Item 7

Overview and Scrutiny Board

30th May 2012

Health and Wellbeing and Role of Scrutiny

Recommendations

1) That the Overview and Scrutiny Board consider the report, asking questions in relation to its content and making recommendations as considered appropriate.

2) That the Overview and Scrutiny Board consider the links between Public Health and Overview and Scrutiny.

3) That the Overview and Scrutiny Board considers how best the Overview and Scrutiny Committees can be involved in monitoring the process and outcomes of the JSNA.

1.0 Background

1.1 The Overview and Scrutiny Board has requested a report on Health and Wellbeing in Warwickshire and the role of Scrutiny specifically:

- The link between the Health and Wellbeing Board (H&WB) and Scrutiny;
- An overview of the relationship between Public Health and Scrutiny; and
- How each of the Overview and Scrutiny Committees could be involved in the monitoring of the JSNA (ie what role can each of the OSCs play in helping to monitor the JSNA, beyond the Health OSC).

2.0 Current Situation

2.1 <u>H&WB Board and Scrutiny</u>

2.2 The interface and relationship between the Health and Wellbeing Board and Scrutiny is unclear at this time. While Scrutiny remains, the provisions of the Health and Social Care Act 2012 are not yet in force and the H&WBB is in shadow form. Cabinet and Corporate Board will consider these issues at their meeting on 18th May and a way forward is anticipated.

2.3 <u>Relationship between Public Health and Scrutiny</u>

2.4 The Public Health Outcomes Framework outlines four main domains of Public Health. These are:

- Effect of wider determinants of health, i.e. employment, transport, housing.
- Health Improvement and lifestyle modification, i.e. smoking cessation.

- Health Protection, i.e. preventing and managing communicable diseases.
- Avoidable mortality and morbidity i.e. evidence based healthcare.

2.5 Looking at the four domains, it is clear that Scrutiny has potentially an important role to play particularly with regard to variation in health outcomes and reducing health inequalities.

2.6 Public Health is currently in a transition state with full transfer to the County Council due at the end of March 2013. Public Health will be accountable to the H&WBB to discharge its responsibilities under each of the four domains outlined above.

2.7 The Health and Social Care Act 2012 also outlines the role of the Director of Public Health as:

- The principal adviser on health to elected members and officials;
- The officer charged with delivering key public health functions;
- A statutory member of the Health and Wellbeing Board; and
- The author of an independent Annual Report on the health of the population.

2.8 The Director of Public health is keen to discuss with scrutiny members and the Council how Overview and Scrutiny of the Public Health function is delivered.

2.9 Joint Strategic Needs Assessment (JSNA)

2.10 At its meeting on 11th April 2012, the Adult Social Care and Health Overview and Scrutiny Committee considered the JSNA process and Annual Review (2011). The Committee supported the report. It is clear from the JSNA topic profiles that all scrutiny has an interest in the JSNA.

2.11 The Director of Public Health welcomes members' views on how best the Overview and Scrutiny Committees can be involved in monitoring the process and outcomes of the JSNA. A copy of the JSNA is attached at Appendix A.

3.0 Timescales

3.1 Questions raised by Overview and Scrutiny Board identify significant issues which need to be addressed. It is expected that a clear way forward will be identified following Corporate Board/Cabinet discussions.

3.2 For information, an outline of the Health and Social care Act 2012 is attached at Appendix B and C.

Appendices

Appendix A – Joint Strategic Needs Assessment

Appendix B – Health and Social Care Act 2012: At a Glance

Appendix C – Overview of the Health and Social Care Act 2012

Item No 6

Adult Social Care and Health Overview and Scrutiny 13 April 2012

Warwickshire Joint Strategic Needs Assessment Annual Review (2011)

Recommendation

Overview and Scrutiny Committee is asked to receive and accept the Warwickshire Joint Strategic Needs Assessment Annual Review (2011).

1.0 Background

1.1 In 2007, the Local Government and Public Involvement Act placed a duty on upper tier local authorities and PCTs to undertake a JSNA. Warwickshire's first JSNA was published in 2009. It is recommended that the JSNA is refreshed at least every three years.

1.2 The purpose of the JSNA is to identify current and future health and wellbeing needs; to establish a shared, evidence based consensus on key local priorities; and to form a key element of the commissioning cycle.

1.3 The JSNA informs development of the Health and Wellbeing Strategy and is central to commissioning decision making, challenging delivery and service redesign.

2.0 The current JSNA

2.1 The 2009 JSNA was well regarded and provided a helpful and comprehensive snapshot of data and statistics, however it consisted of a static written report and was not at the level of detail required by commissioners. The approach to developing the current JSNA is different. The aim is to have a dynamic, interactive, ever changing JSNA. This is being achieved through:

- The establishment of a JSNA website. This is a rich source of data and information and will be regularly updated. It will include forums where questions can be asked and online discussions can take place. The website is now live and can be located at www.warwickshire.gov.uk/jsna

- Undertaking an annual review and producing topic summaries from that review. This will ensure that there is clarity and a shared consensus on the issues that require particular focus in the upcoming year.

2.2 The JSNA Annual Review (2011) is attached for your information and was initially launched at a stakeholder event on 7th March 2012. It contains ten key

themes and these are presented in a 'life course' style spanning from childhood to old age.

2.3 The ten themes identified from the 2011 annual review are:

- Educational Attainment
- Looked after children
- Lifestyle factors affecting health and wellbeing
- Long-term conditions
- Mental wellbeing
- Reducing health and wellbeing inequalities
- Disability
- Safeguarding
- Dementia
- Ageing and frailty

2.4 In identifying these ten themes the following criteria were used:

- Magnitude of the issue
- Poor outcomes currently being achieved
- Worsening situation
- Significant inequalities (by geography or population group)

3.0 Timescales/Next steps

3.1 The JSNA has now been launched and Warwickshire's Health and Wellbeing Board sees the JSNA as an essential tool to inform commissioning decision making to improve outcomes.

3.2 An editorial board is being established to ensure ongoing engagement of stakeholders and a coordinated approach to regularly updating the JSNA.

3.3 Commissioners are committed to utilising the JSNA and to making progress in the ten key areas

Background Papers (Please list below, with electronic links where applicable)

JSNA website: www.warwickshire.gov.uk/jsna **Warwickshire Joint Strategic Needs Assessment Annual review 2011 (attached)**

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Warwickshire JSNA

Warwickshire Joint Strategic Needs Assessment

Annual Review 2011

Warwickshire County Council

NHS Warwickshire

Foreword

Welcome to the Joint Strategic Needs Assessment (JSNA) Annual Statement which sets out the current and future health and wellbeing needs for people in Warwickshire.

No agency alone can fully achieve better health and wellbeing for our county's residents without working in partnership with others. Our work requires the contribution of a wide range of agencies to improve health and social care; housing; learning and achievement; growth in the economy and household income.

As the JSNA is the cornerstone for the way in which we will build our plans to improve the health and well-being of our communities, it is crucial that all agencies share the same intelligence through this assessment.

This year we have made substantial changes to the process and presentation of the JSNA and this document highlights our key areas for attention.

We have chosen five themes and 10 topics that cover the milestone events in people's lives from cradle to old age. Topics have been chosen using a number of criteria which include;

- the magnitude of the issue
- poor outcomes currently achieved
- worsening situation

Rather than remaining static, the JSNA is a live document. As circumstances change, outcomes vary and intelligence and analysis is updated, the JSNA will evolve and maintain its relevance. With the launch of the JSNA website, local information system, summary statement of need and a question/feedback facility we are hoping the JSNA will become an even more up to date, interactive and user friendly tool.

This Annual Statement marks the beginning of a new approach and hopefully the start of a conversation with commissioners of health and social care, but also importantly the public, patients, clients and partners to enable us to accurately outline the needs for our community. We look forward to working with you all to deliver a robust, fully engaged JSNA for Warwickshire.

