BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 29th July, 2011

Present:- Councillors Vic Pritchard (Chair), Loraine Morgan-Brinkhurst MBE (Vice-Chair), Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons, June Player, Sharon Ball, Sarah Bevan and Katie Hall

Also in attendance:

1 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the emergency evacuation procedure.

3 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Simon Allen (Cabinet Member for Wellbeing) had sent his apology to the Panel.

4 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

6 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

There were none.

7 CABINET MEMBER UPDATE (15 MINUTES)

The Chair informed the meeting that Jane Shayler (Programme Director for Non-Acute Health, Social Care and Housing) would introduce the update (attached as Appendix 1 to these minutes) in the absence of Councillor Simon Allen.

Following the update from Jane Shayler the Panel asked the following questions and made the following points:

The Panel asked what steps had been taken so Bath and North East Somerset residents are looked up properly in care centres following the investigation from BBC Panorama into abuse of vulnerable adults.

Jane Shayler informed the Panel that the Council undertakes regular contract review visits to all residential, nursing and home care providers plus some other short notice visits if particular concerns have been raised. All review visits are announced. Those inspection visits do not simply involve meeting with the registered manager and going through paper files, they also involve, walking through the facility and talking to service users, carers and staff. A simple checklist approach is not sufficient. The Council also regularly meets with the Care Quality Commission (CQC) (at least on 6 monthly basis). Also, locally we have established a Care Home Task Force comprised of GPs, consultants, nurses, social workers and other practitioners who have regular contact with residential and nursing care homes and are likely to pick up early signs of a drop in standards and/or of safety concerns. The Care Home Task Force also includes commissioning and contracting staff who gather "intelligence" about care homes coming from the Care Home Task Force and other sources liaise with CQC and ensure appropriate action is taken.

In response to a question about unannounced inspections, Jane Shayler informed the Panel that whilst commissioning and contracting staff do not make unannounced visits, they do work closely with CQC who can and do make unannounced visits to residential and nursing homes as well as other care services that are regulated by CQC..

The Panel asked whether the Care Home Task Force was not the part of their Member induction. Jane Shayler confirmed it is not although the relevant Cabinet Member was aware of its existence. The Panel asked that, in the light of the recent events in Bristol, the existence of the Care Home Task Force should be widely known. Jane Shayler confirmed that efforts would be made to raise awareness of the Care Home Task Force as well as the other ways in which anyone, including Elected Members, with any concerns about the safety and/or quality of care, could raise those concerns.

The Panel debated the Domiciliary Care Strategic Partnership issues with Jane Shayler and **RESOLVED** that a detailed report, or briefing update, on this subject should be presented to the Panel at the next meeting on the 7th October.

The Chairman thanked Jane Shayler who presented the update on behalf of the Cabinet Member.

Appendix 1

8 NHS UPDATE (15 MINUTES)

The Chairman invited Jeff James (Bath and North East Somerset and Wiltshire NHS Chief Executive) to give an update to the Panel (attached as Appendix 2 to these minutes).

The Panel asked the following questions and made the following points:

The Panel asked about the minimum waiting times for hospital admissions in Bath and North East Somerset.

Jeff James replied that the Corporation and Competition Panel are overseeing the contracts awarded to providers. The Panel published national and local report/s in terms of what the expectations from providers are nationally and locally. The PCT, as a commissioner, would always encourage competition between providers and one of the issues that would be looked at is minimum waiting time/s for hospital admissions. Jeff James also explained that the minimum waiting time should also reduce the number of people needing the service. The PCT would spend next few weeks in understanding on what the implications from the national and local reports are.

The Chairman thanked Jeff James for the update.

The Panel **RESOLVED** to have further and detailed update on minimum waiting time for hospital admissions.

Appendix 2

9 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES)

The Chairman invited Diana Hall-Hall and Mike Vousden to take the Panel through the update.

Some Members of the Panel expressed their concern related to the Out of Hours Access to GP Services in the report and encouraged the Local Involvement Network to continue to monitor this issue.

The Chairman thanked Diana Hall-Hall and Mike Vousden for their update.

10 HEALTHWATCH STATUS REPORT (15 MINUTES)

The Chairman invited Derek Thorne (NHS BANES Assistant Director for Communications and Corporate Affairs) to introduce the report.

