MILTON KEYNES COUNCIL

Minutes of the meeting of the HEALTH AND COMMUNITY WELLBEING SELECT COMMITTEE held on TUESDAY 07 FEBRUARY 2012 at 7.00pm.

Present: Councillor Long (Chair)
Councillors Campbell, Clarke, Eastman, Exon, Councillors McKenzie, Wharton and Zealley

Officers: L Bull (Strategic Director Community Wellbeing), M Hancock (Assistant Director [Joint Commissioning]), J Moffoot (Assistant Director [Democratic Services]), E Richardson (Overview & Scrutiny Officer)

Apologies: Mr A Hastings

Also Present: Councillors Bald, Brock, Crooks and Lloyd. F Cox (Director of Commissioning Development and Transition), R Duckett (Interim Programme Director), S Frossell (Interim Director of Public Health), M Millar (Chief Executive, MK Foundation Trust) and 1 member of the public.

HCW18 MINUTES

RESOLVED –

That the Minutes of the meeting of the Health & Community Wellbeing Select Committee held on 22 November 2011 be approved and signed by the Chair as a correct record.

HCW19 THE IMPLICATIONS OF THE HEALTH AND SOCIAL CARE BILL FOR PUBLIC HEALTH SERVICES

Sue Frossell, Interim Director of Public Health, gave a presentation on the implications of the proposed changes in the way Public Health services would have to be delivered in the future. There had been several papers issued on this subject recently and her aim was to give an overview of the implications for Public Health services, the implications for the Council and the practicalities involved in delivering these changes.

Current Public Health Services would be divided between three separate bodies:

- Public Health England (PHE) – an executive agency with responsibility for the assessment of progress against Public Health outcomes (measuring local authority performance etc) and health protection, providing expertise on the control of infectious diseases, radiation chemicals, response to outbreaks and emergencies ;

- NHS Commissioning Boards – responsible for screening and immunisation programmes, healthy life styles, making every patient contact count, preventing premature mortality through early intervention and preventing infant mortality;
- Local authorities, which would be taking on responsibility for a range of activities, including:
    - Public Health advice to NHS Commissioners;
    - Tobacco control and stop smoking services;
    - Alcohol and drug misuse services;
    - Public Health services for children and young people aged 5-19 (all by 2015);
    - The National Child Measurement Programme;
    - NHS Health Check assessments;
    - Comprehensive sexual health services; and
    - Emergency preparedness.

Both the opportunities and risks, together with the practical implications associated with the transfer of Public Health services to the Council were highlighted.

Opportunities included a new duty to promote health and reduce inequalities which would cut across most Council departments delivering social care services; the Public Health budget would be ring fenced; the Director of Public Health and other specialist staff would transfer to the Council's employment; the Council would be able to influence and develop a more powerful relationship with the local NHS body; and through the establishment of the new Health and Wellbeing Board it would be able to influence the local healthcare agenda.

One of the main risks was that there may be insufficient resources to cover the Council's new statutory responsibilities; there was currently a huge discrepancy in the Public Health spend per head across the country, depending on the budget allocated to each area (for example the per capita spend in Milton Keynes was only £30 per annum, whereas in Tower Hamlets it was £130).

Other risks included the problems associated with the recruitment and retention of staff with the necessary skills and having to account for the delivery of services with which the Council is unfamiliar.

Practical implications included the transfer of staff which involved both TUPE arrangements and the physical location ie where will they sit? During the transition period there was the need to maintain the provision of services and to ensure that the appropriate resources to maintain and deliver services were also transferred. There were also issues around the access to NHS intelligence and the compatibility of systems.

In answer to questions, the Committee noted that:

(a) The National Child Measurement Programme had been running for 4 years. It had been introduced in order to get a national

picture of childhood obesity and was being used to inform health policy such as the Change4life campaign. Height and weight were measured in order to obtain a Body Mass Index (BMI) reading. A BMI between 25-30 was overweight, over 30 was obese. The Committee expressed its concern that childhood obesity was likely to be a much more prevalent problem in poorer areas of the borough.

(b) At present there was not a clear picture of how the finances would work, but the current whole Public Health budget would need to be divided between the 3 bodies delivering Public Health Services in the future. The Council would have statutory responsibilities which it would need to deliver, but if the budget provided was not sufficient, then this would pose a financial risk to the Council.

(c) There were also risks associated with the transfer of staff; some staff currently working in the Public Health field may decide not to transfer to the Council and look for other opportunities within the NHS. This could create a skills shortfall at what could be a critical time for the continued delivery of essential Public Health services.

(d) Public Health was a new role for the Council and there was a risk that it could get lost or marginalised amongst all the other services the Council was already providing. Getting Public Health to fit properly into the Council structure would involve support across other Council departments; for example, the relationship between Public Health and housing would need to be assessed. However, this should all come together as part of the work of the Health and Wellbeing Board. The challenge was to develop a joint vision for the future.