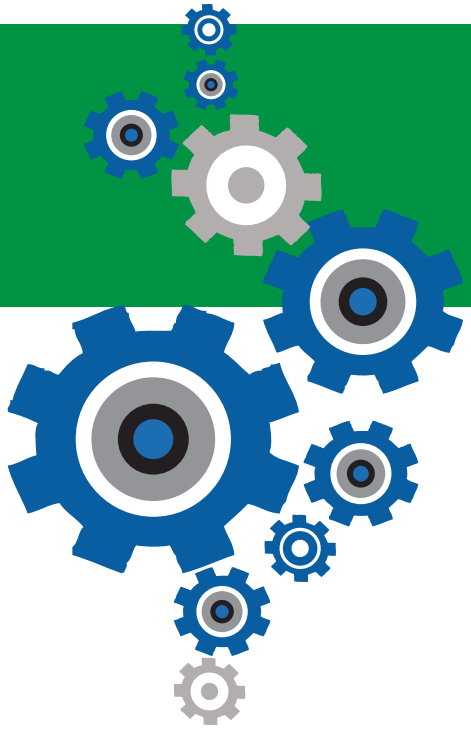
Dr John Linnane
Joint Director of Public Health
NHS Warwickshire/Warwickshire County Council

Wendy Fabbro
Strategic Director People Group
Warwickshire County Council

Warwickshire County Council

NHS Warwickshire

Introduction



Welcome to the 2011 Annual Review for Warwickshire's Joint Strategic Needs Assessment (JSNA). The purpose of the JSNA is to analyse and examine the current and future health and well-being needs of the local population, to inform and guide the commissioning of health, well-being and social care services.

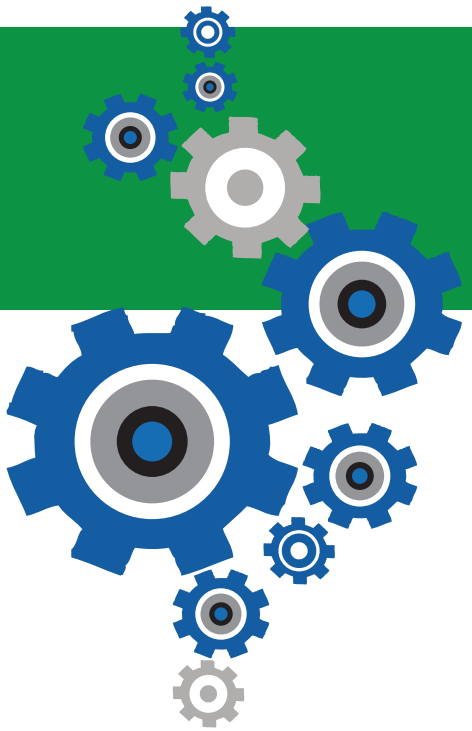
The JSNA aims to establish a shared, evidence based consensus on the key local priorities across health and social care and is being used to develop Warwickshire's Health and Wellbeing Strategy, Commissioning Plans for the Clinical Commissioning Groups (CCGs) and Transformation Plans for the local Health Economy.

The following set of key themes has been developed to inform the Health & Wellbeing Board of the emerging key messages from the JSNA. The information provides a 'position statement' and a 'snapshot' of our work so far at the end of 2011. It includes the key headline messages from our initial analyses and provides the basis for further, more detailed needs assessment work.

The themes have been loosely structured to follow a 'life-course approach' and are not just an amalgamation of facts and figures. Where possible, a broader range of qualitative information (e.g. knowledge, pathway information, consultation activity with stakeholders, service users, professionals, etc.) has also been included.

Further information is available at
www.warwickshire.gov.uk/jsna

Contents



Warwickshire JSNA

Warwickshire County Council

NHS Warwickshire

Warwickshire JSNA

Children & Young People

Educational Attainment

Looked After Children

Warwickshire County Council

NHS Warwickshire

Educational Attainment

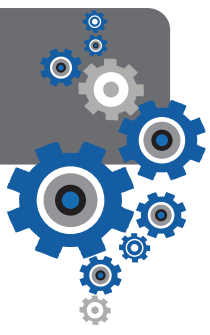
Research shows that education is a key determinant of health, with the more educated reporting lower morbidity from common acute & chronic diseases, lower anxiety/depression & experiencing better physical & mental functioning. Many of Warwickshire's children and young people achieve the expected national standards of educational attainment but significant disparities exist on a geographic and demographic basis. The tackling of this under achievement and health and well being inequalities among certain groups is crucial for reasons including raising aspirations, improving opportunities and reducing social & economic inequalities.

- The proportion of children in Warwickshire (66% in 2011) achieving a good level of development as assessed through the Early Years Foundation Stage Profile continues to increase year on year. However, there is an average year on year difference of 10% in achievement levels between the lower achieving north (Nuneaton & Bedworth and North Warwickshire) and the south (Warwick and Stratford).
- At Key Stage 2, geographical differences become more marked & attainment gaps are not decreasing. There are geographical differences between those achieving the expected level (level 4 and above), an average year on year gap of 6% between the north and the south. Differences between those achieving level 5+ are even more considerable with the gap increasing to an average of 9%. This demonstrates that higher level performance is less evident in the north than the south.
- At Key Stage 4 (KS4), the target level attainment is for five or more GCSE grades A*-C including Maths and English GCSE. For this, Warwickshire is above the national average, with 60.5% of pupils reaching this standard. Attainment levels in the north are lower than those in the south. This gap is not decreasing & less than half (48%) of pupils in the north achieve this level.
- Children with a special educational need (SEN) in Warwickshire achieve better than the national KS4 target level attainment, but the gap between SEN children and non-SEN children is still significant and remains consistently large.
- A 32.5 percentage point difference in 2011 exists between those eligible for free school meals and those who are not, in terms of achieving the KS4 target level attainment. This gap has remained consistently large over the last 3 years.
- There is little difference in achievement at GCSE level by broad ethnic group with Mixed, Asian, Black & Chinese pupils tending to do slightly better than their White counterparts. However, the gaps widen when breaking down these ethnic groups further.
- 14% of the 60 children who had been looked after continuously for at least 12 months as at 31st March 2011 who were eligible to sit their GCSEs in 2010/11 achieved the KS4 target level attainment, significantly lower than the Warwickshire average.
- Of the 54 children looked after continuously for 12 months at 31 March 2011 who completed year 11 during the 2009/10 academic year, 24 (44.4%) were in full time education, 1 (1.9%) was in f/t employment, 18 (33.3%) were in p/t employment, education or training & 11 (20.4%) were unemployed.
- For 95.7% of young people post-16 their destinations were positive as at November 2011. 89.5% continued in f/t education, 0.6% were involved in non-employed training, 5.1% were employed and 0.5% were involved in voluntary or part time activities.
- Negative outcomes account for 4.3% of young people with 3.1% not in education, employment or training (NEET) and 1.2% where data is not available/young person has left area (NALA).
- In 2010, 87% of young people educated in Warwickshire special schools had positive destinations post 16; 83.3% continued in f/t education, 2.8% were involved in non-employed training, 0.9% were employed & 0% engaged in voluntary or p/t activities.
- In Adult & Community Learning, there were 6,035 enrolments by 3,749 learners. Participation rates of ethnic minorities and from deprived communities were greater than the population average. The overall achievement rate of 92% is significantly above the national average. Much of this learning is non-accredited, but 629 qualifications were achieved in literacy, numeracy, ESOL and ICT.

Outcomes Sought

- Pupils are ready for school, attend and enjoy school with key indicators measuring attendance, exclusion and attainment.
- Achieve personal and social development and enjoy recreation, as reported in the Annual Pupil survey
- Positive outcomes for pupils post 16
- Transitions between settings and from children's to adult services are well managed
- Re-engage adults, particularly those with low prior attainment in learning to support their own & their children's development

What are we going to do about it?



- Warwickshire Children and Young People's Plan
- Warwickshire Child Poverty Strategy
- National Pupil Premium Strategy
- Public Health Outcomes Framework

Who Needs to Know This?

- Commissioners and practitioners of children services, and those involved in the transition to adulthood
- Children's Trust partners – see website for Children and Young People's Plan
- Head teachers

Looked After Children

As 'corporate parents', the County Council, officers and practitioners from across a range of agencies and services are responsible and accountable for the care, well-being and future prospects of children and young people in care.