The Panel asked the following questions and made the following points:

The Panel expressed their concerns that the shape of the HealthWatch Board would be set up and led by the provider and not having the public involved in the organisational set up.

Derek Thorne responded that there would have to be organisational entity as such and the Council would have to procure that entity.

The Panel also expressed their concern that the Health Scrutiny role would be taken away from this Panel once the new board is in place.

Derek Thorne replied that the board would try to achieve more accessible consumer voice.

The Panel expressed their concern of having a HealthWatch board member as non-voting Wellbeing Panel Member. Members of this Panel are the elected Members who represent their communities and there might be possible conflict of interest from the HealthWatch nominee. The point was made that this issue would need further consideration before any final decision was made.

Derek Thorne said that the next step would be creation of specification for procurement process (expected for November/December 2011).

It was **RESOLVED** that the Panel noted the report and that the comments/views made by the Panel be taken on board by relevant officer/s.

11 NHS REFORM AND INTERIM COMMISSIONING ARRANGEMENTS (20 MINUTES)

The Chairman invited Jeff James to introduce the report.

The Panel asked the following questions and made the following points:

The Panel asked about the latest on the GP led commissioning.

Jeff James responded that the GP led commissioning group for Bath and North East Somerset had been launched with the established leadership of 7 GPs. The group had been working very closely with the NHS. The NHS decided that the group could start operating on their own as from October-November next year. Some of GPs had been actively involved in the Partnership Board for Health and Wellbeing work.

It was **RESOLVED** to note the report.

12 SERVICE DEVELOPMENT FOR PET/CT SERVICES FOR ADULTS (20 MINUTES)

The Chairman invited Anne Jarvis (Director South West Specialised Commissioning Group) to introduce the report.

The Panel asked the following questions and made the following points:

The Panel asked why Bristol City Council declared substantial variation on this matter.

Anne Jarvis responded that the main reason was about the travel.

Councillor Eleanor Jackson felt that the weightings outlined in the chart on paragraph 4.7 of the report (pg 36), where weighting of 60% was given to Affordability/Value for Money criteria and only 5% for Patient Engagement & Experience criteria, were not acceptable. Therefore, with the reason that this change of services had been financially driven, Councillor Jackson moved a motion to declare substantial variation. Councillor June Player seconded the motion.

Voting: 2 in favour and 8 against. Motion failed.

Councillor Bryan Organ moved a motion to support the proposal to award the two year contract to Cobalt Healthcare. Councillor Sharon Ball seconded the motion.

Voting: 8 in favour and 2 against. Motion carried.

It was **RESOLVED** to:

- Note the rigour and outcome of the PET/CT re-tendering process;
- Note the improved quality of service, patient experience and value for money the new contract will deliver;
- Note the involvement of the public, patients and carers and the support of the patient and carer who were on the assessment panel;
- Support the proposal to award the two year contract to Cobalt Healthcare.

13 GREAT WESTERN AMBULANCE SERVICE JOINT SCRUTINY COMMITTEE MEMBERSHIP AND UPDATE (10 MINUTES)

The Chairman invited Councillor Tony Clarke, who is recently appointed Chair of the Great Western Ambulance Services (GWAS) Joint Scrutiny Committee to address the Panel.

Councillor Clarke said that it is important for the Council to have 3 Members on the GWAS Joint Scrutiny Committee. The GWAS significantly improved in the last few years but the recent poor rating from the audit commission would need to be looked at. Although this is Joint Scrutiny Committee there is nothing stopping this Panel to scrutinise ambulance issues relevant to Bath and North East Somerset area.

It was **RESOLVED** to:

- Note the report; and
- Agree that Councillors A Clarke, E Jackson and S Ball be nominated to sit on the GWAS Joint Scrutiny Committee.

14 PROGRESS IN ESTABLISHING A COMMUNITY HEALTH & SOCIAL CARE SERVICES COMMUNITY INTEREST COMPANY (20 MINUTES)

The Chairman invited Jane Shayler to introduce the report. Jane Shayler informed the Panel that the 10 day period to challenge the intention to award the contract to the Bath and North East Somerset Community Health and Care Services Community Interest Company had expired without any challenge.

It was **RESOLVED** to note the update report.

