THE NEW APPROACH TO THE NHS, PUBLIC HEALTH AND SOCIAL CARE

Radical changes are underway in how health and social care are to be organised in England. This paper gives some information which will be useful background for the workshop on NHS and Social Care Reform. We have written in *italics* information which is relevant to how you might get involved in influencing decisions at a local level. You might find the two final pages of this paper a useful summary - and do please look at the questions we ask you to have a think about, that will help you participate during discussions at the workshop.

Q: WHO CURRENTLY PLANS AND FUNDS ('COMMISSIONS') TREATMENT AND CARE FOR PEOPLE WITH HIV?

A: HIV treatment and care are currently commissioned by local Primary Care Trusts (PCTs), which are NHS managerial bodies. PCTs often collaborate together to commission HIV treatment and care on a wider geographical basis (e.g across London). Other NHS and public health services are also commissioned by PCTs.

HIV social care is commissioned by local authorities.

PCTs will be abolished in April 2013 - and new commissioning arrangements will be put in place

Q: WHO WILL BE COMMISSIONING TREATMENT AND CARE FOR PEOPLE WITH HIV ONCE PCTs HAVE GONE?

A: Most secondary care (for example, hospital care) will be commissioned by '**clinical commissioning groups**' - which will be groups of GP practices. Clinical commissioning groups will not cross local authority boundaries - all GP practices will have to be part of a clinical commissioning group. The governing body of a clinical commissioning group will include at least one nurse and one doctor who is a secondary care specialist; *and there must be at least two lay members, one leading on patient and public involvement*, and one overseeing key governance issues. *The clinical commissioning groups will be obliged to consult on their local commissioning plans.*

Primary care (for example, GP services) will be commissioned by a new national body, the **NHS Commissioning Board**. The NHS Commissioning Board will also be responsible for authorising the new clinical commissioning groups.

HIV treatment and care is almost always hospital/clinic based in the UK. But the way HIV treatment is to be commissioned will be different from most hospital-based NHS care - it will <u>not</u> be commissioned by clinical commissioning groups. Instead it will also be commissioned by the NHS Commissioning Board. The NHS Commissioning Board will commission HIV services at an extended local level, equivalent to a 'cluster' of the current PCT boundaries.

The NHS Commissioning Board will have an obligation to involve patients, carers and the public in their commissioning decisions.

There remain questions as to how the NHS Commissioning Board will ensure its work is integrated with the rest of local health and social care. The NHS Commissioning Board will not be routinely

represented on local Health and Wellbeing Boards (see below for an explanation of these Boards), but only involved for relevant local commissioning decisions. Yet many decisions of Health and Wellbeing Boards around wider health and social care will affect people with HIV.

Q: HOW WILL SOCIAL CARE BE COMMISSIONED?

A: Local authorities currently commission social care and will continue to do so under the new arrangements. There will be an even greater emphasis on ensuring that healthcare and social care are well integrated from the patient's perspective. Social care should, amongst other things, support the person living with HIV in staying well. *Local authorities will be expected to publish annually '**local accounts**' of the quality and outcomes of their social care services to ensure local accountability.*

Q: WHAT ABOUT PUBLIC HEALTH (including sexual health services)?

A: Public health refers to wider services and actions which can benefit the health of the local population, and decrease rates of ill-health and the need for NHS care. They will often be services specifically designed to prevent ill-health such as smoking cessation courses, exercise clubs for the elderly, or, in the case of sexual health, HIV prevention activities or support in safer sex. The Government wishes to prioritise public health at both national and local levels.

PCTs currently commission public health but once PCTs are abolished this role will be undertaken by **local authorities**. The senior official with this responsibility in the local authority will be the Director of Public Health.

A new national body will be set up called **Public Health England**, an executive agency of the Department of Health, with overall responsibility for public health, including surveillance, national immunisation programmes and national health promotion campaigns.

Public Health England will also have a ring-fenced budget for health improvement at the local level which will be distributed to local authorities to improve public health. A ring-fenced budget is a budget which has to be spent solely as intended, in this case on public health, and not be diverted for any other purpose. We still do not know whether the amount to be set aside will be sufficient to meet public health needs. With the money for public health, local authorities will also receive a 'mandate' from Public Health England with some broad guidance as to how the money should be spent, including what services it is mandatory for them to provide. Sexual health services will be a mandatory service.

Local authorities will be given within their public health responsibilities the role of commissioning local sexual health services. This will include testing and treatment for STIs, contraception (outside GP practices), termination of pregnancy services, and sexual health promotion and prevention. Local sexual health (GU) clinics will also be commissioned by local authorities. So clinics will have most of their services commissioned by their local authority but with any HIV treatment and care commissioned by the NHS Commissioning Board.

Q: HOW WILL LOCAL PERFORMANCE ON HEALTH AND SOCIAL CARE BE EVALUATED?