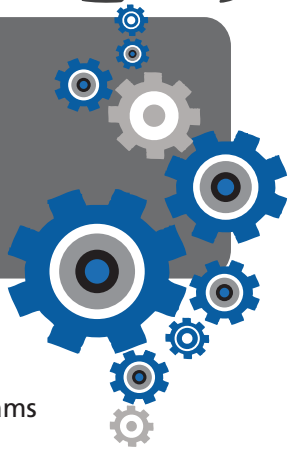
- The number of Looked After Children (LAC) has increased over the last 3 years; by 11% between 2009/10 (574) and 2010/11 (636); by 7% between 2008/09 (536) and 2009/10; and by 11% between 2007/08 (482) and 2008/09.
- The rate of LAC per 10,000 population is highest in Nuneaton & Bedworth, and increased from 167 at 31st March 2010 to 197 at 31st March 2011.
- The majority of children who have started to be looked after over the last three years have been aged between 10 and 15 years. However, over the last four years, there has been an increase in the number of children under the age of 1 who are being accommodated, up from 12.2% during 2007/8 to 17.2% during 2010/11. There has also been an increase this year in the number of young people aged 16-17 starting to be looked after, up from 8.5% in 2009/10 to 19.7% in 2010/11.
- The majority of looked after children have a main need category of 'abuse & neglect'. However, it is worth noting that the number of children with a main need of 'absent parenting' has increased in line with the overall increase in the number of unaccompanied asylum seeking children in Warwickshire, up from 66 in 2009/10 to 87 in 2010/11.
- Warwickshire had a total of 60 children who had been looked after continuously for at least twelve months as at 31st March 2011, who were eligible to sit their Key Stage 4 exams in 2010/11. Of these, 14% achieved the target level attainment of five or more GCSEs at Grade A*-C including Maths and English. This is significantly lower than the GCSE attainment of all children in Warwickshire, which sits at 60.5%.
- There were 54 children looked after continuously for 12 months at 31st March 2011 who completed Year 11 during the 2009/10 academic year. For 79.6% of these children their post 16 destinations were positive. 44.4% continued in full-time education, 1.9% were in full-time training, 33.3% were in part-time employment, education or training, whilst 20.4% were unemployed. Whilst this figure is higher than the previous year, nationally it stands at 18%.
- The rate of offending by LAC in Warwickshire remains relatively constant from 2008 with a rate of 5.3%, below the national comparator at 31st March 2011 which was 7.3%.

Outcomes Sought

- To narrow the gap in outcomes for looked after children and young people as compared with that of the general population
- To have access to universal and targeted health and educational services to meet their assessed needs and circumstances, that will promote the best possible outcomes
- To receive support and positive opportunities to progress into further education, training and employment
- To have both placement choice and stability
- To be subject to clear plans and to be able to participate in decisions and matters that affect their lives
- To sustain improved health and emotional wellbeing and to have opportunities to develop resilience and skills to prepare them for change, independence and adulthood.

What are we going to do about it?

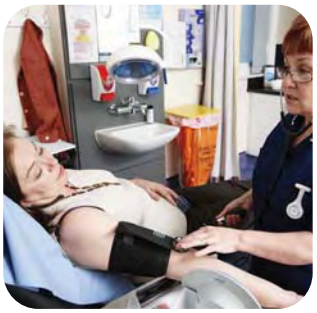
- Warwickshire Children and Young People's Plan
- Corporate Parenting Policy and Strategy
- Foster Care Development Plan
- Virtual School for Looked After Children
- Leaving Care Strategy



Who Needs to Know This?

- Commissioners of Children's Services
- Children's Trust Partners
- Schools
- Districts and Boroughs – particularly housing teams

Warwickshire JSNA



Lifestyle

Lifestyle Factors Affecting Health and Wellbeing

Warwickshire County Council

NHS Warwickshire

Lifestyle Factors Affecting Health and Wellbeing

Reviewing the public health outcomes for Warwickshire show the need to prioritise and focus on a number of key issues. These should not be treated in isolation from each other – they are interlinked, cut across all sectors of society and require a joined-up approach to tackling them.

- In Warwickshire, approximately one teenager becomes pregnant every day, with over half resulting in a termination. Warwickshire has reduced the under-18 conception rate by 12.2% since the inception of the Teenage Pregnancy Strategy in 1998. However, Warwickshire still has one of the highest conception rates among our statistical neighbours. Much of the reason for this is the hot-spot areas within the county.
- The number of Sexually Transmitted Infections (STIs) is on the increase. The total number of STIs in Warwickshire has risen by more than 20% since 2003. Overall, the 15-24 year age group had the highest number of diagnoses for all STIs, although Chlamydia which has the highest number of infections, mainly affects the 16 to 19 year age group.
- Warwickshire has low overall levels of child poverty but small localised pockets with relatively high levels do exist. 14,760 (13.2%) children are in 'poverty' in the county (2008). However, more children are likely to be in poverty than official statistics suggest as they do not reflect the impact of the economic down turn & recession. Nearly a third of all Warwickshire's children living in 'poverty' live in only 10% of the Super Output Areas.
- Obesity can have a severe impact on people's health, increasing the risk of type 2 diabetes, some cancers, and heart and liver disease. One in four adults in Warwickshire is estimated to be obese. This equates to 110,000 people and this figure is growing every year. According to the latest data, 20% of Reception age children and over 31% of Year 6 age children are classed as being overweight and obese.
- According to the 2009/10 Warwickshire Partnership Place Survey, 26.5% of respondents across the County reported achieving the recommended levels of exercise (5 x 30 minutes per week). It is notable that even in the district achieving the highest levels of exercise, some 70% of people do not achieve recommended levels.
- There are 32,000 people in Warwickshire who are drinking so much alcohol it is harming their health and this is increasing every year. The rate of alcohol-related hospital admissions has more than doubled since 2002/03 and is continuing to rise.
- There are 130,000 people in Warwickshire who smoke. In Warwickshire nearly 1,000 babies were born to women who still smoked at the time of delivery in 2010/11.
- Approximately 2,500 cases of cancer are diagnosed in Warwickshire each year, and about 1,400 deaths (representing 27% of all deaths) occur from cancer each year in the County.
- The number of repossession claims in Warwickshire has changed significantly over the last decade, from a low of 460 in 2002, to a high of 1,335 in 2007. During 2010, a total of 750 housing repossession claims were made against households in Warwickshire.
- The number of households on local authority housing waiting lists has risen for all of Warwickshire's boroughs and districts since 1997. Warwickshire has seen a 120% increase in the number of households on its local authority waiting lists from 1997 to 2010; Rugby has increased by 32% but Warwick has increased by 199%.

Outcomes Sought

- A reduction in the number and proportion of overweight and obese adults and children
- Increased levels of physical activity and healthy eating
- A reduction in alcohol-related harm to individuals, families and communities in Warwickshire
- A reduction in the rate of under 18 (15-17 years) conceptions
- Increased levels of uptake within the National Chlamydia Screening Programme
- A reduction in the number of people who start smoking coupled with an increase in the number of people who are supported to quit

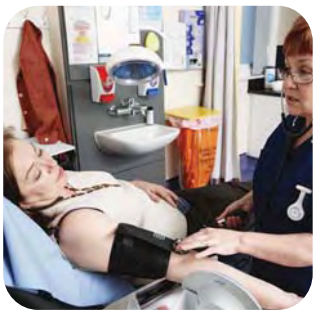
What are we going to do about it?

- Joint Director of Public Health Annual Report 2011
- 'Healthy Lives, Healthy People: A call to action on obesity in England' - This document sets out how action on obesity will be delivered as the move is made towards the new public health system.
- Warwickshire 'Respect Yourself' Campaign
- Warwickshire Alcohol Harm Reduction Strategy & Implementation Plan
- Warwickshire Child Poverty Strategy

Who Needs to Know This?

- Commissioners in Public Health
- Headteachers
- Councillors
- GPs and other health professionals
- Voluntary Sector
- Districts & Boroughs

Warwickshire JSNA



Ill-Health

Long-Term Conditions

Mental Wellbeing

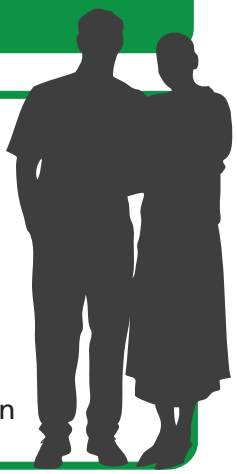
Warwickshire County Council

NHS Warwickshire

Long-Term Conditions

Long term conditions are those conditions that cannot, at present, be cured but can be controlled by medication and other therapies. Examples of long term conditions in Warwickshire include high blood pressure, diabetes, asthma, arthritis, heart disease and chronic obstructive pulmonary disease. People live with these conditions for many years, often decades, and they can impact on their quality of life by causing disability and early death.

- Nationally, around 1 in 3 people live with at least one long term condition. In Warwickshire, this equates to an estimated 178,000 people.
- People with long term conditions are more likely to see their GP, be admitted to hospital, stay in hospital longer, and need more help to look after themselves than people without long term conditions. They are also increasingly involved in managing their own conditions with the support of a health care team.
- High quality management of long term conditions help to keep people healthier and independent for longer.
- People with long term conditions need to be helped to understand their condition to manage it as well as possible, but in Warwickshire we have very few services that can help people learn about their condition, or have the right rehabilitation to improve the management of their condition
- Warwickshire GPs usually work with people to manage their long term condition and for the most part this care is very good, but we know that there are some people that are not getting the right treatments that they need, for example:
    - 20% of people with high blood pressure do not achieve the recommended level of control
    - 11% of people with diabetes have dangerously poor levels of blood sugar control
    - 10% of people with heart failure are not taking the recommended treatment
    - 6% of people who have coronary heart disease are not taking blood thinning medication that has been proven to reduce the chance of a heart attack and death.

