**NORTH YORKSHIRE COUNTY COUNCIL**

**SCRUTINY OF HEALTH COMMITTEE**

**21 January 2011**

# Changes in the NHS: An Update

**Purpose of Report**

1. The purpose of this report is to update Members on recent developments since publication of the original White Paper, Equity and Excellence: Liberating the NHS in July.

## Liberating the NHS - Legislative Framework and Next Steps

2. The White Paper was followed up by a series of consultations on different aspects of the proposals. The Legislative Framework and Next Steps published in December 2010 summarises the outcomes of those consultations and provides a blue print for the Health and Social Care Bill that is expected shortly.

3. In particular the Framework summarises how the original proposals in the White Paper have been amended – See APPENDIX 1.

4. APPENDIX 2 sets out the implementation plan.

## Public Health White Paper

5. The Public Health White Paper was published on 30 November 2010. Within the new system:

- Local authorities will lead action on public health, playing an important new role in promoting people's health and wellbeing, with new freedoms to make a major impact on health improvement and to tackle health inequalities;

- A new, dedicated, professional public health service – Public Health England – will be created as part of the Department of Health to strengthen the national response on emergency preparedness and health protection, be a centre of public health advice and expertise, and support local health improvement efforts;

- There will be ring-fenced public health funding from within the overall NHS budget to ensure that it is not squeezed by other pressures, for example NHS finances, although this will still be subject to the running-cost reductions and efficiency gains that will be required across the system. Early estimates suggest that current spend on areas that are likely to be the responsibility of Public Health England could be over £4 billion;

- ❖ Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors;

- ❖ There will be ring-fenced budgets for upper-tier and unitary local authorities and a new health premium to reward progress made against elements of a proposed public health outcomes framework, taking into account health inequalities;

- ❖ We will shortly put forward detailed proposals for the establishment of health and wellbeing boards in every upper-tier local authority to bring together the NHS, public health, social care and children's services to support joined-up local decisions on health and wellbeing; and

- ❖ The NHS continues to have a crucial role. Public health will be part of the NHS Commissioning Board's (NHSCB) mandate, with public health support for NHS commissioning nationally and locally. There will be stronger incentives for GPs so that they play an active role in public health.

6. The Local Government Association briefing which gives a useful interpretation of the White Paper is attached as APPENDIX 3.

**Taking Forward the Proposals in North Yorkshire**

7. To prepare for the changes locally the County Council and NHS North Yorkshire and York are in the process of establishing a Transition Board. This transitional arrangement will help in moving towards a Health and Wellbeing Board in due course.

8. A draft Terms of Reference and initial thoughts on membership of the Transition Board is set out in APPENDIX 4.

9. It is anticipated that the first meeting of the Transition Board will take place within the next three or four weeks.

**Recommendation**

10. That this report be noted.

**BRYON HUNTER**
**SCRUTINY TEAM LEADER**

**County Hall**
**NORTHALLERTON**

11 January 2011

Background Documents: None

## Liberating the NHS: Legislative framework and next steps

### How the Government has modified its original proposals

As a result of the consultation the Government has decided to:

- allow a longer and more phased transition period for completing our reforms to providers: for example, retaining some of Monitor's current controls over some foundation trusts while the new system of economic regulation is introduced;

- significantly strengthen the role of health and wellbeing boards in local authorities, and enhance joint working arrangements through a new responsibility to develop a "joint health and wellbeing strategy" spanning the NHS, social care, public health and potentially other local services. Local authority and NHS commissioners will be required to have regard to this;

- create a clearer, more phased approach to the introduction of GP commissioning, by setting up a programme of GP consortia pathfinders. This will allow those groups of GP practices that are ready, to start exploring the issues and will enable learning to be spread more rapidly;

- accelerate the introduction of health and wellbeing boards through a new programme of early implementers;

- create a more distinct identity for HealthWatch England, led by a statutory committee within the Care Quality Commission (CQC);

- increase transparency in commissioning by requiring all GP consortia to have a published constitution;

- change our proposal that maternity services should be commissioned by the NHS Commissioning Board. This reflects the weight of consultation responses arguing that, in order to focus on local needs, maternity services should be the responsibility of GP consortia, backed by national support to secure improvements in quality and choice;

- recognise that our original proposal to merge local authorities' scrutiny functions into the health and wellbeing board was flawed. Instead we will extend councils' formal scrutiny powers to cover all NHS-funded services, and will give local authorities greater freedom in how these are exercised;

- phase the timetable for giving local authorities responsibility for commissioning NHS complaints advocacy services, and allow flexibility to commission from other organisations as well as from local HealthWatch;

- give GP consortia a stronger role in supporting the NHS Commissioning Board to drive up quality in primary care;

- create an explicit duty, for the first time, for all arm's-length bodies to co-operate in carrying out their functions, backed by a new mechanism for resolving disputes without the Secretary of State having to act as arbiter. In particular, Monitor and the NHS Commissioning Board will have to work jointly in setting prices, rather than have Monitor decide and the Board able to appeal.