A: The Government is stressing that under the new arrangements the focus for evaluation of progress will be **outcomes** (rather than activity) - in other words the difference any service actually makes to people's lives. They are therefore planning three Outcomes Frameworks - for the NHS, for Public Health and for Social Care - which are meant to be coordinated and which will identify *key **indicators** against which people in a local area can measure impact and progress.*

Q: WHO WILL MONITOR PERFORMANCE AT A LOCAL LEVEL?

A: *Local authorities will retain their scrutiny powers over health care through overview and scrutiny committees (comprising local councillors) or comparable arrangements. This is one means whereby concerns and questions can be raised on local health and social care services. Any NHS-funded commissioner or service provider can be required to attend these scrutiny meetings. Consideration is being given as to how HealthWatch can be effectively involved in scrutiny processes.*

HOW LOCAL DECISIONS WILL BE MADE WHICH AFFECT YOU

Under the new arrangements the Government expects NHS services, social care and health improvement to be coordinated and 'joined up' at the local level. Your local authority is the body expected to bring the planning and delivery of these different services together in a local Health and Wellbeing Board.

Q: WHAT IS A HEALTH AND WELLBEING BOARD?

A: The role of local authorities will be 'to lead on improving the strategic coordination of commissioning across NHS, social care, and related children's and public health services'.

They will have to do this through a 'health and wellbeing board', a local authority body which will bring together the key NHS, public health and social care leaders in each local authority area to work in partnership. *Their meetings will generally be in public. They will have a legal duty to involve users and the public in their work*.

Q: WHO WILL BE ON THE HEALTH AND WELLBEING BOARD?

A: Clinical Commissioning Groups in the area will all be represented on the board. The Director of Social Services, the Director of Children's Services, the Director of Public Health *and local HealthWatch will also all have to be members, as well as at least one local councillor*.

But it will be up to the local authority to make the final decision as to who else might join the health and wellbeing board. There is no limit on the number of local councillors who can be appointed to the Board. *Participation can be invited from local representatives of the voluntary sector and other relevant public service officials. The Department of Health also states that 'They will also want to ensure input from professionals and community organisations that can advise on and give voice to the needs of vulnerable and less-heard groups'*.

Q: WHAT WILL BE THE MAIN ACTIVITY OF THE HEALTH AND WELLBEING BOARD?

A: Their main purpose is to ensure that NHS services, social care and health improvement (for example STI and HIV prevention work) all join up and support each other. This is very important for people with HIV who very often need social care support in addition to NHS services and who also have an interest in broader health improvement around sexual health.

To do this the health and wellbeing board will develop a **joint strategic needs assessment (JSNA)**. The JSNA will analyse the local current and future needs of adults and children, bringing together a wide range of data and users views. There will be a legal obligation on NHS and local authority commissioners 'to have regard' to the JSNA when they make commissioning decisions.

The JSNA will be a key opportunity for people with HIV, the voluntary sector, HIV clinics and other services to influence the direction and decisions around services at the local level and ensure the interest of people with HIV are listened to.

One advantage of the JSNA is that it will mean commissioners (most of whom in the NHS will be GPs) will get 'an insight into parts of the population that are either unregistered or invisible to general practice' - again important for the many marginalised individuals and groups who may be particularly vulnerable to HIV, and because some people with HIV do not tell their GP about their HIV diagnosis.

Once the JSNA is agreed the next step will be for the health and wellbeing board to develop a **joint health and wellbeing strategy (JHWS)**. The JHWS will span NHS, social care and public health, as well as possibly taking account of other relevant areas such as housing and education. The JHWS will be the overarching framework within which commissioning plans are developed for the local area, setting out how the needs in the area will be addressed and health inequalities reduced. *The Health and Wellbeing board will consider whether commissioning plans are in line with the JHWS and raise the matter formally if they are not.*

Q: HOW WILL HEALTHWATCH REPRESENT THE INTERESTS OF SERVICE USERS?

A: *Under the new arrangements Local Involvement Networks (LINks) will become the local* ***Health Watch****, a 'local consumer champion across health and care'. They will be commissioned and funded by the local authority to*

- *promote patient and public involvement,*
- *seek views on local health and social care services which can be fed back into commissioning,*
- *support patients in exercising choice (e.g helping them choose a GP practice)*
- *inform Health Watch England about what is happening locally and report concerns about the quality of providers independently of the local authority.*

There will be a requirement that local Health Watch membership is representative of different users. HealthWatch will be a member of the local Health and Wellbeing Board.

There will also be a national body, Health Watch England, part of the Care Quality Commission (CQC), which can as a result of information raised by local Health Watch propose to CQC investigations of poor services. It will also provide advice and support to local Health Watch in the fulfilment of their functions, and to the NHS Commissioning Board, Monitor, and the Secretary of State.

SOME KEY DATES [subject to passing of Health and Social Care Bill]

October 2011

NHS Commissioning Board established in 'shadow form'

October 2012

NHS Commissioning Board starts authorising clinical commissioning groups

HealthWatch England and local HealthWatch established and operational - ready to participate in clinical commissioning groups and local Health and Wellbeing Boards as they are set up

April 2013

PCTs abolished.

Clinical commissioning groups begin commissioning local secondary care (or for an interim period the NHS Commissioning Board if clinical commissioning groups not yet ready in a local area).