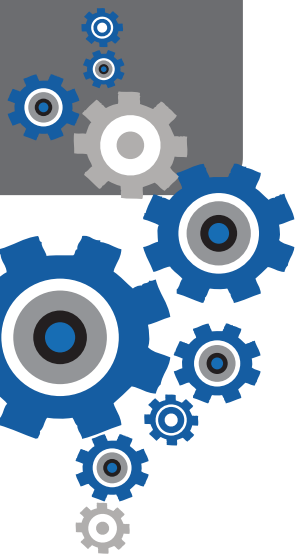


Outcomes Sought

- Improved clinical outcomes for people with long term conditions
- Greater use of telehealth, telecare and aids and adaptions to support people with long term conditions
- Better rehabilitation services for people with long term conditions
- More expert patient programmes for people with long term conditions
- Reduced hospital admissions and deaths for people with long term conditions
- Improved coordination of health and social care services for people with a long term condition

What are we going to do about it?

- Quality and Outcomes Framework
- Long Term Conditions Strategy, NHS Warwickshire, 2007/08
- Prioritising Need in the Context of Putting People First: A Whole System Approach to Eligibility for Social Care, 2010



Who Needs to Know This?

- GPs and other health professionals
- Clinical Commissioning Groups
- Primary Care and NHS Commissioners
- Hospital Trusts
- Social Care Commissioners

Mental Wellbeing

Mental illness affects not only the individual with the condition, but also family, friends and wider society. Around one in four people will suffer from mental illness during their lifetime.

- National data suggests 1 in 10 children under 16 has a clinically diagnosed mental illness and that between 10% and 13% of 15 and 16 year olds have self harmed; however, access to reliable local data is limited.
- In 2008, it was estimated that there were 5,960 young people aged 5-10 years old and 3,550 young people aged 11-16 years old with a mental health condition. It is estimated that among young people aged 5-10 years old the most prevalent type of disorder is a conduct disorder. Emotional disorders are the most common disorder among those aged 11-16. A CAMHs mapping exercise in 2007/8 showed that there is a higher prevalence of mental health disorders in the north than the south.
- Analysis from the 2011 Annual Pupil Survey suggests that nearly three quarters of secondary school pupils in Warwickshire feel either happy 'all of the time' or 'most of the time'. This represents a slight fall from 2010.
- People with mental illness have a higher risk of poor physical health; equally physical activity improves mental wellbeing. Primary pupils engaging in more than five sessions of physical activity per week has declined considerably from 35.8% in 2010 to 29.8% in 2011. Secondary pupils' physical activity has also declined from 29.6% in 2010 to 26.1% in 2011.
- Research links bullying in adolescence to mental illness in young adulthood. In 2010, a quarter of primary pupils said that they had been bullied in the last 12 months which decreased to 22.8% in 2011. In 2010, 13.7% of secondary pupils said that they had been bullied but this increased to 16.2% in 2011.
- At least one in four people will experience a mental health problem at some point in their life, one in six has a mental health problem at any one time and at least half of all adults will experience at least one episode of depression during their lifetime.
- Suicide remains the most common cause of death in men under the age of 35 in Warwickshire.
- One in ten new mothers experience postnatal depression.
- Local data indicates that over 13,000 Warwickshire residents accessed specialist mental health services in 2008/9. Overall, the proportion of patients accessing such services is higher for females than males and increases with age. However, many more individuals will be treated by their GP, private counselling, or have not yet identified that mental illness is affecting them.
- In 2010/11, 3,745 adults and older people with a functional mental health problem (i.e. not dementia) received social care professional support and of these 449 also received a funded social care service. Of those receiving support 633 were in paid employment.
- Since the start of 2010, Warwickshire Libraries have loaned over 11,000 self-help books and audio CDs as a means of early intervention for common mental health conditions.
- In 2010/11, 77% of people with a mental health need requiring social care support were living in 'settled accommodation' (i.e. not residential care, homeless, prison or hospital)
- In 2010/11, 19% of people with a mental health need requiring social care support were in paid employment
- Increasing physical activity can enhance independence, well-being, mental health and quality of life.

Outcomes Sought

- Mentally and emotionally healthy.
- Improve the emotional and mental health of individual children and young people.
- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support

What are we going to do about it?

- Warwickshire Children and Young People's Plan
- Director of Public Health Annual Report 2011
- Supporting People 5 year strategy
- Joint Mental Health Needs Assessment - A full needs assessment incorporating detailed data analyses and findings from a comprehensive consultation process with a wide range of stakeholders.
- Emotional Well-being and Mental Health Strategy 2011 - 2014
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Putting People First
- Think Local Act Personal

Who Needs to Know This?

- Commissioners in Public Health and Social Care
- Voluntary Sector
- GPs and other health professionals
- Councillors

Warwickshire JSNA

Vulnerable Communities

Reducing Health and Wellbeing Inequalities

Disability

Safeguarding

Warwickshire County Council

NHS Warwickshire

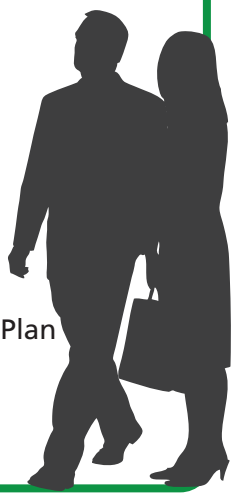
Reducing Health and Wellbeing Inequalities

In Warwickshire, significant disparities exist both on a geographic and population group basis. The health of the most disadvantaged in our society should be our top priority. However, there is a need to ensure that our programmes target people across the inequality profile. In line with the Marmot report, the highest priority should be given to children from pre-conception through to adolescence.

- Latest data suggests widening health inequalities in Warwickshire. All of the top 13 most deprived areas from the Index of Multiple Deprivation (IMD) 2007 have shown considerable deterioration in rankings in the IMD 2010, suggesting that the gap between the most and least deprived areas of the County is widening. According to the 2010 indices, more areas of Warwickshire are ranked within the top 30% most health deprived areas in England compared with the 2007 indices.
- People in some areas of Warwickshire live for 13 years less compared to other areas. There is considerable variation in life expectancy at birth at ward level across the County ranging from 75 in Abbey ward, Nuneaton, to 88 in Leek Wootton, Warwick.
- Amongst the 10 wards with the highest teenage conception rates in Warwickshire, four are in Nuneaton & Bedworth, four are in Warwick and two are in Rugby. Six are within the top 10% most deprived areas of the county – representing a significant positive relationship between deprivation and teenage conception.
- It is also important to consider inequalities which persist across the wider determinants of health, including employment, education, and housing etc.
- Inequalities also exist within different population groups eg. by ethnicity, gender and age. More work is needed to fully understand this picture across Warwickshire.

Outcomes Sought

- Reducing infant mortality, and reducing early mortality from cardiovascular disease and cancer
- Reducing poverty, and increasing educational attainment, skills & jobs for those most in need
- Embedding the reduction of health inequalities in the decision-making process of all public agencies and partners
- Improving equality of access to services especially primary care
- Continue the development of partnerships to jointly promote activities which support individuals to lead healthy lifestyles
- Increase the promotion of alcohol education campaigns and alcohol treatment services
- Coordinate the implementation of the 'Making Every Contact Counts' approach
- Ensure the provision and quality of smoking cessation services, and the NHS cancer screening programme
- Contribute to the formation and implementation of local Tobacco Control Implementation Plan
- Continue to promote mental health and wellbeing as a foundation stone to good health across the population, building on the notion of 'no health without mental health'
- Increase the promotion of positive sexual health with a focus on HIV prevention



What are we going to do about it?

- Strategic Review of Health Inequalities in England Post-2010 (The Marmot Review)
- Warwickshire Health Inequalities Strategy - the existing Health Inequalities Strategy is being subsumed into the Draft Health and Wellbeing Strategy
- Joint Director of Public Health Annual Report 2011

Who Needs to Know This?

