Shadow Health and Wellbeing Board

Wednesday, 9th May, 2012 in Cabinet Room 'C' - County Hall, Preston, at 2.00 pm

Agenda

TEA, COFFEE AND BISCUITS
Available from 1.45pm

1. **Welcome from the Chair and overview of the agenda - 2.00pm**

2. **Apologies for Absence - 2.10pm**

3. **Minutes of the meeting held on 8 March 2012 - 2.15pm** (Pages 1 - 6)
   To agree the minutes of the meeting held on 8 March 2012.

4. **Strategy Task Group Meeting Update Report - 2.20pm** (Pages 7 - 16)
   Report attached.

5. **What is the leadership role of Board Members of the Health & Wellbeing Board - facilitated discussion - 2.40pm**
   Ian Roberts to facilitate discussion.

6. **Update on NHS Reform and progress implementing the Health & Social Care Act - 3.20pm** (Pages 17 - 26)
   Report attached.

7. **Public Health Update from Lancashire County Council - 3.40pm** (Pages 27 - 28)
   Report attached.

8. **Any Other Urgent Business - 4.00pm**

9. Programme of Meetings 2012 and Date of Next Meeting - 4.05pm

The Board is asked to note the programme of meetings for 2012 and the date of the next meeting as indicated below:

Date of Meeting
29 May 2012, Rowan Room, Woodlands, Chorley
10 July 2012, Cabinet Room 'D', County Hall, Preston
4 September 2012, Rowan Room, Woodlands, Chorley
18 October 2012, Rowan Room, Woodlands, Chorley
16 November 2012, Rowan Room, Woodlands, Chorley

All meetings are now a 2pm start, with tea, coffee and biscuits available from 1.45pm.

The Board is also asked to note that the next meeting of the Board will be held on Tuesday 29 May 2012, 2pm in the Rowan Room at Woodlands, Chorley.

END OF MEETING

Shadow Health and Wellbeing Board

Minutes of the Meeting held on Thursday 8 March 2012 at 1.30pm at Brockholes Nature Reserve, Samlesbury, Nr Preston.

Present:

County Councillor Valerie Wilson	Lancashire County Council (in the Chair)
County Councillor Mike Calvert	Lancashire County Council
County Councillor Susie Charles	Lancashire County Council
Richard Jones	Lancashire County Council
Helen Denton	Lancashire County Council
Maggi Morris	Director of Public Health (LCC / PCT)
Dr Peter Williams	East Lancashire Clinical Commissioning Group (CCG)
Dr David Wrigley	Lancaster CCG
Dr Robert Bennett	Chorley and South Ribble CCG
Dr Simon Frampton	West Lancashire CCG
Dr Tony Naughton	Fylde and Wyre CCG
Peter Kenyon	Lancashire PCT Cluster Board
Sally Parnaby	Lancashire PCT Cluster Board
Councillor Bridget Hilton	Central Lancashire District Councils
Councillor Margaret Lishman	East Lancashire District Councils
Councillor Cheryl Little	Fylde District Councils
Lorraine Norris	Preston City Council (representing Lancashire District Councils)
Canon Michael Wedgeworth	Third Sector Lancashire
Walter D Park	Lancashire Link
Ian Roberts (Observer)	Greengage Consulting
Habib Patel	Lancashire County Council
Deb Harkins	Lancashire County Council

Apologies for absence were received from Frank Atherton, Director of Public Health (LCC / PCT), Janet Soo Chung, Lancashire PCT Cluster, Dr John Caine, West Lancashire CCG whom was replaced by Dr Simon Frampton, and Dr Ann Bowman, Greater Preston CCG.

1. Welcome from the Chair and overview of the agenda

County Councillor Valerie Wilson welcomed everyone to the meeting and in particular the CCG representatives who were attending for the first time. The Board received a brief introduction to the Brockholes venue which explained how the reserve came into being and aspirations for its future development.

Session 1 – The programme of work for the Shadow Health and Wellbeing Board

Ian Roberts, Greengage Consulting, and Habib Patel, Lancashire County Council, gave a presentation outlining suggestions for areas that the Board can focus on. Ian talked about the objectives and plan for the initial Board meetings as follows:

- The programme of work for the Health and Wellbeing Board.
- Health and Wellbeing priorities.
- Delivering our priorities.
- How should the Board operate within the Lancashire health system?
- Housekeeping.

Habib explained the statutory role of the Health and Wellbeing Board including:

- Needs of the population (Joint Strategic Needs Assessment (JSNA)).
- Determine priorities (Strategy).
- Promote integration (commissioning, service delivery).
- Hold to account (performance manage).
- Voice on behalf of the people of Lancashire.

Habib posed some questions for the Board to consider regarding the Health and Wellbeing Strategy:

- What is the purpose of the board's strategy?
- How do we want the strategy to be delivered, County/CCG footprint/Locality?
- How do we get buy in from stakeholders on priorities and delivery?
- How do we performance manage the strategy?
- What is the role of the Board in delivering /monitoring the strategy?

Ian also explained that he had met with 14 out of 18 Board members to discuss their aspirations for the Board and provided feedback on the information gathered from this exercise so far.

Habib closed the session by setting out the timescales and programme for the future Board meetings and expressed an aspiration that the Health and Wellbeing Strategy be signed off at the 10th July 2012 Board meeting.