15 WORKPLAN

The Panel **AGREED** the future workplan with the following additions:

- Domiciliary Care Strategic Partnership update (for October 2011)
- Minimum waiting time for hospital admissions (date to be confirmed)
- 'What is it like to be an older person in BANES – to look at the life overall rather than under the series of separate headings' (date to be confirmed)
- Dementia care in BANES (date to be confirmed)
- Psychological therapy services for adults (including the provision of counselling services in BANES) (date to be confirmed)
- Ambulance Services update (to be confirmed)

The Panel also **AGREED** to have an away day and visit the Community Health and Social services provided by the Council.

Jane Shayler said that she will be in touch with the Panel for the preferred date. The Panel agreed to have a half an hour catch-up with Samantha Jones (Corporate Policy Manager for Equalities) on Corporate Equalities issues.

The meeting ended at 1.20 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Cllr Simon Allen, Cabinet Member for WellBeing
Key Issues Briefing Note

Wellbeing Policy Development & Scrutiny Panel – July 2011

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1. PUBLIC ISSUES

Winterbourne View/Castlebeck

The Care Quality Commission (CQC) has published its report on Winterbourne View, the Castlebeck run independent hospital at the centre of a BBC Panorama investigation into abuse of vulnerable adults. The CQC inspection was undertaken in May this year. Bath & North East Somerset had no one placed at Winterbourne View during the period covered by either the Panorama investigation or CQC's inspection. The CQC report found that there were "systemic failings" in protecting vulnerable people in their [Winterbourne View's] care. In all, the CQC report published on 18th July finds that the company was failing to meet 10 of the 16 essential standards at Winterbourne View prior to its closure last month. Reports on all of Castlebeck's locations will be published later this summer while 150 services with similar characteristics to Winterbourne View are also being reviewed by CQC.

2. PERFORMANCE

Domiciliary Care Strategic Partnership

Over recent months the performance of one of the five Domiciliary Care Strategic Partners has fallen, with a number of care packages being handed back to the local authority for re-allocation to alternative providers. At the present time, per week, 121 clients receive a total of 999 visits equating to 690 care hours (ordered visits and ordered hours delivered may vary slightly). Target hours in the contract are 1870, however, this level of performance has never been achieved since the start of the contract period. For comparison, hours delivered by the other four Strategic Partners range between 670 (against target hours of 770) and 1326 (against target hours of 719). The Strategic Partner delivering significantly above target hours has achieved this by being very responsive to referrals, which are offered to all Strategic Partners on a rotational basis in line with the contractual framework.

A decision has now been reached by agreement that the contract is unlikely to extend beyond the current contractual period and will therefore terminate on 31st March 2013. The remaining hours/packages of care associated with the contract will need to be transferred to other strategic partners or re-tendered and this will need careful planning and management to ensure that it does not affect continuity and quality of care for service users and carers. Staff associated with the contract will also need to transfer to alternative employers and, considering the volume of work delivered, TUPE implications are likely to apply. Initial meetings with Trades Unions representatives have been held to discuss and agree key messages for affected members and staff. A comprehensive project plan now needs to be developed with all key stakeholders to ensure a smooth transition of service for users and staff.

Extra Care Vacancies

Extra Care housing is an independent living model of service which delivers 24 hour care and support to older and vulnerable people living in their own homes, usually within a purpose built complex. In Bath & North East Somerset there are currently five extra care schemes in operation comprising 140 individual units of accommodation with associated care services provided at all locations by Community Health & Social Care Services (CH&SC). A further 10 units of Extra Care are currently being developed within an existing sheltered housing complex.

Extra Care provides a cost effective alternative to residential care and forms a key part of the Council strategy for promoting the independence of older people and reducing overall spend on residential care. However, recent use of Extra Care has fallen, with the Midsomer Norton scheme in particular seeing occupancy levels as low as 74%.

Two potential issues appear to be affecting performance. The first is that nomination arrangements within CH&SC appear to have been less closely co-ordinated since the introduction of the new single panel arrangements (a possible unintended consequence of the new process for agreeing placements above an agreed threshold). The second relates to the perception of Extra Care amongst potential health and social care referrers with feedback suggesting that the schemes are sometimes viewed as "not supportive enough", that is, that they cannot cater for people with relatively high care and support needs, or an "unnecessary stage" in an individual's pathway from living at home and residential care.