- Commissioners in Public Health and Social Care
- GPs and other health professionals
- Voluntary Sector
- Councillors

Disability

The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

- Using the DDA definition, there are estimated to be 80,000 disabled people living in Warwickshire, 19% of the over 16 population.
- All Warwickshire's districts and boroughs have lower proportions of their adult populations who are disabled than national and regional averages. In the County, North Warwickshire has the largest proportion of its adult population estimated to be disabled, at just below 22%.
- On 31st March 2011, 1,230 people were registered blind or severely sight impaired in Warwickshire, with 1,486 registered as partially sight impaired.
- Prevalence rates indicate Warwickshire's disabled children population to be between 3,750 and 6,750 (between 3% and 5.4% of all children).
- In January 2011, 19.7% of the Warwickshire school population were defined as having a special educational need (SEN). Nuneaton & Bedworth has the highest percentage (23.2%) with Rugby (19.5%) and Warwick (19.3%) having the next highest rates.
- Data on Disability Living Allowance claimants aged under 16 gives an indication of prevalence of disability among the population. Rugby has the highest rate of claimants (14%, 490 claimants) but Nuneaton & Bedworth has the highest number of claimants (700 claimants, 9%).
- Prevalence rates indicate that there are 9,310 people aged 14 and over in the County with some form of learning disability. This is projected to increase to 9,570 by 2015, with a reduction in numbers aged 14-18 but a large increase in those aged 65 and over.
- Within this group of 9,310 people, 220 people have profound and multiple learning disabilities and 1,560 people have severe learning disabilities. This means there are 1,780 with profound or severe learning disabilities. By 2015, this figure is predicted to rise to 1,830 with the increases occurring in the 65 and over age group.
- It is estimated that there are currently 8,050 people in Warwickshire aged between 18 and 64 with a serious physical disability, this is projected to increase to 8,600 by 2030.
- In 2010-2011, 1,480 people aged between 18 and 64 with a physical disability were assessed to need a funded social care service.
- In December 2011, 30% of social care customers with a learning disability and 9% of social care customers with a physical disability were living in residential or nursing care.

Outcomes Sought

- Effective integrated working to promote early intervention
- Improved educational achievement so more children and young people are able to reach their true potential and gaps are narrowed between the attainment levels of vulnerable pupils and their peers
- Increased choice & control for all people with disabilities
- People with a disability are able to live a fulfilled life including accessing a range of community activities and are able to get paid employment
- People with a disability have a place of their own to live
- Better health and well-being for people with disabilities
- Carers of people with disabilities are supported to have a fulfilled life of their own
- Vulnerable children and adults are kept safe from harm including bullying and anti-social behaviour
- Transitions are managed, including from children's to adults services

What are we going to do about this?

- Warwickshire Children and Young People's Plan
- 'A Good Life for Everyone' - Warwickshire's Joint Commissioning Strategy for Adults with a Learning Disability 2011 – 2014
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Putting People First
- Think Local Act Personal

Who Needs to Know This?

- Commissioners of children and adult disability services
- Head teachers and GPs
- Third sector organisations supporting people with disabilities
- District and Borough practitioners, for example Housing officers

Safeguarding

Ensuring that Warwickshire's vulnerable children and adults are safe from harm is a key priority. Safeguarding Children and Adults Boards meet on a regular basis with representation from all of the key organisations in Warwickshire including the County Council, Police, Health, District & Borough Councils, Ambulance and Fire Services, Hospital Trusts, Probation, Coventry & Warwickshire Partnership Trust and Voluntary Agencies.

- At 31st March 2011, 478 children were subject to a Child Protection Plan (CPP) compared to 503 at 31st March 2010, representing a 5% decrease. Once again this year, the largest group of children to become subject to a CPP were those aged 1-4 years. These figures are snapshots as of the 31st of March.
- The rate of children subject to a CPP per 10,000 is highest in Nuneaton & Bedworth, followed by Rugby.
- The proportion of children subject to a CPP who are aged under five, including unborn children, has increased slightly to 47.9% (229) in 2011 from 45.3% (228) in 2010. Of these, 12 were unborn at 31st March 2011 & 9 unborn at 31st March 2010.
- In 2010/11 862 adult safeguarding referrals were received, this compares to 826 in 2009/10 and in 2011/12 the number of referrals is expected to exceed 1,000. In 2010/11 Warwickshire had a rate of 20 referrals per 10,000 adult population compared to the national average of 26 referrals.
- 28% of safeguarding referrals were from Nuneaton and Bedworth and 22% from Warwick District. These are directly comparable with the percentage of customers in each district, therefore there appears to be no greater risk of Safeguarding incidents based on where people live.
- 50% of safeguarding referrals related to an incident in the customers own home, 33% were in a care home.
- 53% of alleged perpetrators in 2010/11 were professional (abuse by worker or institutional abuse) and 47% were personal relationships (family, friend or informal carer).

Outcomes Sought

Children and Young People are:

- Safe from maltreatment, neglect, violence and sexual exploitation
- Safe from accidental injury and death
- Safe from bullying and discrimination
- Safe from crime and anti-social behaviour in and out of school
- Have security, stability and are cared for

Adults:

- Reduce the number of safeguarding incidents
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm
- Improving services and support for victims of sexual violence
- All customers are aware of how to make a safeguarding referral
- Reduction in 'Mate Crime' and 'Hate Crime'

What are we going to do about it?

- Warwickshire Children and Young People's Plan
- Warwickshire Children Safeguarding Board
- Adult Safeguarding Policy
- Adult Safeguarding Board Performance Report
- Adults Safeguarding Plan – In development
- Keeping Safe Plan for Customers with Learning Disability

Who Needs to Know This?

- Practitioners and Commissioners in Children and Adult services
- Members of the multi-agency safeguarding boards
- GPs and health professionals
- Police
- Third sector organisations supporting vulnerable people
- Whole community

Warwickshire JSNA

Old Age

Dementia

Ageing and Frailty

Warwickshire County Council

NHS Warwickshire

Dementia

The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific conditions, including Alzheimer's disease, stroke, and many other rarer conditions. Dementia is increasingly becoming one of the most important causes of disability in older people. In terms of Global Burden of Disease, it contributes 11.2% of all years lived with disability. This figure is higher than stroke, musculoskeletal disorders, heart disease and cancer.

- The Alzheimer's Society statistics indicate there are currently some 750,000 people living with dementia in the UK. This represents one person in every 88 (1.1%) of the UK population. By 2021, it is estimated there will be over 940,000 people living with dementia and this is predicted to soar to 1.7 million by 2050. This represents a 125% increase in the number of people living with dementia between 2010 and 2050, or a 3% per year increase.
- It is estimated that in Warwickshire, there were around 6,500 people aged over 65 living with dementia in 2010.
- In 2008, 3,353 people in Warwickshire were registered with their GP as having dementia, meaning over 50% of the predicted number of people with dementia are undiagnosed.
- Between 2010 and 2030, it is estimated that the number of older people with dementia in Warwickshire will double, to more than 13,000. The majority of these will be aged 75 and over.
- Currently, in the UK, around two thirds of people with dementia live in private households.
- The Alzheimer's Society estimates that in 2007 the total cost of dementia in the UK was £17 billion per annum, or on average £25,472 per person with late onset dementia.
- It is not currently known how many people with dementia are funding their own care both in residential care and in their own home.

Outcomes Sought

- **Awareness and Understanding:** A key part of understanding mental ill health is to promote positive mental health and also the awareness of dementia and the services to enable individuals to live well. A lack of understanding of dementia can lead to a number of problems including symptoms not being recognised early enough leading to poor access to services and poor outcomes.
- **Early Diagnosis and Support:** Early diagnosis is key to providing the right support to both service users and carers in a timely manner.
- **Living Well with Dementia:** Users and carers highlight that once diagnosed with dementia they require a range of services that fully meet changing needs. Whilst there are already a number of services in Warwickshire that offer both support and services to people living with dementia, it is recognised that there is more to be done to make sure the highest quality support and services are available to people with dementia and their carers.
- **Making the Change:** Service users and carers in Warwickshire have told us that the National Dementia Strategy recommendations for an informed and effective workforce are key to improving services.
- **Transform health care for people with dementia and their families**

What are we going to do about it?

- Joint Director of Public Health Report 2010: Best Health for Older People in Warwickshire p30/31
- Living Well with Dementia in Warwickshire
- National Dementia Strategy
- Dementia UK - Alzheimer's Report
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Putting People First
- Think Local Act Personal

Who Needs to Know This?

- Commissioners in Public Health and Social Care
- Third sector organisations supporting vulnerable older people
- GPs and other health professionals

Ageing and Frailty

Alongside general population growth in Warwickshire, there will be a particularly high rate of increase in those aged 65 and over, a trend reflected across all districts and boroughs. Whilst living longer is a cause for celebration, from a public sector point of view, the two key impacts are the additional pressures that will be placed upon services (particularly health and social care) and the quality of life experienced by residents as their life expectancy increases.