Local authorities have full powers and funding for local public health.

Full transition of responsibilities to Public Health England completed.

Four questions to think about

What improvements would you like the NHS Commissioning Board to make to how HIV treatment and care are planned and resourced?

Do you find that the different parts of your healthcare and (if relevant) social care work well together? or are there ways they can be better coordinated?

GPs are going to have an increasingly important role in planning local services, including psychological support, cancer and cardiovascular disease services. How would you like GP practices to get more knowledgeable and more involved in healthcare for people with HIV?

How can we make sure interests of people with HIV are well represented at a local level? - what opportunities are there for people with HIV to influence local services? and what are the potential difficulties?

Principal changes to the NHS in England

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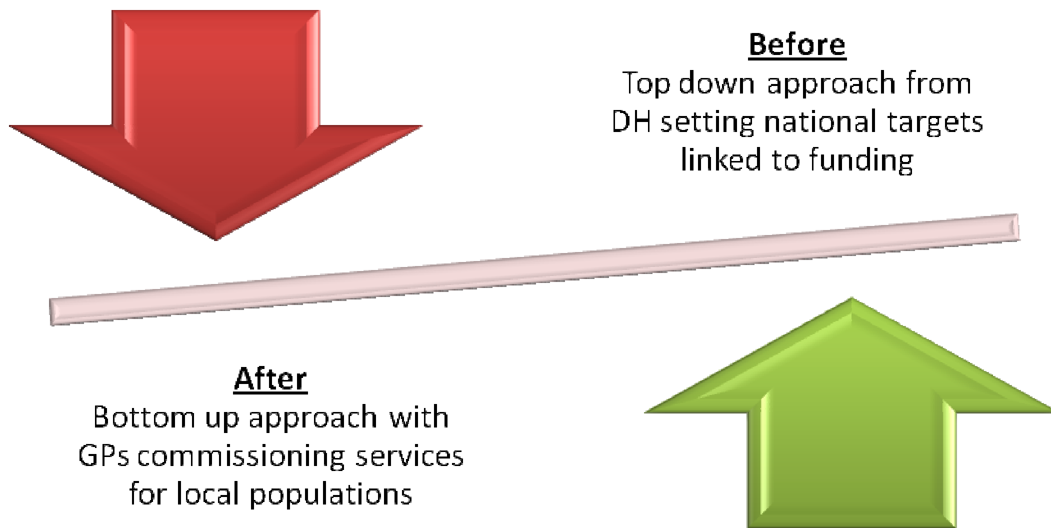

Principal changes to who does what

Before

PCTs provide sexual health prevention, HIV treatment & care

DH provides national health promotion & campaigns

After

Local Authorities to provide comprehensive sexual health services

Local Health & Wellbeing Boards establish the health needs of the community

NHS Commissioning Board buys specialised HIV treatment & care

Public Health England focus on national health threats & provide advice, expertise & some national campaigns

Specialist HIV Services (Treatment & Care)

Before	After	What this could mean
• PCT commissions all services including clinical treatment & care.	• NHS Commissioning Board tasked with commissioning the specialist clinical treatment of HIV services nationally.	• Could drive up standards of care & the development of centres of excellence. • Avoids handing commissioning to HIV inexperienced GPs. • Fails to address the need for greater involvement of GPs & primary care in the delivery of HIV related care. • Does not bring HIV care & self management processes to the patient. • Continuity of care & service provision fragmented by complex commissioning arrangements.

HIV Prevention & Testing

Before	After	What this could mean
• PCT Commissioned.	• LAs will commission local prevention work & campaigns. • LAs will commission HIV testing (as a part of specialist sexual health services).	• Fragmentation between LAs & Public Health England could affect preventative work (i.e. lower quality campaigns) or higher costs (i.e. duplication of effort). • Scope exists in areas of high HIV prevalence & late diagnosis to prioritise prevention & testing as a part of the new Health Premium.

Specialist Sexual Health Services (GUM Clinics)

Before	After	What this could mean
• PCT Commissioned.	• LAs will commission integrated sexual health services including STI (testing, diagnosis & treatment), contraception & termination of pregnancy services.	• Could improve the overall approach to sexual health as LAs already have many of the determinants of sexual health within their remit (social deprivation, education, etc). • A number of decades have passed since LAs had any control over sexual health services & therefore there is a lack of experience in sexual health commissioning in LAs. • There is a potential for the politicisation of decision making as locally elected councillors are given more say in how sexual health services are commissioned.

Sexual Health Services (Community Based)

Before	After	What this could mean
• PCT Commissioned.	• GPs to provide contraception & some community based sexual health services.	• Consortia could prioritise these services more within local areas. • No real drivers for GPs to do more. Status quo may remain.

National Prevention Programmes

Before	After	What this could mean
• DH Funded.	• Public Health England Commissioned.	• Not clear that PHE will commission programmes or how they will coordinate with LA campaigns. • Movement towards measuring outcomes doesn't fit with public health campaigns. Difficult to measure outcomes across populations.