POLICY BRIEFING

Health reforms go live: what happens next?

Author: Christine Heron, LGiU associate and Janet Sillett

Date: 27 March 2013

Summary

The structural reforms of the Health and Social Care Act 2012 are implemented on April 1 bringing huge changes for the NHS and local authorities. This special briefing considers:

- the state of progress in major elements of reform such as clinical commissioning groups, health and wellbeing boards and public health
- issues to look out for in the coming months such as competition, conflict of interest, reconfiguration, and sector-led improvement
- comment on the key challenges ahead

This briefing will be of use to all local authorities and particularly to members and officers with an interest in health and wellbeing, public health, adult and children's social care, social care commissioning and corporate policy. It should, however, also be relevant to a wider group of members and officers such as those working in housing and planning with links to public health and health and wellbeing boards. The briefing will be useful to partners in health and the voluntary sector, such as members of local Healthwatch and CCGs.

Briefing in full

Background

Since the start of health reforms, LGiU has worked with local authorities on issues of implementation and LGiU associates have produced resources for the LGA and the Department of Health on major elements of reform including local Healthwatch (LHW), public health transition, and health and wellbeing boards (HWBs). This policy briefing draws on this experience to describe how the reforms have progressed and what to look out for over the coming months.

LGiU LOCAL GOVERNMENT INFORMATION UNIT

POLICY BRIEFING

The reforms were established in the Health and Social Care Act 2012 with the Government's professed aim of changing the NHS system so it is equipped to deal with the increasing demand for good quality healthcare at a time of decreasing resources. The major elements that must be in place by April 1 2013 are as follows.

- The NHS Commissioning Board (NHS CB) is intended to operate at armslength from the Department of Health (DH) so it is free from everyday political interference. It is responsible for leadership and oversight of clinical commissioning groups (CCGs), direct commissioning of primary care and some specialist services, improving quality and safety across the NHS, and overall NHS financial control. It operates to a mandate from the DH.
- CCGs are intended to put clinicians who have regular contact with patients in charge of commissioning and delivering local health services to make them more responsive to local needs. Promoting competition (or patient choice) will be a key responsibility, overseen by the financial regulator Monitor. CCGs are responsible for £64.7 billion of the £95.6 billion NHS budget.
- HWBs are intended to ensure that local areas work together on health, public health and social care. Every top-tier council must set up a HWB which have mandatory membership including CCGs and local Healthwatch (LHW). HWBs are responsible for joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) that promote integrated commissioning and delivery.
- Local authorities take over leadership for most elements of the local public health system, which will be overseen by directors of public health.
- Public Health England (PHE) is an executive agency of the DH responsible for a national approach to improving health and addressing health inequalities. PHE centres will support local authorities in their new public health roles, while the performance information they produce will show where local authorities are not meeting their responsibilities.
- Local authorities are responsible for commissioning LHW which is intended to give a voice to people who use services, patients, carers and the public so they can help shape health and social care in their area. LHW has statutory powers such as the right to 'enter and view' many health and social care services, and to make recommendations to the Care Quality Commission (CQC).
- Healthwatch England (HWE) is the national consumer body for health and social care, hosted by the CQC. It will support LHW and analyse local information to identify national trends.

POLICY BRIEFING

Progress so far and what to look out for

NHS Commissioning board

The NHS CB has been operating in shadow form for a year. Board membership is largely in place, with some key members as follows:

- Chair Professor – Malcolm Grant, President of University College London
- Chief Executive – Sir David Nicholson
- Interim Chief Operating Officer and Deputy Chief Executive – Dame Barbara Hakin
- National Medical Director – Professor Sir Bruce Keogh
- Deputy Medical Director – Professor Steve Field (formerly led NHS Future Forum).

Directors for the four regions are in place:

- North – Richard Barker
- Midlands and East – Dr Paul Watson
- London – Anne Rainsberry
- South – Andrea Young.

Members with a local government (chief executive) background include Director of Policy Bill McCarthy and Non Executive Director Moira Gibb.

Formal information about members is available on the NHS CB website, while The Guardian has also produced informative pen-pictures of the main board members.