- Between 2012 and 2030 it is projected that the number of people aged 65 and over is projected to increase by 48%, the number of people aged 85 and over is projected to more than double, rising by 119%.
- Dementia is expected to increase by almost 90% in people aged over 60 by 2030.
- In the 2001 Census showed there are 53,000 people providing unpaid care in Warwickshire, of those 58% were aged over 50 and 18% were aged over 65.
- An estimated two thirds of over 75 year olds in Warwickshire live with one or more long term conditions, many of which are not known to the older person's general practitioner.
- By 2030, it is estimated that more than 37,000 people over 65 in Warwickshire will be obese, with greater risks for diabetes, heart disease and other associated health problems.
- In the next 20 years, new cancer cases are projected to increase by 100% in men aged over 70 and 50% in women aged over 70.
- Frail older people stay in hospital longer, occupy two thirds of hospital beds and are the main users of long term care services, much of which is unnecessary.
- Some 22% of all non-planned emergency inpatient admissions are to people aged over 75.
- The proportion of spend for hospital activity on the over 75 year old population is 26% of all activity and 39% of non-elective costs.
- In 2010/11 81,330 items of equipment were provided by the Integrated Community Equipment Service to meet both health and social care needs
- In 2010/11, 8,920 older people were assessed to need a funded social care service from Warwickshire County Council. This represents 9% of the population, if this percentage of the population continued to need social care support in 2030 over 13,000 people would require services. 7,309 people had needs that were supported in the community including services such as home care (4,416 people), equipment and adaptations (3,347 people), day care (773 people) and 472 people taking a direct payment to purchase their own care. 2,180 people required permanent residential or nursing care.
- Extra Care Housing offers the residents of Warwickshire alternative accommodation options to institutional, residential and nursing care; supporting their independence and well-being in their home environment.
- There are a number of screening programmes targeted at the over 50s population, for example bowel cancer screening, but uptake varies by age and depending on where people live.
- 68% of social care service users feel in control of their daily lives, compared to the national average of 75%.
- Currently 60% of customers who receive reablement do not require any on-going support for at least 3 months after receiving reablement. Since its pilot in April 2010 reablement has helped over 2,000 older people. The new model for reablement will see approximately 60 new referrals per week into the reablement service. 60 referrals per week represents 70% of the estimated adult social care referrals for new customers and changing needs for existing customers.

Outcomes Sought

- Improve end of life care
- Reduce the risk of falls and fractures in older people
- Reduce excess deaths during winter months
- Meet needs arising from social isolation and rural living
- Encourage healthy living in old age
- Choice and control and services to promote independence
- Joined Up Services that are community based
- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support

What are we going to do about it?

- Joint Director of Public Health Report 2010: Best Health for Older People in Warwickshire
- Supporting Independence (prevention) Strategy 2011 – 2014
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Putting People First
- Think Local Act Personal
- Care and Choice, Delivering better outcomes for Older People, 2008-2015

Who Needs to Know This?

- Commissioners in Public Health and Social Care
- Providers of accommodation for older people, and also practitioners involved in housing adaptations
- Third sector organisations supporting vulnerable older people
- GPs and other health professionals

What we know so far… Health and Social Care Act 2012 at a glance

April 2012

BMA

What we know so far…

This paper forms part of a series of BMA briefing papers, which set out what we know so far on a range of key topics following the Government's health reforms in England[1].

The Health and Social Care Act 2012, which concluded its 15-month passage through Parliament on 20 March 2012 and received Royal Assent on 27 March 2012, now defines much of the Government's policy in primary legislation[2]. The Act legislates for the NHS reforms first set out in the White Paper, *Equity and Excellence: Liberating the NHS*, which was published in July 2010.

Following the legislation's passage through Parliament, a considerable amount of regulations and further guidance is expected, providing detail on how the new Act will work in practice.

This briefing paper focuses on bringing together the available facts and drawing attention to gaps in knowledge rather than giving an account of BMA policy. Further documents stating the BMA's policies and positions are available at **www.bma.org.uk/nhsreform**.

This paper provides a factual summary of the main changes to be effected by the new legislation, covering the following areas:

- Duties of the Secretary of State
- New commissioning arrangements
- Monitor, choice and competition
- Foundation Trusts
- Care Quality Commission
- National Institute for Health and Care Excellence
- Education, training and research
- Public health
- Local government
- Patient involvement
- Information and confidentiality

An overview of the health and social care structures envisaged by the legislation can be found in the **Annex**.

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1 Other briefing notes in the series include: The NHS Commissioning Board; New Providers; Foundation Trusts; Local Accountability; Choice and Any Qualified Provider; Monitor and Regulation. These briefing notes are available at **www.bma.org.uk/nhsreform**

2 The Health and Social Act 2012 is available at **www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf**

Main policy areas

Duties of the Secretary of State

- The Act places duties on the Secretary of State for Health to promote a comprehensive health service in England and also to promote autonomy. The Act outlines that the Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England and explains that the duty to promote a comprehensive health service will take priority over the duty to promote autonomy should they conflict.

- The Act also places duties on the Secretary of State to: act to secure improvement in the quality of services; have regard to the need to reduce health inequalities; promote research on areas relevant to the health service and the use of evidence within the health service; promote equality of provision; ensure that there is an effective system for the planning and delivery of education and training; protect public health. The Secretary of State also has powers of intervention in relation to failure by various bodies connected with the health service.

- The Act enables the Secretary of State to set priorities for the NHS through a mandate for the NHS Commissioning Board. The Secretary of State also has regulation-making powers outlining requirements for NHS commissioners.

New commissioning arrangements

- The Act establishes the **NHS Commissioning Board** and it will be accountable to the Secretary of State for meeting the requirements outlined in the mandate. The mandate will be subjected to consultation, publication and consideration in Parliament. The Act also establishes **Clinical Commissioning Groups** (CCGs) to be responsible for commissioning local services. Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) will be abolished by April 2013. The Board will become a full statutory body in October 2012 and most CCGs are expected to be authorised by April 2013.

- The Act places various shared duties on the Board and CCGs including: promoting the NHS Constitution; ensuring effectiveness and efficiency; securing continuous improvements in the quality of services commissioned; reducing inequalities; enabling choice; promoting patient involvement; securing integration; promoting education and training, innovation and research.

- The Board also has specific duties including: promoting autonomy; ensuring regard to impact on services in certain areas (i.e. to have regard to the possible consequences of its commissioning decisions on the provision of health services to those living in areas of Scotland or Wales close to the English border); avoidance of variation in provision of health services (the Board must not, as part of its functions, set out to vary the proportion of services delivered by providers due to their status, i.e. public or private sector).

- CCGs and the Board are required to obtain advice from a people with 'a broad range of professional expertise.' In undertaking this, input can be sought from **clinical senates** and **clinical networks** (although these bodies are not mentioned in the Act). The Act also calls for close working with Health and Wellbeing Boards.

- The Board will oversee CCGs and they will be financially accountable to it. The Board will also provide guidance and advice to CCGs.

- Authorisation of a CCG by the Board will only be possible if certain criteria are met (e.g. that it has: the means to undertake commissioning responsibilities; an accountable officer; a governing body with lay and wider clinical membership; a constitution which outlines processes for decision-making, accountability and dealing with any conflicts of interest).

- In order to achieve authorisation, CCGs will have to demonstrate that they have access to adequate commissioning support services (including back office functions such as payroll as well as more complex services such as data gathering and analysis to inform the commissioning process).

- The Act introduces a 'quality reward' intended to recognise CCGs and practices within it in order to incentivise high-quality commissioning. Details of this reward will be fleshed out in secondary legislation.

Monitor, choice and competition

- **Monitor** will be the economic regulator for all NHS funded services. All providers of NHS healthcare services, unless exempted, will need to hold a licence with Monitor, which will maintain and publish a register of licence holders. It will be able to set different conditions for different types of licences, depending on the services provided or the areas in which services are delivered. Conditions are likely to include a requirement to pay fees, to provide Monitor with information considered necessary for price setting, and to do, or not do, specified things to prevent anti-competitive behaviour which acts against the interests of patients.

- The Secretary of State will have the power to exempt some individuals, groups of providers or certain types of health services from Monitor's licensing requirements.

- Monitor will not be permitted to set or modify licence conditions for the purpose of promoting competition or to encourage the growth of the private sector over existing state providers, or vice versa. It will have powers to set and enforce licence conditions to enable integration and cooperation between healthcare providers.

- In order to address anti-competitive behaviour in areas where choice and competition already operate, Monitor will have concurrent functions with the Office of Fair Trading (OFT). Monitor will work with the NHS Commissioning Board to set out guidance on how choice and competition should be applied to particular services.