In light of this fall in performance, nomination arrangements have been clarified and re-affirmed with all relevant parties. Also, a road show is planned to raise awareness of Extra Care and promote it as a viable alternative to residential care.

3. SERVICE DEVELOPMENT UPDATES

Loans Scheme for Homeless Households

The Non Acute Social Care Commissioning team has this month commissioned Bristol Credit Union (BCU) to carry out the loans function of the Homefinders service. Homefinders is a Council initiative that prevents homelessness by enabling people to access the private rented sector using loans for rent in advance and deposits. Roughly 60 household per year are assisted to take up new tenancies through this route. From 1 September, having identified a property that they would like to rent, individuals will now be able to arrange for advance payments to be covered by a loan from Bristol Credit Union, of which they would become a member. As part of this process, BCU will suggest the tenant sets up a Rent Direct payment. Rent Direct ensures that Local Housing Allowance payments are received into the individuals account and are directed to the landlord. This means that the individual is less likely to get into arrears and is more likely to make a success of their tenancy. Membership of BCU also opens up other financial options, such as current and savings accounts, loans for other purposes and information on benefits.

Housing Support Gateway

The 'Housing Support Gateway' was launched on June 23rd. This is an online single point of access to a large number of housing related support services, (supported housing and floating support) in B&NES. It is linked to the Homesearch Register.

Clients can apply online by themselves or with the help of other stakeholders and the system 'matches' the applicant to the services that can best meet their needs. We are hoping that the initiative will make it easier for people to apply, (they'll only have to do one form to be considered for lots of services); ensure that the people in the most need will receive the services; reduce void times, and give us as commissioners a lot of intelligence re demand and use of housing related support services.

The website address is www.housingsupportgatewaybathnes.org.uk

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NHS B&NES Key Issues Briefing Note

Overview and Scrutiny Panel – 29th July 2011

NHS Reforms
Update information on the reform programme and the PCT cluster arrangements is provided in a separate report.

Public Health
The Health and Social Care Bill will transfer public health to Local Authorities The Department of Health have recently released an update on the proposed pubic health changes in England. A specific briefing paper has been prepared and this is attached for information.

Health and Wellbeing Boards
A key aspect of the reform programme is the establishment of health and wellbeing boards. Both the partnership board and the PCT board have approved a set of principles and outline governance arrangements for the creation of a health and wellbeing board in B&NES.
We are in a strong position to build on the integration work already established over several years and plan to take an evolutionary approach whereby the existing partnership board, alters its membership to include both clinicians and HealthWatch representation, revises its terms of reference and moves into a the new role from April 2012.
The health and wellbeing board will be responsible for:

- developing a joint strategic needs assessment (JSNA)
- preparing the health and wellbeing strategy
- considering whether the commissioning arrangements for social care, public health and the NHS are in line with the health and wellbeing strategy
- considering whether the GP Consortia's commissioning plan has given due regard to the health and wellbeing strategy
- reporting formally to the NHS Commissioning Board, GP Consortium, council leadership if local commissioning plans have not had adequate regard to the health and wellbeing strategy.

Membership

Membership for the health and wellbeing board in B&NES is proposed as:

For NHS B&NES	**For B&NES Council**
Chairman	Leader
Chief Executive	Chief Executive
1 Non Exec Director	1 Councillor
Chair of Clinical Commissioning Group	1 Councillor
Accountable GP	Director of Peoples Services
Additional Members	
Healthwatch x 2	Acting as consumer champion
Director of Public Health	Acting across both organisations in joint role
Finance Advisor	Nature of membership to be agreed

Cluster Management Arrangements

A single executive team of Chief Executive and five Directors is being established across the two PCts within the B&NES and Wilts cluster. Three appointments have recently been made.

Jennifer Howells is now in post as joint Director of Finance. Jenny has held the position of Joint Director of Finance across the two Trusts since March this year and her appointment through the latest process now confirms her position with us for the next two years.

Suzanne Tewkesbury has been appointed Director of Human Resources, Communications and Corporate Services to. Suzanne has held the position of Director of HR at NHS Wiltshire since 2007.

Mary Monnington has been appointed Director of Nursing. Mary has worked for South Somerset Primary Care Trust and latterly NHS Somerset as Director of Nursing since 2001.

Advertisements are now out for the roles of Interim Director of Commissioning Development and Medical Director. It is anticipated that interviews will be held for these two posts during August.