The Board has undertaken a phenomenal amount of work in preparation for April, such as a vast transfer of staff, authorising CCGs and commissioning support units (CSUs), and developing clinical networks, clinical senates and many new operating models – all done while managing the NHS. Frankly, it is no wonder that politicians were reluctant to lose Sir David Nicholson at this crucial time.

The NHS CB operates on a four-region basis and with 27 local areas teams (LATs). Senior appointments to LATs are in place and the broad parameters for the work of regions and LATs have been determined. Regions and LATs are mainly formed from Strategic Health Authority (SHA) and PCT cluster staff and take over similar responsibilities. As well as oversight of CCGs, they are also responsible for direct commissioning of local GP, dental and ophthalmic services, while ten LATs have responsibility for areas of specialist national commissioning or commissioning services such as military or prison health. The role of LATs in commissioning primary care may appear to sit strangely with the professed aim of putting more commissioning in the hands of clinicians. However, since many of the clinicians on CCG boards will be GPs who provide primary care services, there would be a direct conflict of interest in also commissioning those services, hence the need to use a

different commissioner. This is one of a number of awkward compromises that have had to be made in the new structures.

LATs are newly formed and there is much to do to establish consistency of approach within the NHS CB as a whole, with PHE, with CCGs and other local NHS organisations, and with strategic partners in HWBs. While developing from PCT/ SHAs will give some stability, there is also a challenge to make sure that new and less bureaucratic ways of working are developed. LATs are making contact with HWBs to determine how they will attend boards in their area, for instance dividing responsibility between the director team. Hopefully this is taking place in full discussion with local government.

The Francis report into Mid Staffordshire Foundation Trust (LGiU briefing below) had a significant impact on the NHS CB. Not solely through the need to keep quality and safety at the top of the agenda, but for the personal implications for David Nicholson who was West Midlands SHA chief executive during some of the time when the terrible lapses in care took place. In addition, Dame Barbara Hakin is under investigation by the General Medical Council following allegations of pressure on United Lincolnshire Hospitals Trust to meet targets when she was chief executive of East Midlands SHA in 2009. (United Lincolnshire is the trust run by sacked chief executive, whistleblower Gary Walker). Further information in Health Service Journal (HSJ) article.

'Bullying culture' in the NHS is a repeated theme, and, rightly or wrongly is likely to reappear in the coming months. For instance, a recent HSJ survey found that 20 percent of CCG leaders who responded said their relationship with the NHS CB regional team was unhelpful, very unhelpful or bullying.

The NHS CB can be congratulated for reaching the first foothill of a mountain of change.

However, it would probably be unwise to place a bet that Sir David will be in post in eighteen months time.

Clinical Commissioning Groups

All CCGs have now been authorised by the NHS Commissioning Board. Of the 211 CCGs in England 15 have legal directions which mean, for instance, that the NHS CB sign offs financial or service plans. Forty two CCGs have been authorised in full. One hundred and sixty eight CCGs have a number of non-legal conditions which describe the additional work the NHS CB expects them to undertake before they are fully authorised e.g. managing financial risk, involving clinicians and joint commissioning with local authorities. NHS CB LATs will oversee the directions and conditions using six levels of support. An assurance framework will be developed

setting out in more detail how LATs should performance manage CCGs, with a light touch for those with no or few conditions and greater oversight for those in which the NHS CB has less confidence.

CCGs and their constituent GP practices vary considerably in their state of development; some have been operating in shadow form for some time, others were subject to changes in configuration until quite recently. Local authorities will need to be aware of the conditions and directions on their local CCGs, and in particular any relating to how they work with local authorities and to financial planning. These are available in the authorisation outcome reports on the NHS CB website.

CCGs will be under intense pressure to balance their budgets, yet some begin in April with questions about their financial state, and the sustainability of some of the providers in their areas. Also, budgets will be tight and the formulae used by the NHS CB to calculate their share of the NHS budget will no doubt be subject to revisions. There will be contingency funds and NHS CB hold-back (much in the way that the NHS operated previously). Restrictions of access to certain services and reconfigurations are inevitable almost everywhere.