## Liberating the NHS: Legislative framework and next steps

### Transition Plan

**2010/11 Design and early adoption**

- The Department of Health confirms the design framework, subject to Parliamentary approval
- The Department of Health gives permission to pathfinders and early implementers to model the new arrangements and explore key issues for wider roll-out
- Refinement of HealthWatch following the choice and information consultations
- The Department of Health publishes transition plan setting out the role of LINks in influencing local services while local HealthWatch prepares to start exercising functions
- The Government begins working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy

**2011/12 Learning and planning for roll-out**

- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, and the Public Health England programme
- Sharing lessons from the GP consortia pathfinder programme and early implementer health and wellbeing boards
- More pathfinders and early implementers, including local HealthWatch
- Plans drawn up for GP consortia, involving all GP practices
- Emerging consortia to lead the process for identifying which PCT-employed staff should be “assigned” to them
- Plans to be drawn up for health and wellbeing boards
- NHS trusts to apply for foundation trust status, or be planning to apply in 2012/13
- The new Provider Development Authority to be established by 1 April 2012
- SHAs to establish PCT cluster arrangements in preparation for the NHS Commissioning Board

**2012/13 Full dry run**

- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters are accountable to the Board, and the Department will have made

substantial progress on its change programme and established Public Health England. The Provider Development Authority will oversee NHS trusts

- More learning from GP pathfinders and health and wellbeing board early implementers
- Authorisation process of comprehensive system of GP consortia begins, with all practices becoming members, acting under delegated arrangements with PCTs
- Health and wellbeing boards are in place
- Comprehensive local HealthWatch arrangements in place
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions
- Consortia notified on 2013/14 allocations
- By the end of the year, a significant number of NHS trusts have achieved foundation trust statue
- All applications for FT status to be made by end March 2013

**2013/14 First full year of the new system**

- From April 2013, PCTs abolished and all consortia assume new statutory responsibilities
- From April 2013, health and well being boards assume their statutory responsibilities
- Consortia and health and wellbeing boards learning from their participation in the full dry run
- From April 2013, Monitor's licensing regime is fully operational, and the Government aims to have the new special administration regime in place
- From April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy
- At end March 2014, the Provider Development Authority ceases to exist
- By 1 April 2014, all NHS trusts to have become FTs, and NHS trust legislation is repealed

# LG Group On the Day Briefing: Healthy Lives, Healthy People: Our strategy for public health in England (Public Health White Paper)

1 December 2010

*Healthy Lives, Healthy People: Our strategy for public health in England*, published on 30 November, expands on the Government's proposals for public health originally set out in *Equity and Excellence: Liberating the NHS*. This briefing sets out the Local Government Group's (LG Group) initial response to the proposals.

## Summary of LG Group key messages

- The White Paper is wide ranging in its proposals. Further details on a number of issues are still outstanding including: the outcomes framework for public health; details of public health funding; and a further 10 consultation documents on specific aspects of health improvement and health protection. Without them it is difficult to have a completely clear picture of the proposed new landscape for public health and the role of council within it.
- We are fully committed to localism and welcome aspects of the White Paper which increase localism and acknowledge the breath of local government activity that can have a direct influence on public health outcomes. We therefore strongly welcome the intention of *Healthy Lives, Healthy People* to give back councils a leading role in improving, promoting and protecting the health of their local communities.
- Further details on public health funding and the outcomes framework are due out before the end of the year. But it is vitally important that councils have sufficient financial and human resources, and the freedom to deploy them, to support this enhanced role. A £4 billion figure for the overall Public Health ring-fence is being floated. The LG Group is seeking clarification on how much of that will filter down to local authorities for delivery of this important agenda for which they are going to be held responsible.
- The transfer of public health responsibilities and staff to local authorities will create a number of complex employment issues which will need to be managed effectively. Urgent clarification of the proposals around staff transfer is needed as the employment implications for councils are of major concern.
- We seek clarification on the scope of the role and responsibilities of Public Health England (PHE), with a view to keeping to a minimum centrally directed functions and resources. We have concerns about the centralisation of functions into PHE which go against the localist vision of this paper.
- It is important that local government is fully accountable to its local population for its record on health improvement and health inequalities. To this end it is important all staff working in its public health function, including the Director of Public Health (DsPH), is properly accountable to the council.
- We will be developing a more detailed Local Government Group response to Healthy Lives, Healthy People and we welcome your views, comments and concerns on the proposals.