(e) The Committee expressed concerns about key services becoming underfunded as the Public Health budget was already being raided because of deficits elsewhere in NHS funding. The Council may only have enough resources to concentrate on the delivery of statutory Public Health functions only rather than on the development of new initiatives. Particular focus will need to be given to primary and secondary prevention services in order to prevent longer term problems

The Committee suggested that the work to integrate Public Health Services into the Council be reported back to the Select Committee on a regular basis; it may want to do more detailed work on the provision of Public Health Services during the next municipal year.

The Committee noted that the transition plan needed to be completed by the end of March and that the Shadow Health and Wellbeing Board was working on a draft strategy for Public Health.

RESOLVED –

1. That the Public Health staff who were transferring from the NHS to the Council and the opportunities afforded the Council to improve its services by the transfer be formally welcomed.
2. That the Committee monitors the transfer and integration of Public Health Services during the next Council year.
3. That the Committee reviews the impact of the transfer of Public Health services to the Council on a regular basis.
4. That the Interim Deputy Director of Public Health be congratulated on her new post and thanked for her contribution to the meeting.

HCW20 TRANSFORMING COMMUNITY HEALTH SERVICES

The Committee received a presentation from Felicity Cox, Director of Commissioning Development and Transition and Rachel Duckett, Interim Programme Director, on Transforming Community Health Services. The vision for the future delivery of community and mental health services was "To improve health, reduce inequalities and ensure access to effective and high quality services". This is underpinned by four key principles:

- Improve health outcomes – new commissioning framework outcomes were published on 3 February 2012;
- Transformation of service delivery models so they are more co-ordinated and are focussed around patients, users and carers rather than around the needs of health service staff;
- Helping people to keep well through self-care, health promotion and prevention i.e. support for people to keep well is dovetailed into the Health and Wellbeing strategy;
- Ensuring that users and carers experience seamless and integrated care through better sharing of information and the development of information sharing protocols.

Competition, collaboration and integration will produce effective partnerships which can deliver integrated care by building upon the existing excellent relationships across both health and social care services. Providers will have to be responsive to the local health strategy and deliver more for less by being more effective. Increased efficiency means that cost savings can be put back into the provision of better frontline services.

The Transformation of Community Health Services also links into the current Healthier Together Programme (formerly the Acute Services Review).

The proposed model of integrated care was rooted in the Milton Keynes health economy and integrated primary, secondary and local authority provision. Again there were four key strands to the model and patients could access all or just part of them at any stage in their treatment:

- Rapid response – a 24/7 single point of access to support admission prevention and crisis management and co-ordinate further care.
- Out of hospital care – virtual and actual community beds and locality based community teams to provide step-up, prevention and crisis management; rehabilitation and step down care after secondary intervention.
- Networked specialist clinicians who can support locality based teams with expertise to ensure the right decision is taken at the right time to deliver the correct level of care.
- Planned care which identifies patients through risk assessment and integrated pathways through communication using local GP clinical commissioning models.

The delivery of effective integrated healthcare will need to take advantage of the existing relationships and good practice already in place across local acute, community and mental health services. The preferred option would be a managed transfer to a new integrated provider through a merger of the Milton Keynes Community Health Service and the Milton Keynes NHS Foundation Trust. The Milton Keynes NHS Foundation Trust and the Northamptonshire and Milton Keynes Cluster will both consider the merger at board meetings during February. If they agree, the regulator will carry out an assessment of the merger plans during April to June. However the regulatory process means that there are risks relating to the delivery of this option. It will be evaluated by the strategic health authority which will want to be sure that the new service provider can deliver. If the regulator gives the go ahead then the new service could be up and running from July.

If the above merger is not possible, then a full procurement and tendering process will need to be implemented. This will take much longer and will delay the start of the new service until well into the autumn.

In answer to questions, the Committee noted that:

- The Milton Keynes NHS Foundation Trust's financial recovery programme was working and they had developed a strong business case in support of the merger;
- The provision of acute services had been placed with Bedford Hospital for 12 months in order to give time to see what was best for Milton Keynes.