Conflict of interest is a bubbling issue for CCGs. A recent BMA analysis found that 83 percent of the 211 boards have members with potential conflicts of interest. Four hundred and tweny six of the 1,179 GPs in executive positions on boards have a financial interest in a health provider beyond their own practice such as directorships of firms that provide services such as out of hours care and/or shareholdings in large private health firms. A further 12 percent have links with not-for-profit organisations and nine percent declared conflict of interest through a family member. To help address this a code of conduct produced in 2012 requires board members to remove themselves from decisions they could benefit from and the NHS CB intends to issue further guidance. Even so, the extent of involvement in the private sector and, to some extent, the voluntary sector, is so extensive it is likely to lead to significant concerns in some areas.

Commissioning support

CSUs provide back-room functions, such as HR, IT finance and procurement, to CCGs.

The original conception was to ensure that CCGs did not all set up their own functions resulting in costly duplication. There was also an aim to involve the private sector in order to bring commercial skills into the NHS. CSUs are now hosted by the NHS CB until 2016 and are largely made up of staff from PCT clusters. They are expected to become independent organisations by 2016 and to establish partnerships with the private and voluntary sectors.

There are now around 19 CSUs, generally with service level agreements with CCGs lasting until mid-2014. Some larger CCGs or groups of CCGs have kept some or all commissioning support in-house. Recruiting to senior posts in CSUs has proved very difficult for the NHS CB. HSJ reports that the NHS CB's final stage of assurance for CSUs in March found that all 19 units would be viable until the end of 2013-14, but a number urgently needed to improve their business practices. (Anecdotally it seems that only a handful are seen as top performers.) Some will be given a year to improve, others will face intervention from the NHS CB in months if they do not show improvement against targets aimed at their ability to function as an independent unit. Mergers and take-overs between CSUs are expected in the coming months.

The main concerns about CSUs are uncertainties about their role, function and future, and, because they are largely formed from PCT staff, that they have the potential to direct CCGs rather than taking instructions from them; also without competition from the private or voluntary sectors they could become self-perpetuating organisations. Local authorities will need to be aware of the CSU covering their area because of the interface between local authority public health support arrangements to CCGs and the potential for CSUs to provide some public health support such as data analysis; there is also potential for new support arrangements in other areas such as social care.

CSUs are not the most coherent or convincing element of the NHS reforms.

Health and wellbeing boards

All areas now have HWBs; many have been operating in shadow form for a long time and are tackling the complex and demanding agenda of working together, with very few statutory powers, to improve the commissioning of health, public health and social care.

Chairs' networks, which provide an excellent basis for sub-regional cooperation, are established in seven of the nine local authority regions: South East, South West, East of England, East Midlands, West Midlands, North West and North East, with Yorkshire and Humber exploring the development of a network. Some areas with district councils have district boards that feed into the county board.

HWBs have the potential for being a real success story as system leaders in the new health and care landscape. Positive developments through closer integration are being identified, such as joint teams for reablement in Somerset, integrated health and care teams across Kent and integrated care projects in Hampshire. HWBs are however complex partnership arrangements with some newly formed member organisations, and success needs to be nurtured. In some areas, it will be difficult for

HWBs to influence the direction of commissioning and the integration of health, social care and other services, if their role as 'system leaders' is not recognised by their constituent members. With very few statutory powers, it is only the elusive quality of 'leadership' that can stop them becoming sidelined talking shops.

The LGA has worked with the DH and other partners to provide a programme of support for HWBs. Lorna Shaw, responsible for the HWB Leadership Programme, identifies a number of themes that have emerged from the programme.

- Boards have a growing sense of excitement about the opportunities ahead to improve the health and wellbeing outcomes of communities; they also have concerns about whether they have the status to be system leaders and to make real changes.
- A priority for boards is to understand how money flows through the system, so that they can align spending with JHWS priorities.
- The collective role and responsibilities of HWB members in achieving effective community engagement requires some attention. Some boards recognise that this is not the sole responsibility of LHW but many remain unclear as to how to build co-productive relationships with local communities, particularly in order to achieve shared ownership and understanding around behaviour change and where difficult decommissioning decisions may need to be taken.
- An on-going issue is the role of districts and whether there are specific challenges for HWBs operating in two tier areas. This was particularly flagged in relation to the approach to developing the JHWS. Some argued that the JHWS should be developed as a broad framework, with each district encouraged to design its contribution to achieving the strategic direction. While this approach provided greater opportunity for meaningful district engagement and ownership of the strategy, it meant the strategy itself tended to be fairly broad in its focus with a lack of clear priorities.
- There is still uncertainty about the role of HWBs regarding the quality of NHS services and around the extent of its responsibility for health protection.
- The role of the chair and the whole issue of what it means for the HWB to provide system leadership.