Any Qualified Provider

The Department of Health has published guidance on how the NHS will deliver greater choice. This programme of change is entitled Any Qualified Provider (AQP). Full details are available to view at
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

More choice will mean that when patients are referred for selected services, usually by their GP, they should be able to choose from a range of qualified providers who meet NHS quality, prices and contracts.

To date, choice has only been available in non-urgent hospital care, but published guidance now sets out that the choice offer will be extended to community and mental health services for the first time. Following advice from patient groups, clinicians and voluntary organisations, there are eight services that have been recommended as the most suitable:

- Services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Diagnostic tests closer to home
- Wheelchair services (children)
- Podiatry (feet) services
- Leg ulcer and wound healing
- Talking Therapies (Primary Care Psychological therapies, adults)

PCT clusters, supported by Clinical Commissioning Groups may also choose other services which are higher local priorities, if there is a clear case to do so based on the views of service users and potential gains in quality and access

Every area across England will be expected to offer choice in a minimum of three services by September 2012 – Primary Care Trust clusters will engage with local patients, carers and professionals during August and September and identify their three or more community or mental health services. These decisions need to be reached by October with implementation then taking place between April and September 2012.

Healthy lives, healthy people

Update from Department of Health on key issues and proposals for the way forward.

Paul Scott, Assistant Director of Public Health, July 2011

A new public health system, with strong local and national leadership

A system focused on outcomes

The whole system will be refocused around achieving positive health outcomes for the population, rather than focused on process targets and will not be used to performance manage local areas. DH will work with stakeholders to finalise the Public Health Outcomes Framework and publish it later in the year (expected autumn 2011).

A locally-led system: local government

- Local authorities are uniquely placed to tackle the wider determinants of health (such as employment, education, environment, housing and transport), and are a natural home for a public health function focused on improving health and wellbeing across the life course.
- Local authorities will have a role across the three domains of public health (health improvement, health protection and health services quality). The Health and Social Care Bill gives unitary local authorities a new duty to take such steps as it considers appropriate for improving the health of the people in its area. DH plan to give local authorities new functions through regulations for taking steps to protect the local population's health, and for providing clinical commissioning groups with population health advice.
- Local authorities will be funded to carry out their specific new public health responsibilities through a ring-fenced grant. To maximise flexibility DH will place only a limited number of conditions on the use of the grant. The core conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensuring a transparent accounting process.
- Commissioning routes for programmes are set out in Appendix 2 of this summary. DH encourage local services to move forward with planning on this basis.
- In addition to local authorities role in a wider range of activities, DH will specifically prescribe that local authorities deliver the following services or steps:
    - appropriate access to sexual health services
    - steps to be taken to protect the health of the population, in particular, giving the Director of Public Health 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
    - elements of the Healthy Child Programme.

A local community's health advisor - the Director of Public Health

- The Director of Public Health (DPH) will be:
  - the principal adviser on health to elected members and officials
  - the officer charged with delivering key new public health functions
  - a statutory member of the health and wellbeing board
  - the author of an annual report on the health of the population.
- The DPH will have responsibilities across the three domains of public health, reflecting the responsibilities of local authorities. Thus on health improvement, DH expect the DPH to lead on investment for improving and protecting the health of the population locally, and reducing health inequalities through the way the ring-fenced grant is spent (although accountability for the grant rests with the Chief Executive of the local authority).
- On health protection, DH plan to make it a requirement for the local authority to ensure that plans are in place to protect the health of the local population, under regulation making powers in the Bill. This will ensure that Directors of Public Health have a critical role, working closely with Public Health England at the local level and with the NHS, to ensure appropriate public health responses to the whole spectrum of potential problems, from local incidents and outbreaks to emergencies.
- With regard to population healthcare, Directors of Public Health and their teams will provide public health expertise, advice and analysis to clinical commissioning groups and health and wellbeing boards and (for primary care and other directly commissioned services) to the NHS Commissioning Board. This provision of public health input to NHS commissioning will become a mandated step for local authorities, using regulation-making powers in the Health and Social Care Bill. Public health specialists will also come together with other health and care experts in new clinical senates, hosted by the NHS Commissioning Board, to advise on how to make patient care fit together seamlessly.
- Directors of Public Health will be employed by local authorities, but the appointment process will be joint with Public Health England, who will be able to ensure that only appropriately qualified individuals are appointed.
- DH state that local authorities will determine the precise detail of their own corporate management arrangements. DH also state that given the importance of these new local authority public health functions, they would expect the DPH to be of Chief Officer status with direct accountability to the Chief Executive for the delivery of local authority public health functions. DH will discuss with local government and public health stakeholders how best to ensure that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services.