- At present the co-ordination between the primary provision of health and social care services was good but when someone went into to hospital this continuity was lost. The planned integration of services should eliminate this.
- There were legal limits on information sharing but there were things which could be done such as a uniform e-mail address for NHS service providers and access to 'front page' information about patients i.e. name, address, contact details, etc. All data sharing must be compliant with the Data Protection Act and patients would still have to give their permission before other information could be shared across services.
- As hospitals were currently being run by clinicians community health services were not getting the help and support they needed and one of the aims of the transfer was to address this shortfall.
- Hospital doctors were increasingly aware of the need to work effectively with community health teams in order to maximise efficiency and reduce costs. GPs were re-engaging with clinical commissioning groups (CCG) and challenging them where necessary. Each CCG Board now had a representative from another health authority to provide balance and an objective view.
- CCG Boards were participating in patient engagement; patients now sit on the boards and have been offered training and development so that they do not feel intimidated by the healthcare professionals. The Milton Keynes CCG was impressively patient orientated and was using its support budget to enable patient members to contribute effectively.
- CCG Boards would be critical in delivering the local Health and Wellbeing Strategy and ensuring that all service providers were moving in the same direction.
- The Transformation Programme had no specific involvement with the Patient Safety Federation but it was developing standards of care in discussion with all the regulatory bodies involved.
- Funding was based on a per capita formula and there was a time lag on the calculations, particularly in Milton Keynes due to its continued rapid expansion. However it was hoped that the merger of services would provide economies of scale by the use of shared services, such as only needing one set of auditors rather than two. A reduction in overall health costs in Milton Keynes would mean that there would be more money available to re-invest in local services.
- A pilot was being developed using the 111 number for rapid response services and was being built into the urgent care model so that people can be directed to the right area of service.

- If the planned merger was not successful the alternative process would be by open tender. The Transformation Programme would still want the same benefits from the managed process as would be expected from the local merger model. There was a danger that services could be fragmented, but this had not happened in other areas which had used tendering process to integrate services and the team were confident this would not be an issue in Milton Keynes.

The Council wanted to see the provision of integrated services in Milton Keynes maintained and would do its best to ensure that fragmentation, particularly of mental health services, did not take place.

Mark Millar, Chief Executive of Milton Keynes NHS Foundation Trust, commented that the integration of services was the right way forward particularly for Milton Keynes and that the Community Health Service and the Foundation Trust were both financially strong enough and will put in the necessary resources to make it work.

The Chair summed up by identifying the following key issues:

- The aim of the Transforming Community Health programme was to achieve a co-ordinated provision of health services in Milton Keynes;
- The programme would have to balance what services should be carried out in the community and what in the hospital;
- The integration of services needed to link into the Council's strategy on Health and Wellbeing;
- The merger should deliver better use of resources;
- There was a risk of service fragmentation if the open tender procurement process was used.

RESOLVED –

1. That the Cabinet strongly consider supporting the work being done to merge the services provided by the Milton Keynes Community Health Services and the Milton Keynes Hospital NHS Foundation Trust into one local health service provider for the people of Milton Keynes.
2. That the Director of Commissioning Development and Transition and the Interim Programme Director be thanked for their contribution to the meeting.

HCW21 SHADOW HEALTH AND WELLBEING BOARD

The Assistant Director (Joint Commissioning) updated the Committee on the progress of the Shadow Health and Wellbeing Board.

As part of the 2011 Health and Social Care Bill every local authority would have to establish a Shadow Health and Wellbeing Board by April

2012 and a full Board by April 2013. Milton Keynes Council started development work to establish a Shadow Board during July 2011. At its meeting on 20 September the Health & Community Wellbeing Select Committee recommended the establishment of a Shadow Board to Cabinet. Cabinet approved the Terms of Reference at its meeting on 18 October 20111.

The first meeting of the Shadow Board was held on 1 December 2011. Cllr Debbie Brock was appointed Chair and Dr Nicola Smith as Vice Chair. Meeting dates through to September 2012 and a work programme were also agreed

The work programme includes developing a Joint Health and Wellbeing Strategy, a Communication and Engagement Strategy, work on establishing the statutory Board and the transformation of LINk to Healthwatch.

LINk would now continue to April 2013 when it would become Healthwatch. Local authorities had an obligation to work with partners to develop local Healthwatch groups. As well as taking on the LINk functions the new groups would also be taking on other functions such as NHS advocacy for complainants.

The Shadow Board's prime function was to ensure that the arrangements were in place to establish the statutory board in April 2013; there was a lot more work to be done in order to achieve this successfully.

Concern was expressed about the membership of the Shadow Board and that some groups did not appear to be represented and might, therefore, feel that their views were being ignored. However it was felt that it was not possible to include every interested group which represented service users. Tokenism needed to be avoided and equality issues should be centre stage. An effective Communication and Engagement Strategy, with evidence of how it was carried out, would mean that services users would not be lost sight of.

RESOLVED –

That the Assistant Director (Joint Commissioning) be thanked for his update.

HCW22 SOUTH EAST MIDLANDS ACUTE SERVICES REVIEW UPDATE

The Committee noted the update included in the agenda.

RESOLVED –

That the Committee would keep a close watch on the progress of the Review during the coming year.

THE CHAIR CLOSED THE MEETING AT 9.00 PM