- Monitor will be required to exercise its functions with a view to enabling services to be provided in an integrated way, where this would improve quality or efficiency, or reduce inequality of access or outcome for patients. This is aimed at strengthening collaboration and integration where it is in the interests of patients.

- Monitor will have various duties around price setting, including developing standardised pricing currencies for the national tariff, with the NHS Commissioning Board.

- Monitor will also have powers to assist providers in significant difficulty. This will include requiring a provider to appoint a turnaround expert to help them avoid failure and appointing a continuity administrator to take control of a provider's affairs when it is deemed clinically or financially unsustainable.

- Monitor will also have a duty to create a 'risk pool' for struggling providers to access funds to help them tackle their problems.

- Monitor will retain specific oversight powers over all Foundation Trusts (FTs) until 2016, to try to provide continuity and enable governors to build capacity in holding their boards to account. The ultimate intention is for FTs to manage their own governance and financial performance, without oversight. Monitor will perform the role of registrar of FTs. For this purpose, a number of enduring conditions will apply to FTs on a perpetual basis with the aim of ensuring a level playing field for all providers.

Foundation Trusts

- While the original deadline of April 2014 for all trusts to become FTs has been removed from the Government's proposals, the Act still allows for the Secretary of State to bring in the provision to abolish all remaining NHS Trusts at a future date of his/her choosing. The **NHS Trust Development Authority** (which does not appear in the legislation) is to be established in summer 2012. The Government says that the Authority will 'provide governance and oversight of NHS Trusts following the abolition of SHAs in 2013.' Included in its remit is performance management of NHS Trusts, financial scrutiny and powers of intervention if NHS Trusts are deemed to be poorly performing.

- The Department of Health's expectation is that the vast majority of NHS Trusts will have achieved FT status by 2014. The Act also exempts trusts that have entered into 'franchise arrangements' from having to achieve FT status for the duration of those arrangements, and for three years after the arrangements have ended.

- FTs are given greater scope to generate private income although they will have to ensure that the majority of their income is through NHS services (this by default sets the private patient income cap at 49%). An increase in the proportion of an FT's private income of more than 5% would need majority approval by its governors and FTs will be required to document how non-NHS income has benefited NHS services in their annual reports.

- The legislation also sets out the arrangements for FTs undergoing organisational change in the event of mergers, acquisitions, separations and dissolutions.

Care Quality Commission

- The **Care Quality Commission** (CQC) will continue to act as the quality inspectorate across health and social care. The Act removes the CQC's responsibility for assessing the performance of NHS commissioners, which will be taken on by the NHS Commissioning Board, and for carrying out periodic reviews of NHS services. It is hoped that this will allow the CQC to focus its resources on its core role of registering and regulating providers. The Government says that the CQC's remit is distinct from Monitor in that its focus will be on quality; it registers health and adult social care services to ensure quality standards and maintains inspections to make sure those standards continue to be met.

- Under the new joint licensing regime, the CQC will be responsible for licensing NHS and adult social care providers against essential safety and quality requirements. It is likely that the CQC will continue to operate its existing licensing scheme; there have not been any changes announced to date.

- The CQC will continue to inspect providers against the essential levels of safety and quality. It will carry out inspections in response to information that it receives about a provider, which will now come through CCGs and **local HealthWatch** and **HealthWatch England**, as well as the already established channels, such as patient and service user feedback and complaints.

National Institute for Health and Care Excellence

- The National Institute for Health and Clinical Excellence (NICE) will largely remain the same but, under the Act, it will become a Non-Departmental Public Body. NICE's role will still continue to consider evidence in order to make recommendations on medicines, treatments and procedures.

- Its remit will be extended to include social care and its name will change to the **National Institute for Health and Care Excellence** although the acronym, NICE, will still be retained.

Education, training and research

- The Act places a duty on the Secretary of State to exercise his/her functions to secure an effective system for the planning and delivery of education and training for healthcare workers.

- There are also duties on the NHS Commissioning Board and CCGs to have regard to the need to promote education and training in carrying out their functions; and a duty to ensure that commissioning arrangements for health services secure that providers co-operate with the Secretary of State in the discharge of his/her duty to education and training.

- Although not mentioned in the Act, **Health Education England** (HEE) will be established as a Special Health Authority in June 2012. Among its functions will be promotion of high quality education and training as well as authorising and supporting **Local Education and Training Boards** (LETBs). It is expected that the education and training functions of SHAs and postgraduate deaneries will be undertaken by LETBs. The Government has indicated that further legislation will follow on education and training.

- The Act also seeks to provide the legal basis for research in the NHS and places duties on the Secretary of State, the NHS Commissioning Board and CCGs to promote research. Monitor is also required to have regard to the need to promote research into matters relevant to the NHS by those providing healthcare services for the purposes of the NHS. The Government has also confirmed that it will establish the **Health Research Authority** (HRA) as a Special Health Authority with future legislation to make it a Non-Departmental Public Body.

Public health

- The Act restructures public health services nationally and locally. Nationally, the Act places a duty on the Secretary of State to protect the people of England, with central responsibility for health protection and response to emergencies. Although not mentioned in the Act, a new executive agency, **Public Health England**, will be the national body overseeing the public health system and will be accountable to the Secretary of State.

- Locally, the Act grants local authorities responsibilities for health and stipulates that they must employ a Director of Public Health. The local authority must have regard to any guidance given by the Secretary of State in relation to its Director of Public Health, including guidance on appointment, termination of appointment and terms and conditions of management.

- Directors of Public Health have been added to the list of statutory chief officers in the *Local Government and Housing Act 1989* to establish parity with other chief officers in local government such as Directors of Adult Social Services and Directors of Children's Services.

Local government

- The Act introduces new **Health and Wellbeing Boards** to each upper tier local authority. Health and Wellbeing Boards will have a duty to encourage integrated commissioning between health, social care and public health by bringing together representatives of these sectors.

- The boards will be tasked with: leading on the Joint Strategic Needs Assessment; developing a new joint health and wellbeing strategy to inform local commissioning plans; developing agreements to pool budgets.

- The Health and Wellbeing Board will include: the Director of Adult Social Services, the Director of Children's Services, the Director of Public Health, a representative of each CCG, a representative of local HealthWatch and as many local councillors as they choose. It will be accountable to the local authority's Overview and Scrutiny Committee.

Patient involvement

- Duties have been placed on the NHS Commissioning Board, CCGs, Monitor and Health and Wellbeing Boards to involve patients, carers and the public. New patient and public bodies, known as local HealthWatch will be established. Local HealthWatch will act as a point of contact for individuals, community groups and voluntary organisations when dealing with health and social care and will have a representative seat on the Health and Wellbeing Board. HealthWatch will be commissioned by the local authority and held to account by the local authority's Overview and Scrutiny Committee.

- A national body, HealthWatch England, will be established to support local HealthWatch. It will sit as a statutory committee of the CQC. HealthWatch England will be tasked with representing people using health services at a national level and will have a role in advising CQC to review services where appropriate.

- CCGs will have a statutory duty to have regard to the Joint Strategic Needs Assessment and joint health and wellbeing strategy. CCGs will also be represented on the Health and Wellbeing Board.

Information and confidentiality

- The Act enables the **Health and Social Care Information Centre** to be the central point for information collected from NHS and social care organisations in England. The Information Centre will publish a code of practice for health or social care bodies (or those providing health or social care) on how to deal with patient-identifiable or other confidential information.

Glossary

- **Care Quality Commission (CQC)** – The CQC will continue to act as the quality inspectorate across health and social care. The new Act removes the CQC's responsibility for assessing the performance of NHS commissioners, which will be taken on by the NHS Commissioning Board, and for carrying out periodic reviews of NHS services.

- **Clinical Commissioning Groups (CCGs)** – GP practices have formed CCGs in preparation for the formal establishment of CCGs as statutory commissioning bodies from April 2013.

- **Clinical senates and clinical networks** – Clinical networks will be condition or service area specific, and clinical senates 'are intended to bring together a range of experts, professionals and others from across different areas of health and social care to offer access to independent advice about improvements in quality of care across broad geographical areas of the country'[3]. Both senates and networks are intended to pool specialist expertise and thereby support the work of CCGs and will be hosted by the NHS Commissioning Board.

- **Health and Social Care Information Centre** – The Health and Social Care Information Centre will be the central point for information collected from NHS and social care organisations in England.

- **Health and Wellbeing Boards** – Health and Wellbeing Boards will have a duty to encourage integrated commissioning between health, social care and public health by bringing together representatives of these sectors.