Session 2 – Health and wellbeing priorities in Lancashire

Deb Harkins, Lancashire County Council, gave a presentation to explain what the priorities are for health and wellbeing in Lancashire and also to explain what the JSNA tells us.

Deb explained that the JSNA gives high level strategic analysis which is used to inform priority setting. Priorities include Health inequalities, children and young people, mental health and wellbeing, older people, alcohol, drugs and tobacco

Deb highlighted the priorities for addressing the determinants of health inequalities as follows:

- Reduce unemployment.
- Increase income and reduce child poverty.
- Strengthen communities.
- Develop skills and life long learning.
- Reduce alcohol consumption and tobacco use.
- Increase social support.

Key themes of the JSNA include

- Aging and changing population at risk.
- Impact of the economic climate.
- Maximise use of regulatory powers for health and wellbeing.
- Impact of poverty and social inclusion on health, wellbeing and determinants.
- Intergeneration and family issues.
- Pivotal role of primary care (particularly GPs and their teams).
- Ensure the best possible services are available to all when there is a crisis.
- Current and potential contribution of the third sector.
- Support people to be in control of their health, care and wellbeing.
- Natural environment is a key asset for health and wellbeing.
- Mobilise community assets and build community resilience.
- Importance of social relationships.
- Importance of wellbeing in affecting physical health, behaviour, social inclusion and prosperity.
- Identify those at high risk and intervene earlier – make every contact count!
- Risk taking behaviours – harm reduction and recovery.

Finally, Deb explained that the goal of the Health and Wellbeing Strategy was to narrow the gap in healthy life expectancy and finished her presentation with some suggestions for the priority outcomes for the Board as follows:

- Improve maternal and infant health.
- Improve mental health and wellbeing.
- Reduce incidence and survival of long term conditions and support people be in control of their health.

Session 3 – Delivering our health and wellbeing priorities and Session 4 – How Should the Board operate within the new Lancashire Health System

For both of these sessions Ian Roberts facilitated a group discussion on what priorities the Board should focus on and discussion about how the Board sees itself fitting into the new Lancashire Health System.

Board members were split into three groups and were asked to group together suggestions for areas that the Board should focus on. The results were as follows:

Group 1

- Alcohol Abuse and implications, such as Teenage Pregnancy, mother and child health.

- Targeted Health checks including checks for dementia and target people living in rural areas.
- Principal of more focus on early intervention.
- Older people healthier living.
- Listen to the voice of the people.

Group 2

- Emotional Health and Wellbeing – develop more practical pathways.
- How to develop priorities, evidence based.
- Public engagement.
- Balance between universal and targeted services, intensity to depend on level of need.
- Domestic violence.
- Governance and accountability.
- Drugs and alcohol abuse.
- Early family wellbeing.
-

Group 3

- Public engagement – people to take more responsibility.
- Bring priorities together, identify key priorities once all brought together.
- Resources limited, but let organisations lead where they have expertise.
- Avoid unintentional consequences.
- Alcohol abuse.
- End of life care.

Board members also made some suggestions for engagement, it was suggested that Third Sector Lancashire could be utilised along with the Youth Councils and social media to engage with children and young people.

National and local updated for the Board

None noted.

Minutes of the Meeting held on 25 January 2012

Were agreed as an accurate record.

Appointment of additional Clinical Commissioning Group Representatives

The Board noted the appointment of representatives of the Preston, Fylde and Wyre and West Lancashire Clinical Commissioning Groups and the consequential amendment to the Shadow Board's terms of reference. It was also noted that Dr Simon Frampton has replaced Dr John Caine as the West Lancashire CCG representative.

I M Fisher
County Secretary and Solicitor

County Hall,
Preston

Lancashire Shadow Health and Wellbeing Board
Strategy Task Group Meeting

Meeting Report
(Appendix 1 refers)

Introduction

This report summarises discussions of the Health and Wellbeing Strategy Task Group held on 28th March and the 30th April 2012. The meetings discussed production of emerging strategy outcomes and shifts that should be discussed at the shadow Health and Wellbeing Strategy on 9th May. The strategy will then be refined for further discussion at the Board meeting on 29th May and completed for presentation at the Board meeting on 10th July.

1. Purpose of the strategy

Work together …..

- **Achieve shifts in the way that partners work; resulting in more effective collaboration and greater impact on health and wellbeing in Lancashire.**
- **Learn the lessons arising from this collaboration to strengthen future working together**

…. get results

- **Deliver improvements in 'priority outcomes' in Lancashire.**
- **Deliver 'early wins' i.e. specific areas for action that will help deliver the priority outcomes whilst 'modelling' desired shifts in the ways that partners work together**