A survey of chairs and lead officers identified the following as the main outstanding issues on which HWBs would like support post-April.

- How to engage with direct partners and with the agencies boards work with such as PHE and NHS CB LATs.
- Governance, accountability and decision making – how the HWB gives and takes account and specific issues such as who speaks for the board outside meetings particularly when unpopular messages need to be communicated.
- Setting priorities and business planning – agreeing priorities that are fully understood and owned by all partners in the board.

- Board development – recognising that HWBs have not yet taken any difficult decisions; the impact of May elections on relationships and joint work.

Local authority public health

A tremendous amount of work has taken place nationally, regionally and locally to achieve a successful and safe transfer of public health. Recent assessments of progress found that transition is going to plan in the vast majority of local areas, while additional support was being provided for the small number of areas that needed this (generally because of lack of a director of public health (DPH)). However there were still some issues that needed to be addressed such as completing the transfer of contracts, workforce issues such as capacity in consultants and specialists, and establishing relationships with new national and regional structures.

In January, 113 DPH posts were filled, with 20 vacancies. The appointment process has continued, but filling some posts is likely to result in vacancies elsewhere. Arrangements for acting DPH roles are in place in all localities where this may be an issue. A course to accelerate the preparation of aspirant DsPH is underway to help strengthen capacity and professional leadership.

LGiU associates have been involved in two exercises to assist the move from transition to transformation of public health. This work revealed high levels of enthusiasm from public health professionals and local authorities, alongside a willingness to learn from each other and to establish public health as the basis for commissioning services across local authority directorates.

There has been some concern about the distribution of the public health grant across authorities, with Labour MPs (and some academics involved in public health) claiming that the distribution was unfair, with some more deprived areas receiving less per head of population than some wealthier ones. This is probably because the first allocation under the new system was to some extent dependent on historic PCT spending on public health. This will change in future allocations. The longer term issue is, however, how much of the vast NHS budget is given over to public health – very little, and that may need to change.

While there will obviously be challenges in the months and years ahead (not least diminishing resources with which to make an impact) there is much potential for public health to have found a successful home in local authorities.

In a presentation at the annual public health conference bringing together local authorities and public health professionals, Dominic Harrison, Joint Director of Public Health, Engagement and Partnerships at Blackburn with Darwen identified the following as key public health tasks for 2013-14:

- safe transition of public health functions and services

- using unallocated public health spend to prioritise investment in cuts to local authority services crucial for health improvement
- accountability across all local authority directorate spend
- reviewing and re-prioritising inherited public health contracts
- influencing new public health investment priorities
- big ticket changes – integrated wellbeing services aimed at residents with long term conditions & loneliness/good neighbour interventions aimed at reducing social isolation.

Public Health England

PHE's national executive board will work with the NHS CB on national public health issues such as national campaigns. Its structure comprises four regions (corresponding to the NHS regions and encompassing the nine local government regions) and fifteen centres.

- Regions will support the local public health system and will maintain an overview of the whole system's progress in implementing the public health outcomes framework; they will have a special responsibility for workforce development. The four regional directors have been appointed.
- Centres will provide a range of services and expert advice tailored to the needs of local government, CCGs, the local NHS and voluntary/community groups. They will support local authorities and DsPH as public health system leaders and will also help with responding to emergencies where scale is needed. Most of the fifteen centre directors have been appointed and will be in post by 1 April. The two remaining centre director posts are currently being recruited for – Thames Valley and Bedfordshire, and Hertfordshire and Northamptonshire.

While PHE will support rather than direct the public health work of local authorities, the data they produce is intended to identify when local authorities are failing to act effectively.

PHE Chief executive Duncan Selbie's appointment raised some eyebrows due to his lack of public health background, but it seems that his down to earth approach to public health is striking a chord with councils. He has described the transfer to local authorities as 'inspired' and appears to have a view of public health firmly set in social determinants; for instance, pointing to the potential for isolation to shorten life and increase disability.