A locally-led system: the NHS

- The NHS has four main roles in securing population health outcomes:
  - provision of accessible and high quality health care to meet the needs of the local population
  - ensuring that in delivering healthcare the opportunities to have a positive impact on public health are taken (eg. through advice, brief interventions and referral to targeted services)
  - delivery of specific population health interventions (eg. childhood immunisations and national screening programmes)
  - the NHS contribution to health protection and emergency response.

- Appendix 1 identifies a number of services that will be commissioned by the NHS Commissioning Board, funded from the public health budget.
- Local authorities, through their Directors of Public Health, will provide public health advice to clinical commissioning groups. To support the detailed implementation of this policy, DH

will engage with stakeholders on the design of the “core public health offer” from local authorities to the NHS, setting out what support local NHS bodies should expect from the local authority Director of Public Health.

A locally-led system: coordinated by the health and wellbeing board

- Health and wellbeing boards will maximise opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population.
- Health and wellbeing boards will provide the vehicle for local government to work in partnership with commissioning groups to develop comprehensive Joint Strategic Needs Assessments and robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health services, and taking into account wider ranging local interventions to support health and wellbeing across the life course (eg. local planning and leisure policies and working with community safety partnerships and police and crime commissioners).
- Health and wellbeing boards will have a strong role in leading on local public involvement Health and wellbeing boards, in considering their membership, will be free to invite other members to sit on the board in order to maximise the gain from health outcomes and align these with employment, welfare and reductions in offending. Each health and wellbeing board will consider its membership based on local needs and priorities.
- Health and wellbeing boards will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. In line with the Localism Bill, local authorities will have greater discretion over how to exercise their health scrutiny powers, and will be able to challenge any proposals for the substantial reconfiguration of NHS services.

A locally-led system: supported by Public Health England

- Public Health England will bring together a fragmented public health system, strengthen the national response on emergency preparedness and health protection and support public health delivery across the three domains of public health (health improvement, health protection and health service quality) through information, evidence, surveillance and professional leadership.
- Public Health England will support local action by:
    - generating information to support the development of local Joint Strategic Needs Assessments
    - building the evidence base on what works
    - communicating intelligence to local leaders about how best to tackle the public health challenges their population is facing, to support the development of joint health and wellbeing strategies
    - reporting on local government contribution in improving population health outcomes as part of the public health outcomes framework
    - advocacy to promote and encourage action right across society, including by local employers and individuals and families
    - providing robust surveillance and local response capabilities to respond to threats to public health and ensure health is protected.
- Public Health England will play a particularly key role in health protection. Appendix 3 sets out how DH are strengthening the arrangements around emergencies, highlights the clear role for Public Health England and includes the defined route for mobilising NHS and public health services to respond to emergencies.

Clear national leadership

- The Secretary of State for Health will provide national leadership, resources and the legislative infrastructure for public health.
- Public Health England will drive delivery of improved outcomes in health and well-being, and design and maintain systems to protect the population against existing and future threats to health.
- Public Health England will develop an integrated approach to information, intelligence and evidence (working alongside NICE), ensuring that local authorities, the NHS and Department of Health have the understanding, advice and tools they need to successfully drive improvements in health.
- Public Health England will be established as an integrated public health delivery body. It will bring together in one organisation the following:
  - Health Protection Agency
  - National Treatment Agency for substance misuse
  - Regional Directors of Public Health and their teams in the Department of Health and Strategic Health Authorities
  - regional and specialist Public Health Observatories
  - Cancer Registries and the National Cancer Intelligence Network
  - National Screening Committee and Cancer Screening Programmes.
- DH intends to establish Public Health England as an Executive Agency of the Department of Health. It will have a distinct identity and a Chief Executive with clear accountability for carrying out its functions. Its status will underline its responsibility for offering scientifically rigorous and impartial advice. DH will work closely with stakeholders to ensure that Public Health England is focused to offer strong support to Directors of Public Health and their partners in the local system.
- The NHS Commissioning Board will look to Public Health England to ensure appropriate population health advice is available to the NHS from the public health system.
- DH are developing further the detailed accountability relationships between the Department of Health, Public Health England and the NHS Commissioning Board in the new system.