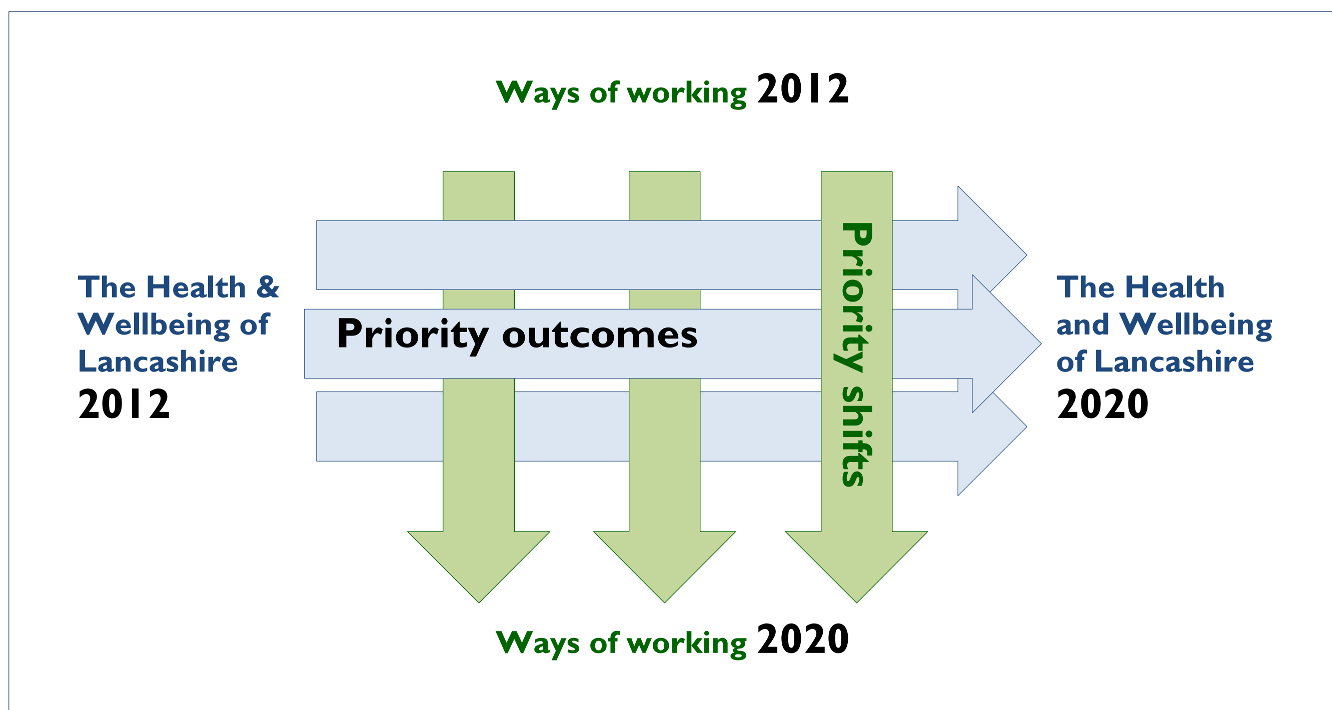
2. The structure of the strategy

The Task Group discussed the possible structure of the Health and Wellbeing Strategy. It was agreed that the strategy should have three parts;

1. **The current position**. A concise analysis and summary of the intelligence available currently (e.g. the Joint Strategic Needs Assessment) on health and wellbeing needs and opportunities in Lancashire.
2. **Priority shifts in ways of working**. The specific shifts in the way that partners work that will result in more effective collaboration and greater impact on health and wellbeing outcomes in Lancashire
3. **Priority health and wellbeing outcomes**. The key improvements to Health and Wellbeing that the strategy will deliver in Lancashire.

The inter-relationship between the 'priority shifts' and the 'priority outcomes' is illustrated in Figure 1.

Figure 1 Overall structure of the health and wellbeing strategy



3. Priority shifts in ways of working

The following shifts in the ways that partners work were identified.

Table 1 Priority shifts in the ways that partners deliver services

• Shift resources towards interventions that prevent ill health and reduce demand for acute and residential services
• Build and utilise the assets, skills and resources of our citizens and communities
• Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice.
• Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care.
• Make joint working the default option; pooling budgets and resources to focus on priority outcomes, commissioning together on the basis of intelligence and evidence; sharing responsibilities for service delivery and combining services in the most effective way; sharing risk.
• Work to narrow the gap in health and wellbeing and its determinants

4. Priority Health and Wellbeing outcomes

The Task Group discussed both the priority outcomes that the strategy will deliver and also possible 'early wins' i.e. specific areas for action that will help deliver the priority outcomes whilst 'modelling' desired shifts in the ways that partners work together.

Priorities for action in Lancashire

The Task Group discussed the 'priority outcomes' for the strategy in Lancashire, informed by intelligence from the Lancashire Joint Strategic Needs Assessment

Table 2 Priority health and wellbeing outcomes in Lancashire

1. **Maternal and child health.**
   - To provide accessible and effective support and services to expectant mothers and their families
   - To promote and safeguard the health and wellbeing of pre-school age children

2. **Mental Health & Wellbeing**
   - To promote emotional health & wellbeing in children and adults
   - To support people of all ages who are affected by mental health play a full and active role in society

3. **Long term conditions**
   - To reduce the incidence of, and mortality from, long term conditions
   - To improve quality of life for people with long term conditions and their carers

4. **Improve health and independence of older people.**
   - To increase healthy life expectancy for those aged 65
   - To support older people and their carers play a full and active role in society

5. Delivering 'Interventions '

The Task Group supported the view expressed by the shadow Health and Wellbeing Board that the strategy must emphasise the delivery of 'concrete' interventions (services, sets of services, pathways) where partners will get significant and demonstrable results and through which the Board can test out and learn from new ways of working.

The Task Group had a view that these "interventions" are those which we cannot allow ourselves to fail. It was described as we have a moral duty to get these interventions right for the people of Lancashire. Appendix I gives a brief rational on each of the chosen interventions.