Local Healthwatch

A January analysis of readiness by the LGA found that the vast majority of local authorities would have LHW in place by April either through competitive tendering or grant-aid to develop the existing LINk provider or a local collaborative. However, it was also possible that a very small number may not have been able to commission LHW because of, for instance, lack of suitable applicants and insufficient time to re-tender. Any such local authorities will use interim arrangements such as continuing with the LINk provider to ensure that the service is in place until LHW can be formally established.

LHW has benefitted from an active Healthwatch Implementation Team, sponsored by the DH and implemented by the LGA, providing an extensive programme of group and individual support. LHW has huge potential to make a valuable contribution to citizen involvement. It is probably fair to say that the previous patient and public involvement mechanism, LINk, was not high on the agenda of many local authorities, often tucked away in a corner of adult social care. In contrast, the profile of LHW is significantly higher which should improve its effectiveness. However, the regulations for LHW have caused controversy as they appear to limit the possibility of LHW members campaigning on behalf of vital services in their areas or speaking out if they believe that public policy is having a detrimental effect on their residents.

The quality of LINks and their predecessors patient and public involvement forums (PPIFs) varied considerably – from those that made a valuable contribution to improvements in their local health and care system, to those that spent time on minor issues or in-fighting. Local authority commissioners have generally been wary of intervening in the work of problematic LINks in case they were perceived as trying to control the legitimate voice of patients and service users. The Francis report which was very critical of the LINk covering Stafford Hospital indicates that this is not an option. On Staffordshire PPIF, the report describes 'mutual acrimony' between PPIF members and between PPIF members and the host, a preoccupation with constitutional and procedural matters and a 'degree of diffidence towards the Trust' as leading to a failure to be effective. Local Involvement Networks (LINks) were described as an 'even greater failure'. 'The albeit unrealised potential for consistency represented by the Commission for Patient and Public Involvement in Health was removed, leaving each local authority to devise its own working arrangements. Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all' (Executive Summary 1.22). On LHW the report says that without a national framework to provide consistency there is a 'danger of repetition of the arguments that so debilitated Staffordshire LINks'.

The Francis report recommends that respect for the independence of LHW should not be allowed to inhibit a local authority – or HWE as appropriate – intervening. It also recommends that there should be a consistent national structure for LHW, guidance for cooperation between LHW, HWBs and scrutiny committees and training for LHW leaders.

Healthwatch England

HWE is run by a committee of whom the chair is Anna Bradley who has a long record in senior roles in consumer organisations such as Which?. Committee members represent a breadth of experience, with local government represented by Councillor David Rogers, chair of the LGA Community Health and Wellbeing Board, and Dave Shields who was a member of the LGA Healthwatch Implementation Team. HWE will provide leadership, support and advice to LHW and will also analyse local information to identify key trends and issues which will be passed to the Secretary of State for Health, the CQC, the NHS CB, Monitor and local authorities. HWE will operate a country-wide Healthwatch network.

Working relationships between HWE, LHW and local government will need to develop in the coming months, and there may well be differences of emphasis, such as whether there will be a national framework as recommended in the Francis review. Also, HWE appear to be operating to a consumer model which has not been the usual approach for patient, public, service user and carer involvement in health and social care. However, given the variable quality of LINks it may be that a professional model may prove helpful in raising performance.

Issues in the coming months

This section discusses some of the pressing or challenging issues that will emerge from the reforms.

Quality and safety in the NHS

Regular reports of serious failings in NHS care took place throughout 2012 and are continuing into 2013 (for instance, CQC report on care for older people in hospitals and care homes, Patient Association report on poor access to out of hours care – see forthcoming LGiU Health, Public Health and Social Care Round-up for March). An HSJ survey of provider chairs found that nearly three-quarters of the 60 that responded believed that a small number of trusts were failing in a similar way to Mid Staffordshire. Only five percent believed it was a one-off. In a previous survey in 2012, 44 percent of chief executives were not confident that regulators could detect another care scandal. The CQC has just announced a new and tighter inspection regime to accompany the reforms (LGiU March round-up). It will be almost inevitable

that many future failings will be associated with the NHS reforms whether or not they stem from these.