Developing a rich and diverse workforce

- DH are working with stakeholders to develop a public health workforce strategy that will include education and training opportunities for people at different entry points, that will provide flexibility for staff to move between different employment sectors and to meet the changing public health needs of the future.
- DH are developing a high level HR “concordat” in partnership with the NHS and Local Government Employers on the effective transition of public health staff between the NHS and local authorities.
- DH are also developing a “People Transition Policy” that will set out the principles applying to the HR and employment processes supporting the transfer of staff into Public Health England.

Financing the public health system

- DH state that ‘a fundamental plank’ of their reform strategy is providing public health with dedicated resources. This will allow a strategic approach to spend on prevention, recognising that public health is a long-term investment, and that effective spend on prevention will release efficiency savings elsewhere, which can then be used elsewhere in the NHS and cross-government more widely.
- DH are continuing to engage with the NHS and local government partners to refine assessments of current baseline spending by the NHS on activity, which in future will be

funded from the public health budget. This work and decisions about the portions of the public health budget that would be distributed to local authorities, transferred to the NHS Commissioning Board to fund commissioning of specific public health programmes; or form the budget of Public Health England itself are dependent on ongoing work, including on the final agreement of commissioning responsibilities.

- DH are committed to ensuring that local authorities are adequately funded for their new responsibilities and that any additional net burdens will be funded in line with the Government's New Burdens Doctrine.
- Public health grants to upper tier and unitary local authorities will be made for the first time in 2013-14 and DH intend to provide shadow allocations for 2012-13 by the end of this year. DH intend to take forward the detailed development of the Health Premium (which will incentivise improvement against a subset of indicators from the public health outcomes framework) with a group of key partners, including local government, over the coming months.

Next steps

Completing the operational design

- DH will produce a series of Public Health Reform Updates through the autumn, including:
  - The Outcomes Framework
  - The Public Health England Operating Model
  - Public Health in local government and the DPH
  - Public Health Funding Regime
  - Workforce strategy

Managing the transition

- Subject to Parliament, upper tier and unitary local authorities will take on their new public health responsibilities in April 2013, at which point they will also take responsibility for Directors of Public Health and their functions.
- Public Health England will be created at the same time, formally taking on the functions of its predecessor bodies.
- Ahead of the formal transfer there is much that can be done to build the local relationships and develop local agreements and shadow arrangements to test elements of the new approach to public health. DH are encouraging local systems to press ahead and develop locally tailored approaches.
- Formal transition plans are to be agreed with the Regional Director of Public Health by March 2012. Ahead of this date DH strongly encourage local authorities and Primary Care Trusts to work together on developing the relationships and joint working that will facilitate a robust transition for April 2013.
- DH plan to recruit a Chief Executive for Public Health England to be in post from April 2012.
- The Regional Directors of Public Health will continue to lead the transition in their regions and DH will continue to work closely with the Faculty of Public Health, the Association of Directors of Public Health, the Public Health Taskforce, the Local Government Group and other key stakeholders in developing detailed proposals and implementing these reforms.

Appendix 1 – Headline recommendations from the Marmot Review into health inequalities *Fair Society, Healthy Lives*

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

NB: More detailed policy recommendations for each of these headline areas can be found at www.marmotreview.org

Appendix 2: Proposed commissioning responsibilities for public health

- Subject to further engagement, the new responsibilities of local authorities would include local activity on:
  - tobacco control
  - alcohol and drug misuse services
  - obesity and community nutrition initiatives
  - increasing levels of physical activity in the local population
  - assessment and lifestyle interventions as part of the NHS Health Check Programme
  - 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 programmes
  - comprehensive sexual health services
  - local initiatives to reduce excess deaths as a result of seasonal mortality
  - role in dealing with health protection incidents and emergencies as described in Appendix 3
  - promotion of community safety, violence prevention and response
  - local initiatives to tackle social exclusion.