Suggested Interventions

- Identify those who are at risk of admission into hospital and provide appropriate intervention
- Holistic support to those vulnerable families (from first pregnancy)
- Early response to domestic violence
- Support for carers (of dementia patients)
- Address loneliness in older people
- Affordable warmth to those who need it most
- Alcohol liaison nurses
- Healthy Weight – environmental measures
- Tackling smoking in pregnancy
- Self-care – encourage people to take control of their own health & wellbeing

The task group proposes that the Board should invite partners from across the county to engage in developing the strategy and early interventions and specify their contribution to the priority outcomes and shifts set out in the strategy.

6. Proposed Actions

What?	*When?*
• Prepare a summary of the emerging strategy - Refine the interventions following discussion with key partners and experts	9th May Board
• Prepare a concise document showing the proposed programme of work for the Health and Wellbeing Board - Prepare a consultation timeline	
• Complete initial engagement with CCG reps, District Councils, Third Sector CYP Trust etc.	29th May Board
• Prepare the narrative for the strategy as a whole	
• Prepare the detailed outcomes, objectives and measures of success	
• Clarify the detail of the proposed interventions	
• Prepare concise summary of the evidence-base of the strategy	
• Prepare vignettes to demonstrate the imperative for the interventions	
• Complete additional consultation on interventions	10th July Board
• Prepare draft strategy for submission to the Board	
• Complete in-depth engagement with partners on the strategy and proposed interventions and secure partner support for implementation of the broader strategy and identified interventions	Sept

APPENDIX 1

Delivering interventions

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1. Smoking in Pregnancy

Outcome:	Maternal and child health Long term conditions
Shift Required:	Promote and support greater individual self-care and responsibility for health Shift resources towards interventions that prevent ill health

Smoking cigarettes in pregnancy is one of the major causes of adverse outcomes for babies, increasing risk of babies being born prematurely, too small, and dying before they can be born at all or in their first year of life. By choosing this area as a focus for intervention we would not only be supporting the mother during the pregnancy but also improving the long term life chances of the new born baby. Rates of smoking in pregnancy in Lancashire are unacceptably high. There is more that partners can do together to support pregnant women quit including; sharing information, offering support every time we see a pregnant women who smokes, providing incentives for women who successfully quit and making intensive stop smoking support available

2. Loneliness in older people

Outcome:	Improve health and independence of older people.
Shift Required:	Build and utilise the assets, skills and resources of our citizens and communities

Social support and good social relations make an important contribution to health and wellbeing. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. There are too many older people in Lancashire that are isolated and do not have enough access to these supportive social relationships. By choosing this as an area for intervention we can provide older people with the emotional and practical resources they need to live

fulfilled lives and be resilient to challenges they face. We will work better together to share information to identify older people at risk of loneliness and use community assets approaches to do what we can to mobilise communities to connect with older people to prevent loneliness.

3. Affordable Warmth

Outcome:	Long term conditions Improve health and independence of older people
Shift Required:	Commit to delivering accessible services within communities Build and utilise the assets, skills and resources of our citizens and communities

Ensuring that people living with long terms conditions are able to keep their homes warm during the winter will reduce the risk of exacerbating long term conditions (particularly cardio vascular and respiratory diseases). It is unacceptable that each winter older people in Lancashire die or are admitted to hospital with ill health caused by poor housing conditions and poverty. CCGs, district councils and the County Council can work better together to ensure that people who are vulnerable to fuel poverty have access to affordable warmth interventions (such as insulation and benefits advice) through an affordable warmth referral scheme. As well as reducing preventable deaths and demand for health services, this will also allow us to work with partners on the wider determinants of health by addressing living conditions.

4. Early response to domestic violence

Outcome:	Long term conditions Shift resources towards interventions that prevent ill health and reduce demand for acute and residential services
Shift Required:	Commit to delivering accessible services within communities Build and utilise the assets, skills and resources of our citizens and communities

Domestic violence can have devastating impacts on the emotional, mental and physical health of children, young people and adults affected by it. It affects a significant proportion of people throughout their lives and places considerable demands on health and social care services and the criminal justice system. There is more that partners in Lancashire can do by working together better to identify those at risk or, or affected by domestic violence and to ensure an early response and collective programmes of support to both victims and perpetrators, to prevent the detrimental impacts spiralling out of control for the whole family.

5. Support for carers (Dementia).

Outcome: Mental Health & Wellbeing

Shift Required: Commit to delivering accessible services within communities
Build and utilise the assets, skills and resources of our citizens and communities
Shift resources towards interventions that prevent ill health

Carers are an essential source of support for thousands of people in Lancashire, supporting people to stay in their own homes and maintain some independence. However, carers can become socially isolated and their own health and wellbeing can suffer. Caring for someone with dementia can place real strain on relationships. Dementia will naturally affect family and friends as well as the person diagnosed. Becoming a carer in this situation may feel like a huge responsibility, with the well-being of someone else resting more on the carer.

Prevalence of depression among carers of people with dementia has been estimated at between 40 and 60% (Redinbaugh) compared to only 8% among non-carers of similar age. There is more that partners in Lancashire can do together to support carers by joining up the services we each commission and provide and using assets approaches to enable carers stay healthy, maintain their social networks and have breaks from caring responsibilities when needed.

