health not wellbeing and preventions. If GP CCG is to be effective it must be on board with the Strategy, and not just odd GPs who might be part of the Shadow HWB.

- If look at life stages, focus on prevention throughout the strategy and ages

- Increased reliance on the Voluntary Sector is high risk approach in the current climate, strategy needs to be clear about how this will be a part of the overall strategic approach to better local health and wellbeing.

- Concern re prioritisation process? Recognise process is to allocate funding to priority areas, but what is the mechanism for dealing with isolated issues – if none will lead to exclusion

- Evidence is required if there is a need, so consultation processes may be an opportunity to highlight gaps and request evidence.

- Marmot too wide to be understood as a concept round the table – may not know how to get into issue interested in. Not lumping all things together i.e. mental health as figures may cover dementia and post natal depression. High overall figures do not show areas to focus on.

- Needs to build on the facts and be understandable. Needs to link into other aspects i.e. transport, accessibility, isolation and aspects of deprivation and how they interact with specific conditions not just as issues in their own right.

- JHWS - Should allow the reader to ask – how does X policy enable me to have a better life – the *What's in it for me?* approach

- Engage each tranche of user in consultation – including what they can influence.

- Recognise early intervention / crisis prevention i.e. healthy eating

- Broaden the JHWS to include emotional health and wellbeing, with interventions that cover wellbeing
- Neglect for children is one of the biggest concerns from the Safeguarding Childrens Partnership Board, but is a complex issue that needs to have a multi-layered approach
- How are local views to the priorities being fed into the JHWS so that the public can contribute to the priorities selected
- Circulate what the specific actions are for the priorities as a broad-brush-strokes approach won't work
- How is this influenced by the Shaping the Future change of healthcare provision in East Berkshire
- Don't neglect the general populous, the working age adults without a specific health or social care need
- Work with employers more to target the prevention in the workplace.
- Make health and wellbeing a part of the education in schools and colleges
- Be sure to be inclusive, be sure to include the minority populations and don't politicise the unpopular issues, such as teenage pregnancies, HIV, travellers needs etc
- Needs to contain meaningful issues, such as employment, housing, welfare rights etc, the issues that effect real people
- Demography and trends of older peoples needs, autism and changes in conditions
- Public awareness and education is vital – advise / educate / support / inform
- Ensure work with the CCG so that the strategy is deliverable and has SMART objectives
- Role of the voluntary sector – should have better involvement and investment
- Have wider family support, not just users of services and main carer, but whole family impacts and needs addressed
- Dementia is a big need area, social and preventative access to services for early on-set, early diagnosis is essential
- Lack of employment for younger people and impact that has on depression for 16-24 year olds should be included, not just NEET numbers
- Housing adaptations for individuals with a long term condition, early diagnosis and planning for health implications
- Concern that Carers should be included and supported in their caring role, especially young carers.

- Utilise education to promote the health inequalities agenda, how are needs and inequalities to be addressed

- Outcomes: how will they be measured, use user and carer feedback, GP practice data, referral numbers and care plans. Scale the way that they are measured (e.g. rank between 1-5) for evidence, or simpler "smilies" for feedback or review of services

- Consider access in wider context, not just transport but physical access into buildings etc

- Use Telecare and telehealth more to support individuals, could reduce visits but still ensure contact to stay in touch, use of technology is crucial

- Listen to the patient as they are often the expert, empower the patient to discuss their conditions with the professionals. Healthwatch could engage and provide advocates if needed.

Marmot objective 1:

- Childcare provision – particular focus on early years
  - more flexible returning to work opportunities for Mothers
  - flexible working for parents
  - wider variety of childcare available – times and prices
  - once child is at school provision of breakfast and after school clubs at a reasonable cost
  - If we want to grow the workforce, then need to make the workplace more available
  - There are currently issues with children starting school at a wide range of levels of development e.g. some still in nappies! Felt this was due to the Health Visitor provision stopping so children are now not seen between the ages of 1 and starting school.

Marmot objective 2:

- Investment in advocacy provision for children and young people
- Investment in good career advice that is not biased by schools just trying to tick boxes for academic league tables
- We should have more of a holistic 'whole child' approach and focus on outcomes for that individual child
- The current focus on university needs to change, as it is not going to be accessible for as many people. Therefore, focus needs to widen to include a range of options e.g. apprenticeships and other routes – they need to be seen as successes as well as getting a university place
- What support will be available for young people not going to university?

Marmot objective 3:

- Need to attract a wider range of businesses to the Borough.
- Age discrimination –needs to be challenged and tackled with employers. Discrimination against both old and young people
- Need to ensure all young people leave school with a CV and the ability to complete a job application – this isn't the case currently
- Make more links to international opportunities e.g. attending European universities can be much more cost-effective

- Develop more volunteering opportunities, but invest in the infrastructure needed to support this

Marmot objective 4:

- It was felt that this is implicit throughout everything that had been discussed
- Focus should be on a person centred approach
- Need to ensure representation of all groups at the H&WB Board and through the JHWS. Some concern that at the moment not enough representation
- GPs are critical to the JHWS – they are gatekeepers a lot of the time and need to get it right
- Accessible and understandable information for both public and professionals is essential

Other Health and Social Care Considerations / Comments

- Concerns were raised about the impact of outsourcing functions from within RBWM, e.g. on Voluntary Sector, and it not being realistic that Voluntary Sector will be able to make up the shortfall in budget provision. How will the true impacts be monitored?

- How will outcomes be measured? *Who* will measure needs to be clear

- Links to the GP CCG – they have the power yet many GPs don't even know what the JSNA is never mind what it concludes / identifies. This is critical issue.

- How will the sub population needs be addressed e.g. specific ethnic or geographic needs. North Maidenhead cited as a good example. Use of faith groups and others to reach the target audiences and have effective mechanisms is not just the same old usual suspects.

- How can people in the room input into JHWS activities?

- In consultation clarify – JSNA and JHWS – what each is – what consultation on each is for

- Co-terminus arrangements for schools? Services used in Borough for non residents – SEN records.

- Concern on benefits system for people who have fluctuating conditions (such as MS) and how that funding may change after 2013

- Information and signposting needs to ensure up to date and accurate and easily obtainable

- Share ideas between partners (LA's, PCT's CCG's and Acute Trusts) and across wider areas. Health & wellbeing board will need to be able to work in partnership to influence priorities

- DLA (Disabled Living Allowance) concerns about impact of financial strain and if it will impact on peoples ability to attend support groups, etc

- People aged 50 years + who are made redundant, what is available for them?