Item No. 4

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **16 SEPTEMBER 2011**

NHS REFORM

Report of the Executive Director, Health, Housing And Adult Services

1.0 PURPOSE OF THE REPORT

1.1 To provide information to members of the board on Government changes to the NHS

1.2 To highlight any implications for Sunderland

2.0 BACKGROUND

2.1 The Government set out a number of changes to the way the NHS operates in its Health and Social Care Bill. The Bill was paused to allow a 'listening exercise' with recommendations from the NHS futures forum submitted to the Health Secretary. In June 2011 the Health Secretary announced changes to the Bill based on these recommendations. The Health and Social Care Bill is due to have its report stage and third reading on 6th and 7th September 2011.

2.2 The main changes for the NHS include a changing role for the Secretary of State, the development of a National NHS Commissioning Board, the creation of Clinical Commissioning Groups and changing roles for Monitor and the Care Quality Commission

2.3 Strategic Health Authorities (SHA's) have recently been clustered in four separate areas: London, North, Midlands and South. On 11 August 2011 Ian Dalton CBE was announced to the post of Chief Executive of NHS North of England. Strategic Health Authorities cluster Chief Executives will assume their roles on Monday 3 October 2011 to continue until the abolition of SHA's in 2013.

2.4 The Department of Health has indicated that despite issuing *Cluster Implementation Guidance* in January there is still significant inconsistency in how the 50 PCT clusters operate. This consistency is vital for the Quality, Innovation, Productivity and Prevention (QUIPP) to deliver the £20bn in efficiency savings and to support the NHS reforms. PCT's will cease to exist during 2013.

2.5 The Government has asked the NHS Futures Forum to continue a new phase of conversations with patients, service users and professionals. The forum led by GP Professor Steve Field, will provide independent advice on four themes:

- Information – how to make information improve health, care and wellbeing
- Education and training – how to develop the healthcare workforce to deliver world-class healthcare
- Integrated care – how to ensure the Governments' modernisation programme leads to better integration of services around people's needs
- The public's health – how to ensure the public's health remains at the heart of the NHS

3.0 THE ROLE AND FUNCTION OF THE SECRETARY OF STATE

3.1 The Secretary of State will continue to be responsible for promoting a comprehensive health service; the Bill does not change this. The Bill does however, include new duties to oversee the health service and report on the health service annually

3.2 In the past the duty to provide has been delegated by the Secretary of State to the health authorities, this is no longer the case as the Department of Health is not a provider of NHS services and has neither the staff nor facilities to make NHS services available to the public

3.3 The removal of the duty to provide is part of the Government's long standing intention to separate commissioner from provider. This does not in any way undermine Secretary of State's accountability or responsibility for the health service

3.4 The Bill sets out that under new proposals the duty to provide will be given directly to the NHS Commissioning Board and Clinical Commissioning Groups

3.5 The Secretary of State will provide national leadership across all three domains of public health:-

i) Health improvement
ii) Health protection
iii) Health services

In addition the Secretary of State will publish a public health outcomes framework.

4.0 THE NHS COMMISSIONING BOARD

4.1 The Board will be a single national organisation with a single operating model however; many of its functions will be delivered sub-nationally such as commissioning of primary care services

4.2 The board will be responsible for deploying around £20bn of the national budget for specialist services and primary care, this will include holding 35,000 contracts for primary care services

4.3 The Board will agree and deliver improved outcomes and account to Ministers and Parliament for progress.

4.4 Support quality improvements by promoting consistent national Quality Standards, a culture which promotes research and innovation. Providing world class support for clinically led service improvement and leadership.