6. Alcohol liaison nurses

Outcome: Mental Health & Wellbeing
Long Term Conditions

Shift Required: Commit to delivering accessible services within communities
Build and utilise the assets, skills and resources of our citizens and communities
Shift resources towards interventions that prevent ill health and reduce demand on acute services

Alcohol misuse is associated with poor outcomes in pregnancy and childhood, mental health and wellbeing and contributes to long term conditions. It also places a significant burden on public services. There is more that partners can do together in Lancashire to reduce the impact that alcohol has on our communities. There is good evidence that alcohol liaison nurses based within hospital settings can reduce the number of alcohol related hospital admissions and free up healthcare resources for other interventions. Alcohol liaison nurses work within hospitals to identify people who are admitted due to alcohol misuse and support them get the right alcohol intervention as quickly as possible to reduce their length of stay and reduce the likelihood of them being admitted again. There are alcohol liaison nurse services in place within hospitals in Lancashire, however there is a view that capacity of the services need to be increased.

7. Identify those who are at risk of admission into hospital and provide appropriate intervention.

Outcome: Long Term Conditions
Improve Health & Independence of Older People

Shift Required: Commit to delivering accessible services within communities
Build and utilise the assets, skills and resources of our citizens and communities
Shift resources towards interventions that prevent ill health and reduce demand on acute services

Admissions that are unplanned represent around 65 per cent of hospital bed days in England. In many cases these admissions could have been prevented with more effective management of long term conditions by the patient, carer or within primary care, with responsive and effective social care and through building resilience within communities. There is more that partners in Lancashire can so by working better together to identify those at risk of admission and delivering joined up support to reduce the likelihood of hospitalisation. General practice and social care data can be used to identify an individual's level of risk of admission. There are currently programmes in place in Lancashire that use this approach to prevent admissions for long term conditions through community matrons and active case management approaches. However there is potential to prevent even more admissions by lowering the level of risk at which intervention is made and integrating heath, social care and third sector services.

8. Self-care – encouraging people to take control of their own health & wellbeing.

Outcome: Long Term Conditions
Mental Health & Wellbeing

Shift Required: Build and utilise the assets, skills and resources of our citizens and communities
Shift resources towards interventions that prevent ill health and reduce demand on acute services
Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice.

Self care means finding the information and treatment you need for minor illnesses yourself and having the confidence to look after your own health. Intervening to increase self care allows people to take more responsibility for their health and wellbeing. However to support this we need to ensure that easy to understand information is available. Self care doesn’t mean people get less help from public

services, it means we empower people to find the information they need themselves via technology, support networks, community groups and so on.

By working better together we can deliver programmes to support people to understand their own and their family's health and become familiar with what to do about common illnesses this is often called health literacy). We can provide the information they need through our services such as websites, libraries, council offices, schools and GP surgeries. We can also work to mobilise community assets such as social networks for self care so that people have a friend or neighbour to support them with self care.

9. Healthy Weight – environmental measures

Outcome:	Long Term Conditions
Shift Required:	Build and utilise the assets, skills and resources of our citizens and communities Shift resources towards interventions that prevent ill health and reduce demand on acute services

The prevalence of overweight and obesity are increasing in both children and adults in England and in Lancashire. Evidence indicates that environmental factors such as the design of a built environment that is not conducive to physical activity and concentrations of calorie dense high fat food shops and take-aways create an environment that works against healthy weight. By working better together there is more that we can do in Lancashire to intervene for an environment that promotes healthy weight . In particular, the planning and regulatory roles of local authorities can be used to reduce concentrations of fast food outlets; especially near schools and to create the conditions that encourage people to walk, cycle and play outside.

10. Joined up support for vulnerable families (first pregnancy)

Outcome:	Maternal & Child Health Mental health & wellbeing
Shift Required:	Build and utilise the assets, skills and resources of our citizens and communities Shift resources towards interventions that prevent ill health and reduce demand on acute services

It is evident that working with the most vulnerable families in a holistic manner has a major impact on the health and wellbeing of that family. Many initiatives are currently being piloted across the country and in Lancashire on early intervention before crisis point. This interventions is to provide support to a vulnerable family at first pregnancy, as this will allow the family to be supported when required the most, but will also have a profound impact on the health & wellbeing of the child.

Note: The shifts: pooling budgets, commissioning together on the basis of intelligence, evidence and narrowing the gap are shifts which will run through each of the suggested interventions.

NHS Lancashire

UPDATE REPORT IN THE PROGRESS IN IMPLEMENTING THE HEALTH AND SOCIAL CARE ACT
(Appendices A and B refer)

1 Purpose

The purpose of this report is to update the Board on the implementation of the proposals contained within the Health and Social Care Act.

2 Background

The Government has reinforced its commitment to the NHS's founding principles but has recognised that standing still will not protect the NHS and that modernisation is essential. The pressures on the NHS are increasing; demand is growing rapidly as the population ages and long term conditions become more common; more sophisticated and expensive treatment options are becoming available. There is a recognition that there is a need for improvement and the Health and Social Care Act provides for a radical re-structuring of the NHS to address these issues.

3 The Health and Social Care Act 2012

The new Act which received Royal Assent on 27 March 2012 is designed to meet these challenges by making the NHS more responsive, efficient and accountable. The key legislative changes are:

- Clinically led commissioning
- Provider regulation to support innovative services
- A greater voice for patients
- A new focus for Public Health
- Greater accountability locally and nationally
- Streamlined arms-length bodies

The Act which completed its passage through Parliament in March 2012 provides clarity and certainty about future direction after a lengthy and protracted period of uncertainty. The real momentum now moves to putting the new health and social care system into place by 1 April 2013 which will deliver these changes on the ground.

A copy of how the structure of the NHS Commissioning Framework will be changed is attached at Appendix A.

4 The new Commissioning System and Structures

This report sets out how the new commissioning structures will operate together with a brief description of their role and functions. Where possible the information has been presented in a context local to Lancashire. The proposals in respect of the transition of Public Health functions into the local authority are the subject of a separate report on this agenda.

4.1 Clinical Commissioning Groups (CCGs)

Local CCGs will sit at the heart of the new system and will bring GPs and other clinicians together to design and implement better systems of care which are focused on delivering better outcomes responding to the needs and wishes of local patients and reducing health inequalities.

The vast majority of aspiring CCGs of which there are around 250 in the county have confirmed their member practices and established an effective geographic area. In Lancashire, there will be eight CCGs, six of which are co-terminous with the Lancashire County Council footprint and two, NHS Blackpool CCG and NHS Blackburn with Darwen CCG, which are co-terminous with their respective unitary authorities, progressing through the authorisation process as follows:

Name of CCG	Population size	Number of constituent practices	Commissioning budget
NHS Lancashire North	158,843	13	£183m
NHS Fylde and Wyre	151,707	21	£233m
NHS Blackpool	178,831	24	£187m
NHS West Lancashire	111,848	23	£120m
NHS Greater Preston	212,000	34	£202m
NHS Chorley and South Ribble	170,000	31	£196m
NHS Blackburn with Darwen	167,000	29	£262m
NHS East Lancashire	371,073	63	£710m

The CCG boundaries are shown on the map at Appendix B.

CCGs will be responsible for commissioning a wide range of services from local acute trust/foundation trust providers' i.e. secondary care, mental health and learning disabilities services and for performance managing the activity levels, quality and patient safety standards and outcomes of those providers. They will work closely with the local authority to integrate health and social care in order to provide services closer to home and to enable patients especially those with long term conditions to remain in their communities.

CCGs will not be required to commission either specialist services i.e. tertiary/complex services, primary care services e.g. GPs, Dentists, Pharmacists or services for particular groups such as Offenders, Armed Forces personnel and Veterans. All of these services which require detailed and specific expertise or which might present conflict of interest to CCGs will be commissioned on a national or regional basis.

The eight emerging CCGs are already operating under delegated authority, increasingly taking on day-to-day commissioning responsibilities on behalf of their local PCTs. This year all eight were involved in developing and negotiating the annual contract with their local provider of secondary and community care and mental health services and they will

progressively move into leading the performance management meetings and the contract negotiations for 2013-14.

In order to become a statutory organisation in their own right and to assume full accountability each CCG has to go through a nationally managed authorisation process between now and March 2013. The content of authorisation is built around six domains and has been developed through a wide range of stakeholder involvement including patients, carers, clinicians and partner organisations.

The six domains are:

Domain 1: A strong clinical and multi-professional focus which brings real added value

Domain 2: Meaningful engagement with patients, carers and their communities

Domain 3: Clear and credible plans which continue to deliver the QIPP (Quality, Innovation, Productivity & Prevention) challenge within financial resources

Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities

Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS National Commissioning Board as well as appropriate commissioning support

Domain 6: Great leaders who individually and collectively make a difference

The thresholds within each domain have been set to ensure CCGs have autonomy to innovate in how they deliver improved outcomes and at the same time are safe as statutory bodies responsible for commissioning health services. The criteria in relation to risk on quality, safety and financial management and related governance, planning and capacity and capability therefore have relatively high thresholds.

The authorisation process is divided into three stages:

1. **Pre-application** – beginning with a self assessment diagnostic. All eight Lancashire CCGs have successfully completed this stage.

2. **Application** – each aspiring CCG will need to submit an application form to the NHS Commissioning Board. The form will provide some detail about the CCG, list the evidence which the CCG is submitting to support its application and enable the CCG to declare compliance with certain criteria

   All Lancashire CCGs are currently preparing their evidence in support of their application.

3. **NHSCB Assessment** – the formal assessment will be based on the evidence gained from several key components including a 360^0 survey, a desk top review, case studies and site visits.

There are three possible outcomes for each CCG and each outcome will be accompanied by a development plan which has been agreed by the NHS Commissioning Board. The three outcomes are:

1. **Authorised –** The CCG can assume the full powers and responsibilities

2. **Authorised with conditions –** the CCG has not met all of the thresholds and will be authorised with limits or directions on how it carries out its functions

3. **Established but not authorised –** this is where the CCGs are established but with conditions that are such that it cannot take on its functions as a CCG. In this case the NHSCB will have to make alternative arrangements for commissioning for that CCG area until the shadow CCG is ready to move forward.

Guidance has been published to support CCGs through the process and a regular series of workshops is supporting specific areas of activity and development.

The timetable for application and assessment has been set out in four waves and CCGs are currently being asked to indicate which Wave they would prefer as determined by their own confidence in their state of readiness.

The deadlines for the four waves are:

	360^0 Stakeholder Survey	**Application Submitted**	**Decision by:**
Wave 1:	June	July	31 October
Wave 2:	July	September	30 November
Wave 3:	September	October	31 December
Wave 4:	October	November	31 January

Locally, the CCGs are still determining which Wave they are intending to apply although the indications are that two of them will seek to apply in Wave 1 with the others in Waves 2 or 3.

4.2 The NHS Commissioning Board

The overarching role of the Board is to ensure that the NHS delivers better outcomes for patients within its available resources. It will do this through its leadership on delivering the NHS Outcomes Framework, supported by its accountability framework for CCGs, its framework for ensuring choice and competition and its framework for emergency planning and resilience.

It is not possible to devolve all commissioning to CCGs nor to expect them to commission services from their member practices and so the government has established the NHS Commissioning Board (as yet in shadow form). The Board will be a national body and its role will include supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups. The Board will ensure that the whole new architecture is cohesive, co-ordinated and efficient.

The Board has been in place for several months, most of the very senior appointments have been made and two public Board meetings have taken place.

The Board will be organised into nine national Directorates, four slim sub-national regions and a national network of local offices. This means that the local office for Lancashire will sit within the North of England region and is similar to the current configuration of the PCT Cluster (NHS Lancashire) and SHA North. The bulk of the staff employed by the NHSCB will be based in the local office and their key functions will include oversight of the CCGs, be members of local Health and Well Being Boards and

the direct commissioning of primary care services, specialised NHS services, military health services, offender health services and a range of public health services.

Interviews for the Regional Director level post are set for early May and it is expected that appointments will be made to the local office structure shortly after that.

4.3 Commissioning Support

A key feature of both the eight CCGs and the NHSCB local office is that the staffing structures will be kept to a minimum and they will be expected to acquire additional services from Commissioning Support Organisations. These CSOs whilst initially hosted by the NHSCB are expected to be outsourced by 2016. The Lancashire and Cumbria joint venture is developing well and robustly and will offer services in areas such as contract management, service redesign, analytical support and other professional services.

The Lancashire and Cumbria unit has already successfully passed the first checkpoint and is well regarded on a national level. It is required to go through a similar authorisation process to CCGs designed to test its marketing strategy, business plan, commercial acumen and ability to deliver high quality services locally on a sustainable basis. The success of this operation is critical to the viability of CCGs as the CSO will provide much of the information and analysis to enable the CCGs to challenge local providers and meet their aspirations on outcomes and against national targets.

Other parts of the new system which will have implications for Lancashire include:

- **Health Education England** – this body will make sure that the health workforce has the right skills, behaviours and training and is available in the right numbers in the right locations to support the delivery of excellent healthcare and health improvement.

- **Health Research Authority** – this has the responsibility of protecting and promoting the interests of patients in health research

- **NHS Property Services Limited** – will hold property for use by community and primary care services including use by social enterprise concerns. It will also cut the costs of administering the estate by consolidating the management functions and disposing of surplus property.

- **Shared Services for national bodies** – shared services solutions are being developed for finance, payroll, communications, Human Resources, IT infrastructure and estates.

5 People transition

Ensuring that staff transition processes operate smoothly and efficiently is at the heart of all the transition processes. Whilst the constrained financial framework means that there will not be roles for everyone in the future it is essential that staff with the necessary skills, experience and organisational knowledge move into new roles to sustain the continued development of services. It is vital that the organisation treats staff with dignity and respect and makes sure that processes are simple, transparent and fair over the next twelve months. Much of the HR Framework has been developed nationally, these overall timetable and deadlines are nationally determined and the scope for local input has been limited. This has led to some anxiety locally but now that the process is underway the anxieties are reducing. The rationale for managing the processes and timeframes nationally is to try and ensure that every member of staff has as much

information as possible about potential roles in successor organisations when considering how the changes might affect them.

In most instances transfers will be confirmed by transfer orders to protect employees' current terms and conditions as if TUPE applies. The aim is that by December 2012 all staff will know their future. A whole series of development and support packages are being made available to individuals and teams to help them to prepare for changes. Whilst there is a recognition that there will not be new job roles for everyone, every effort is being made to secure jobs for as many people as possible and therefore keep redundancy costs to a minimum.