- DH will ask the NHS Commissioning Board to commission all immunisation programmes, to ensure a single commissioner, but ensure that Directors of Public Health have a defined role in supporting reviewing and challenging delivery of services
- DH will consider what role Directors of Public Health should have with regard to national screening programmes, which will be commissioned by the NHS Commissioning Board on behalf of Public Health England.
- In addition to their new public health responsibilities, local authorities are ideally placed to maximise the opportunities to develop holistic approaches to improve health and wellbeing, such as specific services for older people and carers, local employers, local criminal justice and community safety agencies, tacking wider issues, such as air quality and noise and improving access to employment, shops and other local services through sustainable modes of transport.
- The public health budget will also fund the NHS to commission certain public health services, in light of the paragraphs above, and subject to further engagement. This includes:
  - immunisation programmes
  - contraception in the GP contract
  - screening programmes
  - public health care for those in prison or custody
  - children's public health services from pregnancy to age 5 (including health visiting).

- The NHS will also commission and deliver many more interventions that improve public health funded, from within the NHS budget over and above this. For example, providing brief interventions and referral in primary and secondary care.
- DH ask local authorities, the shadow NHS Commissioning Board (once established) and emerging clinical commissioning groups to plan on the basis of the respective responsibilities set out above.

Appendix 3: Emergency preparedness, resilience and response

- There will be clear roles and responsibilities for the Department of Health and Public Health England, Directors of Public Health and the NHS Commissioning Board with a defined route for mobilising NHS and public health services to respond to emergencies.
- The Health and Social Care Bill will update the Secretary of State for Health's powers of direction during an emergency. In addition, new arrangements provide the Secretary of State with a clear line of sight to front line responders through Public Health England and the NHS Commissioning Board.
- The Department of Health will support the Secretary of State in his responsibilities for emergency response. It will represent the health sector in the development of cross government civil resilience policy and support the UK Government's central response to major emergencies.
- Public Health England will provide public health leadership for emergency preparedness and response and will provide independent scientific and technical advice at all levels.
- Subject to regulations being made, it is intended that, within local authorities, Directors of Public Health will ensure plans are in place to protect the health of their population, working closely with Public Health England local units and NHS organisations.
- In the event of an emergency or incident, the NHS Commissioning Board, at an appropriate level, will lead the NHS response to any emergency that has the potential to impact, or impacts on the delivery of NHS services, or requires the services or assets of the NHS to be mobilised, taking scientific and technical advice from Public Health England.
- NHS-funded units will have clearer obligations to prepare for and respond to emergencies, and providers will be required to collaborate in local multi-agency emergency planning and response activity.
- Joint planning and collaborative working will lie at the heart of the health system's preparedness and response arrangements. Public Health England and the NHS Commissioning Board will work together at all levels to ensure nationally consistent health emergency preparedness and response capability. Senior leaders will be responsible for emergency preparedness and response in both the NHS Commissioning Board and Public Health England and in the Department of Health. They and their teams will work closely together, aligning with wider Government resilience hubs established by the Department for Communities and Local Government, and the existing Local Resilience Fora that provide the focus of multi-agency planning and response to emergencies. There will be a clear process to develop and test plans based on national and local risks and challenges.
- These new arrangements will be a significant improvement on the current arrangements.
- DH will manage the transition to this new approach to ensure a continuing robust and effective emergency planning system, including throughout the Olympic period.
- DH will engage with key stakeholders over the coming months to consider further the proposed model for health emergencies and incidents based on these principles.

I promised to keep you up to date with news about the recruitment to the four Director posts across the NHS BANES and NHS Wiltshire Cluster and so I'm writing now to let you know how the process is progressing.

I'm delighted to confirm that Jenny Howells has been officially appointed to the post of Director of Finance to the NHS Bath and North East Somerset and NHS Wiltshire Cluster. Those of you who know Jenny will be aware that she has held the position of Joint Director of Finance across the two Trusts since March this year, so we're particularly happy that her appointment through the latest process now confirms her official position with us for the next two years.

Unfortunately we have not been able to successfully recruit to the positions of the three remaining Director posts – Director of Commissioning, Medical Director and Director of Nursing – so the positions will be opened to expressions of interest from candidates outside of the South West region. Interviews for these posts will be held during June and I will, of course, let you know the outcome of any decisions.

Jeff James, Cluster CEO NHS B&NES and NHS Wiltshire

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