4.5 Promote innovative ways of demonstrating how care can be made more integrated for patients.

4.6 The Board will also have a role delivering preventative and public health services, commissioning on behalf of Public Health England

4.7 The Board will host clinical networks advising on areas of care such as cancer, and the new senates (probably around 15) which will embed clinical expertise in commissioning decisions

4.8 The Board will start to operate in a shadow form as a special health authority in October 2011. By October 2012 the Board will be established as an independent statutory body with powers for the authorisation of Clinical Commissioning Groups

4.9 Approximately 3500 staff will perform functions of the board, operating on a local basis and will be involved in functions such as;

- Operational relationships with CCGs such as support in monitoring finance, performance and commissioning
- Stakeholder relationships including with the local government and HealthWatch

Although it is too early to say how these locality teams will be organised, they will initially reflect the current PCT cluster arrangements

5.0 CLINICAL COMMISSIONING GROUP

5.1 Clinical Commissioning Groups (CCGs) will manage around £80bn from the national budget but will be held accountable by the NHS Commissioning Board.

5.2 The report into developing the NHS Commissioning Board sets out proposals for the Board's role in overseeing the work of CCGs, which includes the following elements;

- A framework with outcomes for which the CCGs are accountable and the resources available to them, the Commissioning Outcomes Framework will be based on NICE national standards and will involve financial performance rewards
- A range of tools to support the effective commissioning which CCGs can adapt to reflect local needs. This should include guidance, modal pathways and standard contracts
- A continuing programme of organisational development

- A system of authorisation so that CCGs take on commissioning and budget responsibilities when they are ready
- A transparent rules-based approach to intervene to support CCGs in difficulty

6.0 MONITOR

6.1 Monitor will be the sector regulator for health. The core duty will be to promote and protect patient's interest

6.2 To carry out their duty Monitor will need to support the delivery of integrated services for patients where this would improve the quality of care for patients or improve efficiency

6.3 Monitors functions include; price setting and supporting the continuity of vital services in the event of financial failure, the licensing of providers and that competition is fair and operating in the best interests of the patients. Monitor will continue to authorise trusts as they seek to become foundation trusts by 2014 and will continue to obtain assurances from the Care Quality Commission as part of the authorisation process

7.0 PUBLIC HEALTH ENGLAND

7.1 Local authorities will take new responsibilities for public health led by jointly appointed Directors of Public Health.

7.2 Local authorities will be supported by a new integrated public health service Public Health England (PHE)

7.3 PHE will bring together the diverse range of public health expertise currently distributed across the health system.

7.4 It will ensure access to expert advice, intelligence and evidence,

7.5 PHE will be established as an Executive Agency, providing greater operational independence within a structure clearly accountable to the Secretary of State for Health

7.6 PHE will strengthen the national response on emergency preparedness, health protection and support public health delivery across the three domains of public health through information, evidence, surveillance and professional leadership.

7.7 PHE will have a particular key role in health protection, protecting people from hazards such as infectious diseases, radiation, chemicals and any emergencies caused by these.

7.8 A series of Public Health Reform Updates will be published during Autumn 2011:

- The Outcomes Framework
- The Public Health England Operating Model
- Public Health in local government and the Director of Public Health
- Public Health Funding Regime
- Workforce

7.9 Subject to Parliament, upper tier and unitary local authorities will take on their new public health responsibilities in April 2013.

8.0 IMPLICATIONS FOR SUNDERLAND

8.1 Key implications include the establishment of new or revised relationships with organisations and individuals within the new NHS landscape at national and local level/

8.2 Revised governance arrangements will be required to support an integrated approach to health and social care for the population of Sunderland.

8.3 Ensuring development of the Health and Wellbeing Board to maximise opportunities from the reforms to integrate NHS, public health and social care plans and provision.

8.4 Through Health and Wellbeing Board ensuring NHS commissioning plans are integrated with and reflect local joint health and wellbeing strategies. These must be informed by a joint – owned city wide strategic needs assessment.

8.5 Development of the Public Health transition plan to include finance, workforce and relationship to PHE.

8.6 Opportunity to implement integrated working at locality level with Clinical Commissioning Group (CCG).

8.7 Provision of local authority support during the CCG authorization process.

8.8 Ensure that functions transferred to the local authority are funded appropriately to minimise impact on the Council's financial efficiency plan.

Overall, combined with the strengthening of democratic legitimacy within health, the NHS Reforms offer significant opportunities to accelerate joint commissioning and provision of services for the benefit of Sunderland residents.

The Board is asked to receive this report for information and note the contents.