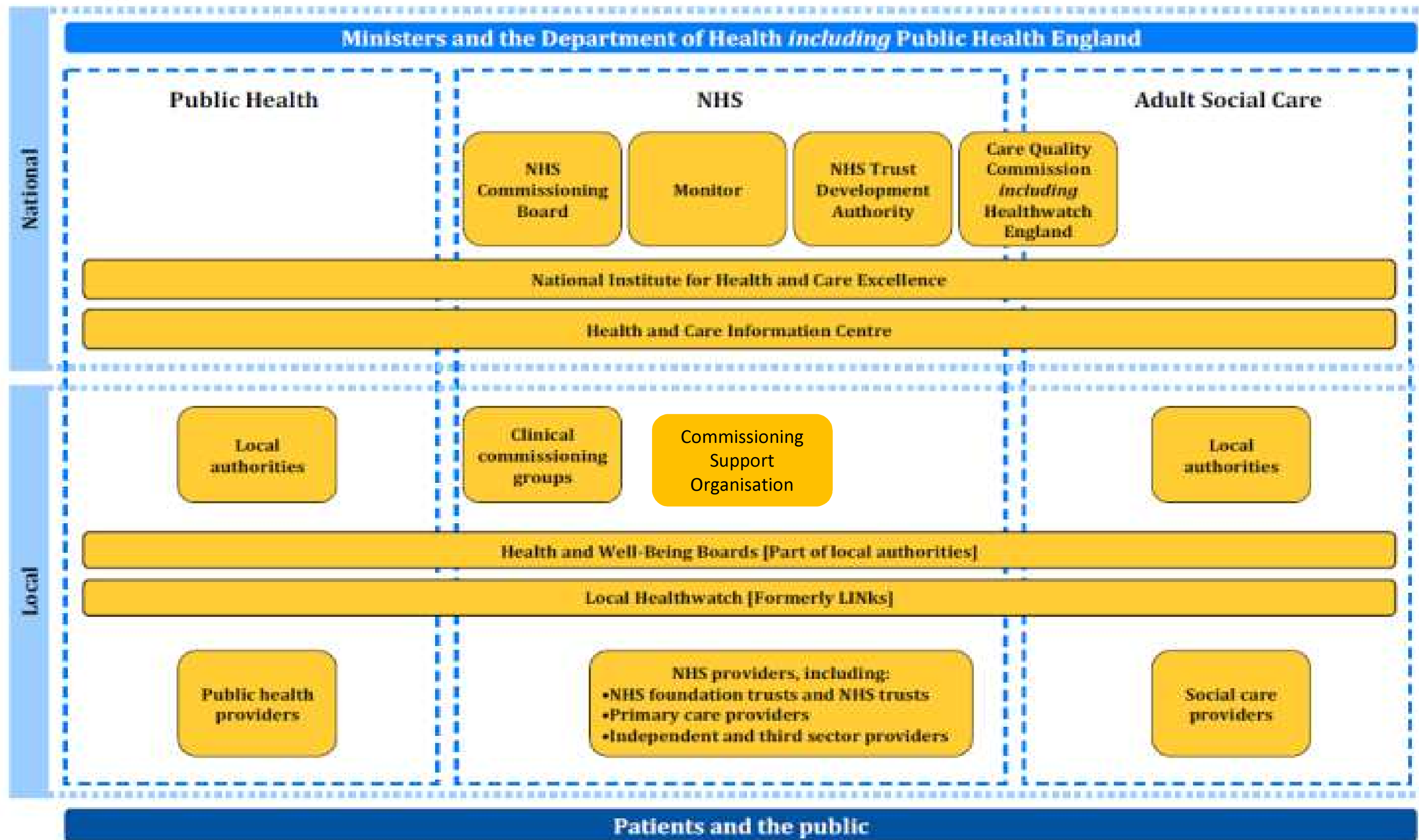
6 Recommendations

The Health and Well Being board is asked to note the report.

Janet Soo-Chung
Chief Executive - NHS Lancashire
May 2012

Appendix A

Overview of health and social care structures from April 2013



Appendix B

Lancashire's CCGs configuration

- Blackburn with Darwen
- Blackpool
- Fylde & Wyre
- Chorley & South Ribble
- Greater Preston
- East Lancashire
- Lancashire North
- West Lancashire

Lancashire Shadow Health and Wellbeing Board - Update on Public Health Transition

From April 2013, responsibility for public health will transfer from the NHS to upper tier local authorities who will be funded by a ring-fenced public health grant to deliver a new duty to take steps to improve the health of the population.

An estimated baseline for the public health grant has been published by the Department of Health and is based on public health spending during 2010/11. The estimated baseline for Lancashire is £45,891,000 which equates to £37 per person. The DOH are currently developing A needs-based allocation formula for the public health ring-fenced grant is currently under development and is expected to be published for consultation after the local elections with a fin allocation formula published along with the actual allocations in December 2012.

While local authority based public health services will be largely free to determine their own priorities and services, they will be required to provide the following mandatory services:

- Appropriate access to sexual health services
- NHS Health Check assessment
- Steps to protect the health of the population
- Weighing and measuring children for the National Child Measurement Programme, and
- Providing public health advice to NHS commissioners

In Lancashire, governance of the public health transition is provided by the Public health Lancashire Steering Group which is chaired by Richard Jones and includes membership from the County Council, a District Council, NHS Lancashire, the Health Protection Agency and the Strategic Health Authority. The three Lancashire Directors of Public Health are key members of the steering group.

In February 2012 a formal consultation was launched on 'Delivering the public health reforms in Lancashire'. This set out: proposals for the functions to be undertaken by the local public health service within Lancashire County Council, including the mandatory services above; a timetable for the implementation of the public health reforms; and a draft Human Resources Framework. The consultation closed on the 22 March 2012. A paper setting out proposals in response to the consultation and a process and timescale for developing a structure for the public health workforce is being considered by the County Council's Management Team and NHS Lancashire Executive Team. It proposes that shadow arrangements are put in place from the end of October 2012.

The Director of Public Health in the County Council will have chief officer status and within Lancashire County Council it has been agreed that the DPH will be an Executive Director reporting to the Chief Executive. Recruitment to the Lancashire DPH post is underway and it is hoped that interviews will take place no later than the end of June.

A Public Health Transition Plan for 2012/13 has been developed which sets out the action that is needed to ensure the safe transition of public health to the county council on 1 April 2012. It outlines six objectives:

1. To ensure effective public health leadership during the transition and beyond
2. To ensure the effective delivery of public health programmes through the transition and beyond
3. To co-design a public health service within Lancashire County Council; build relationships between LCC and public health staff
4. To manage the transfer of NHS public health staff to Lancashire County Council
5. To develop and implement a Business Transfer Agreement to guide the transfer of public health responsibility to Lancashire County Council
6. To ensure the effective transfer of financial and physical assets from the NHS to Lancashire County Council

The Public Health Transition Plan plan was approved in March 2012 by the executive teams of the County Council and NHS Lancashire. It has been reviewed by the Strategic Health Authority with positive feedback about the progress made. Approval of the plan by the Cabinet Member for Health and Wellbeing is anticipated in June 2012.

Debs Harkins, Head of the JHU