## Background and context

The Public Health White Paper outlines the considerable public health challenges facing us. It supports Professor Sir Michael Marmot's recommended 'life course' approach to improving health and addressing health inequalities, which focuses on health and wellbeing throughout life to ensure that everyone is supported to

Briefing

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make healthier choices. It also emphasises the importance of addressing the wider determinants of health such as employment, educational achievement, environmental, social and cultural factors, as well as housing.

It highlights the need to improve wellbeing – mental and physical – as well as treating sickness, and highlights the lead role that local government has in addressing this agenda. Furthermore, the White Paper emphasises the importance of tackling inequalities in health.

## Summary of key proposals

The White Paper: *Healthy Lives, Healthy People* talks about a "*radical new approach that will empower communities, enable professional freedoms and unleash new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats".* It talks about a shift from centralised, top down approaches, announcing that "*Centralism has failed [and] we will end this top-down government. It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre"*.

We strongly support this intention and look forward to working with Government on ensuring that councils and their local communities have the freedoms, powers and resources to make a real impact on health and wellbeing. The major proposals are outlined below.

**A focus on outcomes**
A national outcomes framework for public health will set the broad public health and health inequalities outcomes for all areas and organisations to address. It will be published by the end of 2010.

**LG Group View:** While we welcome the move away from top down targets, the Local Government Group seeks to ensure that the outcomes framework is not overly prescriptive and limits the ability of local authorities to respond to the public health strengths and needs of their particular area which they are best placed to understand.

**Transferring public health**
From 2013, public health responsibilities currently undertaken by Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be divided between Public Health England (PHE) and local councils. The Directors of Public Health (DsPH) will move to local authorities and will be jointly appointed by councils and PHE. The Secretary of State for Health will be able to dismiss the DPH in some circumstances. Further details on both elements below.

**Funding and rewards**
From 2013, upper-tier councils will receive a ring-fenced public health grant to improve the health of the population and to reduce health inequalities. Details of the public health fund will be published before the end of 2010. A new 'payment by results' system will reward Councils for making progress in improving health outcomes and reducing health inequalities.

**LG Group view:** We always welcome proposals that recognise and reward councils for making positive progress to improve health and reduce health inequalities. But we are concerned that a 'payment by results' system could fail to take into account that there are multiple influences on the health choices individuals make and that many individuals, families and communities have very

different starting points on their journey to better health and wellbeing. We believe that financial incentives need to be balanced with additional resources to support those individuals and communities that have least assets and the greatest challenges in relation to health improvement.

**Public Health England**

The White Paper announces the creation of a dedicated and professional public health service, know as Public Health England's (PHE), within the Department of Health. PHE is charged with "bringing together a fragmented system, it will do nationally what needs to be done; it will have a new protected public health budget; and it will support local action through funding and the provision of evidence, data and professional leadership". PHE will be accountable to the Secretary of State for Health, who will have new powers to protect the population's health. PHE will have a close relationship with the NHS, social care, business and voluntary sector partners, and with the NHS Commissioning Board. It will incorporate the current functions of the Health Protection Agency, the National Treatment Agency, the Regional DsPH, the Public Health Observatories and cancer registries. At local level, Directors of Public Health (DsPH) will develop relationships with GP commissioning consortia, through Health and Wellbeing Boards (HWBs).

PHE are likely to hold responsibility for the ring-fenced public health funding which comes from the overall NHS budget. Early estimates suggest that current spend on the areas that are likely to be responsibility of PHE could be approximately £4 billion.

Public Health England's role will include:

- Providing public heath advice, evidence and expertise to the Secretary of State and the wider system
- Delivering effective health protection services;
- Commissioning or providing national-level improvement services, including appropriate information and behaviour change campaigns
- Jointly appointing DsPH and supporting them through professional accountability arrangements:
- Allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework;
- Commissioning some public health services from the NHS
- Contributing internationally-leading science to the UK and globally.

PHE will be responsible for funding and commissioning of health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion (including health visiting and school nursing) and some elements of GP contract such as immunisation, contraception, dental public health**.**

**LG Group view:** We urge the government to adopt a localist approach, devolving everything to the local level unless there is compelling evidence to the contrary. In our response to Equity and Excellence: Liberating the NHS we proposed that local government should take a lead role in commissioning a wide range of services, which may be in danger of becoming 'Cinderella services'. These include: mental health; health and wellbeing of homeless people; long-term conditions; drug and alcohol dependency; and HIV/AIDS services. It would be more joined up for the health promotion and health protection aspects of these services also to be commissioned by local authorities.

Furthermore the analysis of staff engaged in public health and health promotion activity must not ignore large groups of professionals who can have a major impact on health and wellbeing – ie social workers, teachers, housing support workers, youth workers, leisure staff, planners etc.

**Director of Public Health and transfer of public health staff**
All upper-tier and unitary authority will be required to have a DPH, though they can be shared with other councils. DsPH will be employed by local government and jointly appointed with PHE, and will be "the strategic leader for public health in local communities, deploying the local ring-fenced budget to achieve the best possible public health outcomes across the whole local population".
DsPH will be public health professionals with a support team with specific public health and commissioning expertise. Critical tasks for DsPH are:

- Promoting health and wellbeing within local government and advising on health inequalities and developing local strategies to reduce them
- Providing and using evidence relating to health and wellbeing and leading public health through membership
- Advising and supporting GP consortia
- Developing an approach to improve health and wellbeing locally
- Working with PHE health protection units to provide health protection as directed by Secretary of State
- Collaborating with local partners – i.e. GP consortia, other local DsPH, local business etc

Professional accountability for DsPH will be to the Chief Medical Officer. Both the council and the Secretary of State for Health will have the power to dismiss DsPH, which distinguishes them from other senior council officers.

**LG Group view:** Councils are not led by officers but by councillors or directly elected mayors, who are elected by local people. The public health budget will be allocated to the council, not to the Director of Public Health (DPH) and it will be for the council to decide, after taking advice from the DPH, on how to allocate the public health budget and achieve real localism.

The LG Group is not convinced of the need for joint accountability nationally to PHE and locally and seeks clarification on how this will operate in reality – particularly in relation to the appointment and dismissal of DsPH – this represents a significant erosion of the autonomy of councils to make decisions on recruitment, selection and performance management of senior staff. We also seek clarification on the funding that will be dedicated to the public health workforce.

It is LG Groups understanding that as well as DsPH, a not insignificant number of other current NHS staff at various levels will be identified as linked to functions that will be transferring to local government. In the current financial climate it is important that these staff are dealt with fairly and that systems to establish clarity for individuals, including on issues such as TUPE and pensions, are finalised as soon as possible. However the primary decision-making about roles must lie with the councils taking on functional responsibilities.

**The role of the NHS in public health**
The NHS will continue to play an important role in public health. PHE will commission NHSCB to undertake screening, including cancer screening, some aspects of emergency preparedness, childhood immunisations and public health aspects of primary care contracts, through the Secretary of State's mandate to the NHSCB.

Other health professionals, including GPs, dentists, pharmacists, health visitors (who will be employed by PHE) dieticians, speech therapists all have an important role to play in improving health and addressing health inequalities. GPs in particular, will be incentivised – both as primary care professionals and commissioners – to focus on prevention and early intervention. Locally, GP consortia and DsPH will work with councils, the voluntary and community sectors and the business sectors through HWBs to ensure that services and commissioners are maximising their effectiveness on health improvement and reducing inequalities. To incentivise GP practices, the Quality and Outcomes Framework (QOF) will focus far more on primary and secondary prevention, with funding for this work coming from the PHE budget. GPs will continue to provide a range of public health services such as childhood immunisations, contraceptive services, cervical screening etc but in the future PHE may wish to change how services are commissioned and delivered.

**LG Group view:** It appears that the majority of public health services will be commissioned by PHE with very little being delegated to local government. The White Paper offers no satisfactory rationale for PHE to retain the commissioning responsibility or for continuing to include them in the primary care contract for GPs. It is not clear how PHE will make a significant impact on health improvement and health inequalities if it does not seek innovative ways of improving services. For example, by commissioning schools, youth services, children and family centres to provide contraceptive services or child health services in areas where there are low rates of access to GPs.

There is little reference to HWBs beyond their relationship to DsPH and to the wider contribution of local authorities, in particular district councils, in the White Paper. For example homelessness, overcrowding and poor housing is a major factor in health inequalities, physical and mental ill health. This is a real opportunity to devolve power to promote and protect health at a local level and to make health improvement everyone's business. We will discuss with Government how we can raise the profile of HWBs in this role. The paper suggests that PHE will either retain responsibility for public health or delegate the commissioning of primary public health services to GPs. This is a continuation of the way public health screening and interventions are already carried out and will do little to address low levels of take-up of these services by many of our most vulnerable and at-risk individuals and families.

**Addressing health and wellbeing throughout life**

The White Paper takes a 'life course' approach to health improvement outlined in Prof. Sir Michael Marmot's report encompassing:

- Starting well – focusing on maternal and child health and breaking the intergenerational cycle of ill-health and inequalities. There will be a particular focus on children who are at risk of poor outcomes. Details of a new health visitor workforce of 4,200 to improve child health will be published in 2011, though the document does highlight the role of Health and Wellbeing Boards (HWBs) in ensuring that they join up with existing services and plans for early years.

- Developing well – focus on child and adolescent wellbeing, including mental wellbeing and self esteem. Schools have an important part to play in delivering better health outcomes for children and young people in promoting physical activity, providing high quality personal, social and health education, improving self-esteem and mental wellbeing through a range of existing and new programmes.

**LG Group view:** We support the continued development of the Healthy Child

Programme and the announcement of increased numbers of health visitors and refocusing Sure Start Children's Centres for those who need them most. We welcome initiatives such as incentivising children to walk to school and providing more support through nurses and health visitors to encourage and support new mothers to breastfeed. Our view on whether the cost of additional health workers should and can be found from ring fenced public health funds will be influenced by size of the local allocations.

- Living well – encompasses all factors which contribute to health and wellbeing, including housing, planning, the natural environment, access to active transit etc. The White Paper lists a range of new and existing schemes to support people to make healthier choices in relation to eating, physical activity, environmental sustainability and use of alcohol. It highlights many ways that councils can influence health through their housing, planning, environmental, licensing, community development and regulatory functions.

- Working well – promoting good physical and mental health at work. This section focuses on the importance of work in promoting health and wellbeing and the intention of the Government to support people with long term health conditions to get back into the world of work.

- Ageing well – supporting older people to remain active, health and independent within their own homes. It summarises a wide range of universal benefits and more targeted support that enable older people to maintain their health, wellbeing and capacity. A crucial component is the *Vision for Social Care* published on 16 November 2010.

There is a focus on mental health and wellbeing throughout life, with a particular emphasis on mental wellbeing of children and adolescents.

**Health protections and emergency planning**
New arrangements for emergency preparedness and health protection in which PHE will bring together the health protection and emergency planning functions of the Health Protection Agency with the public health functions of PCTs and SHAs. At local level, DsPH will have a leading role in emergency planning.

**LG Group view:** We welcome a clearly defined role for central Government led by the Secretary of State for Health in emergencies which require national co-ordination, but a strong role for local government in local planning and response to public health emergencies. The White Paper does not provide sufficient clarity on the respective roles of the various actors that are involved in local emergency planning and responses to public health threats to communities. It suggests that DsPH and Health Protection Units will work together closely, but there is a need for greater clarity on how this relationship might work in practice. It will also be important that the National Commissioning Board (which the NHS White Paper proposes) and PHE, which will be responsible for assuring NHS preparedness and resilience, engage in joint planning at the local level with local authorities and other key responders through Local Resilience Forums (LRFs), otherwise there is a danger that two parallel silos of planning and response may develop at the local level.

It is also surprising that we will have to wait until autumn 2011 for publication of the key document relating to Emergency preparedness and response, given the importance of these issues in the lead up to the Olympics in 2012.

**Role of business, the voluntary sector and other partners**
The report highlights the role of business and the voluntary sector through the

Public Health Responsibility Deal with five networks on food, alcohol, physical activity, health at work and behaviour change. The Responsibility Deal will be launched with further details in 2011. It is expected to include undertakings from retailers on more socially responsible selling of alcohol and further restrictions on tobacco. Individuals will be encouraged to make healthy choices by the provision of subsidised sporting activities.