- **Health Education England (HEE)** – HEE will be established as a Special Health Authority in June 2012. Among its functions will be to promote high quality education and training. It will also authorise and support Local Education and Training Boards (LETBs).

- **Health Research Authority (HRA)** – The HRA will be a new organisation to oversee the governance and regulation of health research.

- **HealthWatch England** – HealthWatch England will be established to support local HealthWatch. It will sit as a statutory committee of the CQC. HealthWatch England will be tasked with representing people using health services at a national level and will have a role in advising CQC to review services where appropriate.

- **Local Education and Training Boards (LETBs)** – It is expected that the current education and training functions of SHAs and postgraduate deaneries will be undertaken by LETBs.

- **Local HealthWatch** – Local HealthWatch will act as a point of contact for individuals, community groups and voluntary organisations when dealing with health and social care and will have a representative seat on the Health and Wellbeing Board.

- **Monitor** – Monitor will be the economic regulator for all NHS funded services. All providers of NHS healthcare services, unless exempted, will need to hold a licence with Monitor, which will maintain and publish a register of licence holders.

3 Department of Health (2011) *Developing clinical senates and networks* (Dear colleague letter from Kathy McLean, 15 September 2011)

- **National Institute for Health and Care Excellence (NICE)** – NICE's remit will largely remain the same but under the new Act, it will become a Non-Departmental Public Body with its remit extended to also cover social care. NICE will still continue to consider evidence in order to make recommendations on medicines, treatments and procedures.

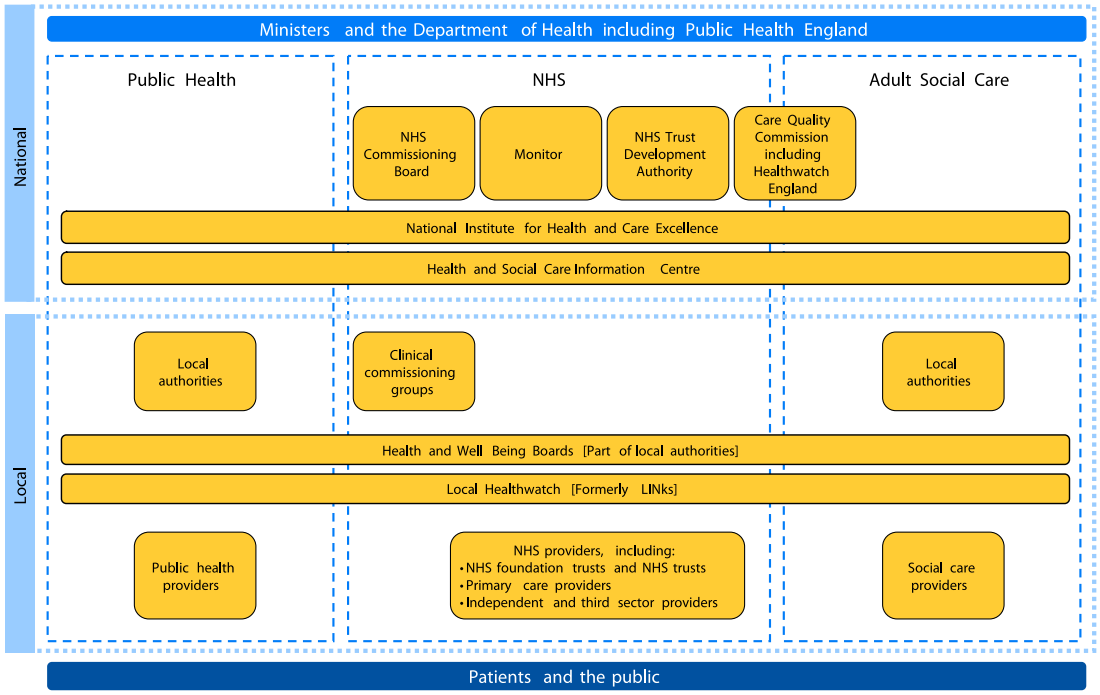
- **NHS Commissioning Board** – The NHS Commissioning Board will be a statutory and independent board expected to play a central role in the new commissioning and managerial architecture of the NHS, following the abolition of SHAs and PCTs and the establishment of CCGs.

- **NHS Trust Development Authority** – The NHS Trust Development Authority is to be established in summer 2012. The Government says that the Authority will 'provide governance and oversight of NHS trusts following the abolition of SHAs in 2013.' Included in its remit is performance management of NHS trusts, financial scrutiny and intervention if NHS trusts are deemed to be poorly performing.

- **Public Health England** – Public Health England will be the new national body overseeing the public health system and will be accountable to the Secretary of State.

Annex

Overview of health and social care structures in the Health and Social Care Bill
April 2013



Source: *Overview of health and social care structures in the Health and Social Care Bill,* Department of Health, February 2012, **www.dh.gov.uk/health/2012/02/bill-factsheets**

The Health and Social Care Bill

- To safeguard its future the NHS needs to change to meet the challenges it faces – only by modernising can the NHS tackle the problems of today and avoid a crisis tomorrow.
- The Health and Social Care Bill puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health.

Case for change

1. The Government is committed to the NHS's founding principles. However, there is a broad consensus that standing still will not protect the NHS. Modernisation is essential for three main reasons.
2. ***Rising demand and treatment costs***. The pressures on the NHS are increasing, in keeping with health systems across the world. Demand is growing rapidly as the population ages and long-term conditions become more common; more sophisticated and expensive treatment options are becoming available. The cost of medicines is growing by over £600m per year.
3. ***Need for improvement.*** At its best, the NHS is world-leading, but there are important areas where the NHS falls behind those of other major European countries. If we had cancer survival rates at the average in Europe, we would save 5,000 lives a year.
4. ***State of the public finances.*** Whilst the Government has protected the NHS budget, this is still among the tightest funding settlements the NHS has ever faced. Simply doing the same things in the same way will no longer be affordable in future.

Key legislative changes

5. The Government's proposals are designed to meet these challenges, by making the NHS more responsive, efficient and accountable. They draw on the evidence and experience of 20 years of NHS reform.
6. ***Clinically led commissioning (Part 1)***. The Bill puts clinicians in charge of shaping services, enabling NHS funding to be spent more effectively. Previously clinicians in many areas were frustrated by negotiating with primary care trusts to get the right services for their patients. Supported by the NHS Commissioning Board, new clinical commissioning groups will now directly commission services for their populations.
7. ***Provider regulation to support innovative services (Parts 3 and 4).***The Bill enshrines a fair-playing field in legislation for the first time. This will enable patients to be able to choose services which best meet their needs, including from charity or independent sector providers, as long as they meet NHS costs. Providers, including NHS foundation trusts, will be free to innovate to deliver quality services. Monitor will be established as a specialist regulator to protect patients' interests.
8. ***Greater voice for patients (Part 5).*** The Bill establishes new Healthwatch patient organisations locally and nationally to drive patient involvement across the NHS.
9. ***New focus for public health (Parts 1 and 2).*** The Bill provides the underpinnings for Public Health England, a new body to drive improvements in the public's health.
10. ***Greater accountability locally and nationally (Parts 1 and 5).*** The Bill sets out clear roles and responsibilities, whilst keeping Ministers' ultimate responsibility for the NHS. The Bill limits political micro-management and gives local authorities a new role to join up local services.
11. ***Streamlined arms-length bodies (Parts 7-10).*** The Bill removes unnecessary tiers of management, releasing resources to the frontline. It also places NICE and the Information Centre in primary legislation.

Factsheet A1 provides an overview of the Health and Social Care Bill. It is part of a wide range of factsheets, all available at:
Web: www.dh.gov.uk/healthandsocialcarebill
Email: healthandsocialcarebill@dh.gsi.gov.uk

FACTSHEET SERIES – HEALTH AND SOCIAL CARE BILL

The full series of factsheets on the Bill include:

A. Overview

A1. Overview of the Bill
A2. Case for change
A3. How the Health and Care system will look (includes a diagram)
A4. Scrutiny and improvements to the Bill

B. Key policy areas in the Bill

B1. Clinically led commissioning
B2. Provider regulation to support innovative services
B3. Greater voice for patients
B4. New focus for public health
B5. Greater accountability locally and nationally
B6. Streamlined arms-length bodies

C. Cross-cutting themes of the Bill

C1. Improving quality of care
C2. Tackling inequalities in healthcare
C3. Promoting better integration of health and care services
C4. Choice and competition
C5. The role of the Secretary of State
C6. Reconfiguration of services
C7. Establishing New Bodies
C8. Research
C9. Education and Training