Reconfiguration

It is widely acknowledged that the NHS must change to meet the need for healthcare from rising numbers of older people, and the demand for better quality healthcare (at convenient times, in convenient places) from better informed patients. To meet these demands at a time of dwindling resources, the NHS CB and CCGs will need to radically change services; major reconfigurations and mergers are already in motion – Greater Manchester, North West London, children' heart surgery providers and many others.

One of the most interesting, seen as a test case for local determination, is in Lewisham. A special administrator appointed to look into the financial problems of South London Healthcare Trust recommended that this trust be dissolved and part of it merged with Lewisham Healthcare Trust. As part of this process the administrator recommended that A&E services at Lewisham be downgraded to an urgent care facility. Lewisham hospital, CCG and Elected Mayor did not support the downgrade, but the administrator's recommendation was partially supported by the Health Secretary who agreed that there should be a downgrade to a smaller A&E facility. Lewisham council has voted unanimously to seek judicial review to challenge the recommendation of the administrator and the decision of the health secretary on the grounds that they operated outside their powers. A particularly controversial issue is that the A&E services in a highly deprived and multi-racial area are perceived to have been sacrificed to servicing the debt from a PFI contract in a less deprived area.

This is an example of local partners in agreement, but there will be many occasions of disputes between NHS clinicians and managers, the public voice and local authorities. Health overview and scrutiny committees are going to be busy and need to establish excellent relationships with LHW. Maintaining clear, evidence-led oversight of potential reconfigurations is likely to be a key area for HWBs.

Competition

Following objections in the Lords and from the medical establishment, the Government deleted a clause from the Regulations on Procurement, Patient Choice and Competition which originally said that CCGs could award contracts without competition when there was only one provider capable of providing the services, but only for technical reasons or reasons of extreme urgency. This was seen as leading to extensive tendering of NHS services. A power for Monitor to require a CCG to tender for a contract has also been removed. The section on anti-competitive behaviour has been amended; this is now prohibited unless it 'is in the interests of

people who use health care services for the purposes of the NHS'. Examples are services being provided in an integrated way e.g. with social care, or co-operation between providers to improve quality.

It is true to say that there is a lack of clarity across the NHS system about where they stand on the legal issues of competition. The extent to which competitive tendering is used will vary between CCGs, and will be likely to be subject to legal test cases in 2013.

Sector-led improvement and regional support

One disparity between local government and the NHS is that the latter has strong, formal sub-national support and supervision while local authorities do not. The current regime of sector-led improvement is aimed at providing a mechanism whereby local government provides mutual support, challenge and improvement. In their work to support local reforms, LGiU associates particularly noted the significant variation in readiness in different elements of reform across the country. Some have been operating in shadow form for some time, and have a clear direction and the relevant expertise so are well placed to take on full responsibility. Others have formed, but this may have taken place relatively recently and possibly following a period of local disagreement. This variation will need to be addressed.

Local authorities have a good tradition of mutual support and much excellent work has been taking place nationally and regionally by the LGA and other strategic partners such as the Association of Directors of Adult Social Services (ADASS) in preparation for the NHS reforms; support for the first year of implementation is set to continue. An area for development will be in regional co-ordination, consistency and support around health issues, since health and public health are relatively new areas of responsibility in regional local government.

Challenge may prove more difficult. A recent LGA report on social care Evaluation of sector-led improvement Companion report: perceptions audit of key stakeholders indicates that some strategic partners are concerned with a lack of independent oversight in the voluntary system so far; it is likely that measures to establish a more robust system of improvement, aligned with outcomes frameworks, will be needed in future so that progress, and lack of progress, can be measured.

Comment

A huge amount of work has taken place nationally, regionally and locally on all aspects of the reforms ending in a frantic dash to pull it all together for April.

Preparation has covered both relationship building to develop mutual understanding, and practical issues of implementation such as staff transfer.

April 2013 is probably best seen as the end of the beginning; much work will still be needed to embed change and to test that all elements of the system are working well and interfacing with each other to improve health and care outcomes.