More details will be available in 2011 but so far, there are plans for a 'Great Swapathon' which will make available £250 million worth of business sponsored vouchers for physical activity sessions.

**LG Group view:**
Local councils have a good record as supporters of local businesses, and as critical friends in relation to regulatory services. Many are already engaged with businesses in promoting community health. It will be helpful to have the national framework of the Responsibility Deal for Public Health as a reference point for local action. New forms of service delivery such as social enterprises might have a role to play in the more effective delivery of public health functions.

## Next steps

Consultation documents on the Public Health Outcomes Framework and on Public Health Funding will be published before the end of 2010.

**Timetable for implementation**

| Action | Timeline |
|---|---|
| Set up shadow PHS | 4/11 – 7/11 |
| Appoint senior leader to set up new public health structure "to set up working arrangements with LAs , including matching of PCT DsPH" | 4/11 – 7/11 |
| Agree and consult on Public Health Professional Workforce Strategy and staff transfer to PHS | 10/11 |
| PHS going live | 4/12 |
| Shadow public health ring-fenced allocations | 4/12 |
| Public health ring-fenced allocations are made | 4/13 |

Further papers to be published by the Department of Health will set out the proposed public health outcomes framework and the funding and commissioning arrangements for public health. A timetable is as below:

| Winter 2010/11 | Spring 2011 | Autumn 2011 |
|---|---|---|
| Health Visitors | Public Health Responsibility Deal | Health Protection emergency preparedness and response |
| Mental Health | Obesity | |
| Tobacco control | Physical Activity | |
| | Social Marketing | |
| | Sexual health and teen pregnancy | |
| | Pandemic Flu | |

The closing date for responses is 8 March 2011. The Local Government Group will be preparing its own response to the proposals and we are seeking your views on the proposals and on the LG Group's own messages. Please send comments, questions, concerns and views to: health@local.gov.uk by Tuesday 2 February 2011.

# Equity and Excellence: Liberating the NHS

## Transition Board – North Yorkshire

## DRAFT Terms of Reference

Introduction

The proposal to form a Transition Board is borne of a shared commitment to ensure that in a time of dramatic change that change is well managed, and draws on the advice and understanding of key stakeholders and experts. The Board is not intended to undertake the new role of a Health and Wellbeing Board, but to oversee key work streams to put new partnerships and commissioning arrangements in place.

The complexity of North Yorkshire is reflected in the locality approach to both commissioning and service delivery across social and health care. A single Transition Board to 'hold the ring' on the transition developments and provide strategic advice will be essential to providing assurance throughout the developmental process.

Purpose

1. Oversee and guide the changes outlined in the Government White Paper, Liberating the NHS

2. Oversee work streams to deliver the new partnership and commissioning arrangements across the North Yorkshire area; taking into account locality sub arrangements.

3. Ensure future guidance is analysed and taken into account.

Tasks

1. Ensure that all work streams benefit from links and advice from regional and national leads on Liberating the NHS.

2. Establish a new Health and Wellbeing Board, locating it clearly within broader partnership arrangements.

3. Plan and oversee the transfer of public health functions to the local authority.

4. Plan for the development of a local HealthWatch organisation

5. Develop governance arrangements to facilitate opportunities for joint commissioning to be delivered (on a locality basis if most appropriate)

6. Ensure key stakeholders are engaged and involved in the development of new partnership and commissioning arrangements.

7. Ensure any new scrutiny arrangements are robust and deliver sound democratic accountability

Membership

Members will need to have sufficient authority to commit their organisations to agreed actions.

Members will be responsible for ensuring that their organisations are kept informed and able to take key decisions.

Suggested core members

Co – chairs: North Yorkshire County Council and NHS North Yorkshire and York Chief Executive – or nominated Deputy
Local GP commissioning consortium chair(s)
Director of Public Health
Directors of Adult and Community Services and Children and Young People's Services
NMHS North Yorkshire and York Locality Director(s)
North Yorkshire CVS Chief Executive
Representatives from acute trusts

Additional members may be invited as required including:

Relevant officers from North Yorkshire County Council
Relevant officers from NHS North Yorkshire and York
'Provider' colleagues
Relevant experts
Regional advisers

Decision making

Decision making will be within the frameworks of partner organisations