There are significant questions about readiness both at a national and local level. Seventy six percent of over 1000 senior managers and clinicians responding to a Guardian survey in 2013 believed that the NHS as a whole would not be ready for the changes on April 1. Two-thirds believed that CCGs were not ready, and around a half that the NHS CB, HWBs and local authorities were not sufficiently prepared. The main concerns were around lack of clarity in accountability and staff shortages. Another concern, widely expressed, is that the system of PCTs and SHAs has been replaced with a similar system of CCGs and LATs; regional NHS has been described as one of the things that, along with cockroaches, will survive a nuclear explosion. There is a real danger that new organisations will fall back into old patterns.

Anyone expecting the NHS reforms to slot seamlessly into place on April 1 will be sorely disappointed. And yet, any initial problems will be largely invisible except for people working in and around the system who will be faced with an escalation of uncertainty about what can and should be done and who to go to for clarification.

This briefing has highlighted some of the major challenges facing all parts of the new system. For local authorities perhaps the biggest challenge is how will they understand and deliver on their leadership role – in public health, promoting integration, monitoring and scrutinising the local healthcare system.

All parts of that system face major policy, as well as practical, issues. Crucially around relationships and accountabilities – there is, for example, still uncertainty about the nature of the relationship between the NHSCB and CCGs and how far the national board will exert authority over local commissioning. And the new structures are facing rising expectations and reducing resources. How will they ensure that there is engagement and participation at all levels, from the community to individual service users? Will CCGs be open and listen to the concerns of residents and patients?

All parts of the NHS have the duty under the Act to integrate services added to their statutory powers. Health and Wellbeing boards have to promote integrated commissioning and delivery. The November mandate from the Secretary of State to the national commissioning board stressed that the development of integrated services was a top priority. Yet none of this is new and the history of bringing services together to benefit patients and service users (particularly for those with long-term conditions or dementia) has not been good. There is an argument made by critics of the reforms that the reforms themselves increase the potential for fragmentation. The success or not of the new system will to some extent be judged

over the next few years partly by how far the government's objectives of greater integration have been met.

What else? Tackling health inequalities must be a major priority. As with integration the case has been made endlessly and there is consensus about the urgent need to deal with the social determinants of health, preventing ill health and premature death. All parts of the new system have been charged with tackling health inequalities. But again the record is not good. Health inequalities are the result of wider social, environmental and economic factors: making a real difference at a time of welfare and public service cuts and austerity will be extremely hard.

The role of councils in addressing these two issues is crucial, and not, of course, new. Local authorities will be building on previous initiatives and interventions. Is local government taking on public health and the new responsibilities under the Act at the best of times or the worst of times (to roughly quote Dickens)? The changes do give local authorities new opportunities and tools to tackle issues locally – to focus on promoting health and wellbeing and on early intervention and bringing services together, both inside and outside the council. Local government has a proud history of public health interventions that worked. Optimistically, health and wellbeing boards have been welcomed across health and local government. This is a part of the new system where there is agreement that there is potential for making positive change and despite the hugely difficult context, local government, with good leadership, should be making that difference.

Related policy briefings

Francis inquiry into Mid Staffordshire NHS Foundation Trust

http://www.lgiu.org.uk/briefing/the-francis-inquiry-into-mid-staffordshire-nhs-foundation-trust-messages-and-implications/

NHS mandate and national outcomes frameworks – implications for local authorities

http://www.lgiu.org.uk/briefing/nhs-mandate-and-national-outcomes-frameworks-implications-for-local-authorities/

POLICY BRIEFING

The public health outcomes framework – a focus on the indicators that are influenced by where you live

http://www.lgiu.org.uk/briefing/the-public-health-outcomes-framework-a-focus-on-the-indicators-that-are-influenced-by-where-you-live/

Proposed regulations for health and wellbeing boards

http://www.lgiu.org.uk/briefing/proposed-regulations-for-health-and-wellbeing-boards-the-governments-intentions/

Health and wellbeing boards: system leaders or talking shops

http://www.lgiu.org.uk/briefing/health-and-wellbeing-boards-system-leaders-or-talking-shops/

Update on Healthwatch

http://www.lgiu.org.uk/briefing/update-on-healthwatch/

Health and Social Care Act 2012, final stages and comment

http://www.lgiu.org.uk/briefing/the-health-and-social-care-act-final-stages-and-comment/

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk