HEALTH AND WELL-BEING SCRUTINY COMMITTEE 15 September 2010

EQUITY AND EXCELLENCE: LIBERATING THE NHS SUMMARY AND CONSULTATION QUESTIONS ON THE LOCAL DEMOCRATIC LEGITIMACY IN HEALTH PROPOSALS

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 The purpose of this report is to provide members with a summary of the 'Equity and excellence in health, liberating the NHS white paper' a summary of the consultation paper, 'Increasing democratic legitimacy in health', and to suggest a response to the consultation paper.

1.2 At an informal meeting of the Scrutiny Committee held on 1 September members discussed the consultation paper and the comments from that meeting are included in this report. From those comments a suggested response to the consultation has been proposed.

2. Background

2.1 On 12th July, the Secretary of State for Health, launched the equity and excellence in health, liberating the NHS white paper. The white paper represents a major restructuring of health services and councils' responsibilities in relation to health improvement, and coordination of health and social care. It aims to remove unnecessary bureaucracy and devolve power to the local level. It proposes the transfer of public health responsibilities to local authorities, with the role of joining up health improvement, health services and social care locally to achieve better outcomes and greater efficiency.

2.2 The government is currently consulting on the detail of four elements of the white paper; these are:

- Commissioning for patients,
- Regulating healthcare providers
- Transparency in outcomes
- A framework for the NHS and local democratic legitimacy in health.

2.3 This report provides a summary of the white paper. Given the importance and relevance local democratic legitimacy in health consultation, this report also provides a summary of this consultation paper.

2. Summary of the white paper proposals

2.1 One of the central features of the proposals in the white paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act for patients and support them in their healthcare

choices. It is proposed that most commissioning decisions will be made by consortia of GP practices, which will push decision making much closer to patients and local communities, and ensure commissioners are accountable to them. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners, to design joined-up services that make sense to patients and the public.

3. Roles and resources for local councils

3.1 Within this new system, local authorities will have an enhanced role in health. Specifically Councils will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

3.2 With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services together with wider services including disability, housing and talking crime and disorder. The local authority will lead the process of undertaking joint strategic needs assessments across health and local authority services and promote joint commissioning between GP consortia and local authorities.

3.3 Primary Care Trusts' public health improvement functions and budgets will be transferred to councils after the abolition of PCTs in 2013. Local Directors of Public Health will be jointly appointed by local authorities and the new national Public Health Service, which will take a national lead on improving public health.

3.4 A ring-fenced public health budget will be allocated to local authorities to support their public health and health improvement functions, with a guarantee to maintain NHS spending in real terms, though there will be efficiencies in the region of 45 per cent of total NHS management costs to offset rising demographic demands. There will be no bail-outs for organisations which overspend public budgets.

3.5 Councils will be required to establish health and wellbeing boards to join up the commissioning of local NHS services, social care and health improvement, underpinned by an extension and simplification of powers to enable joint working between the NHS and local authorities.

3.6 The proposals indicate the requirement to strengthen local democracy, by building on the existing mechanisms whereby people are given a strong voice. The collective voice of patients and the public will be strengthened through arrangements led by local authorities and at National level, through a consumer champion, HealthWatch, located in Care Quality Commission (CQC).

4. Joint licensing role for Monitor and the Care Quality Commission

4.1 Monitor[1] will become the economic regulator for all health and social care providers, with the independent regulator for health and adult social care in England, the Care Quality Commission[2] (CQC) focusing on quality assurance for all health and social care, both public and private. All service providers will have a joint licence overseen by both Monitor and the CQC.

5. GP commissioning consortia

5.1 The government intends to give responsibility to GPs for managing the bulk of NHS resources and for commissioning care on behalf of patients through groups of GPs or GP commissioning consortia, in order to ensure that decisions are underpinned by clinical insight and local health knowledge. They will be supported and held to account by the NHS commissioning board. These commissioning consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty to ensure patient and public involvement.

6. NHS Commissioning Board

6.1 An independent national NHS Commissioning Board will allocate NHS resources to the GP consortia and support them in their commissioning decisions. It will also:

- Provide national leadership on commissioning for quality improvement
- Promote patient involvement and choice
- Support the development of GP commissioning consortia
- Commission national and regional specialist services and community services such as GP, dentistry, pharmacy and maternity services
- Allocate and account for NHS resources.

7. Public Health Service

7.1 A national Public Health Service will be established to integrate and streamline existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation. It will be responsible for vaccination and screening programmes and, in order to manage public health emergencies, it will have powers in relation to the NHS matched by corresponding duties for NHS resilience.

8. Patient and public voice

8.1 Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). At national level, HealthWatch England will provide leadership to local branches and will provide advice to national bodies, including the NHS Commissioning Board, Monitor and the

[1] Monitor - Assesses, licences and monitors NHS Foundation Trusts
[2] CQC - Regulates health and adult social care provision

Secretary of State. It will also have the power to propose CQC investigations of poor services, based on local intelligence.

8.2 Local involvement networks (LINks) will be rebranded as Local HealthWatch and will ensure that the voices of patients and carers are at the heart of the commissioning process. Local HealthWatch will be commissioned, funded by and accountable to local authorities, which will have a legal duty to ensure that HealthWatch is operating effectively.

9. Consultation paper on local democratic legitimacy in health

9.1 This consultation paper aims to build on the proposals in the White Paper to increase local democratic legitimacy in health. The government wants to achieve this through local authorities:

i. being given a stronger role in supporting patient choice and ensuring effective local voice
ii. taking on local public health improvement functions, and
iii. promoting more effective NHS, social care and public health commissioning arrangements. The government wishes to bring about major structural change to give effect to these changes.

10. Proposals for delivering this

10.1 The government is proposing to change Local Involvement Networks (LINKS) into local HealthWatch, commissioned by councils, with an extended remit to provide complaints advocacy and supporting customers in accessing / choosing services.

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Q2 Should local HealthWatch take on the wider role outlined in paragraph 8.2, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Comments from the informal Scrutiny Committee:

Concerns were expressed that the proposals to allow HealthWatch to offer advocacy to those people who find it difficult to voice their problems should not turn HealthWatch into a complaints handling organisation, but one that would actively seek views or receive feedback from activities, of which complaints would be one.

If these proposals are implemented, there will be a need to ensure local HealthWatch have support from service commissioners.

Concerns were expressed about the holding to account of local HealthWatch with Health Watch England expected to have this local knowledge. It seems logical that the national HealthWatch should form part of CQC but it is unclear how local information will inform regulators opinion of services.

Suggested response:

Holding local Health Watch to account for its performance against its contract could be part of the role of Overview and Scrutiny Committees, helping them to hold commissioners and those responsible for health improvement and adult social care to account. Overview and Scrutiny already work collaboratively with LINk on health and social care improvements, which would continue. This measure would ensure local HealthWatch are truly independent of their commissioners, i.e. the Executives of local authorities, while accountable for their performance.

10.2 As part of the consultation, the government would like to know what more could be done to join services in a way that people understand. It states that joint working is vital to developing a personalised health care system that reflects people's health and care needs and that this white paper presents an opportunity to join services up. The consultation paper sets out improvements to integrated working, developed around people and not institutions. This means the whole care pathway needs to be improved – from prevention, treatment and care, to recovery, rehabilitation and re-ablement.

10.3 The paper proposes:

- Building on the existing personal budgets in social care and extending into NHS.
- Developing quality standards across patient pathways.
- An effective inspectorate of essential quality standards that span health and social care delivered through CQC.
- A payment system to support joint working e.g. for hospital readmission, which should encourage full engagement of the health and care economy before discharge from hospital.
- Freeing up providers to focus on the needs of people, with proposals to free up constraints and allow foundation trusts to augment their NHS role, by, for example expanding into social care.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Suggested response:

We are in favour of underpinning joint working with statutory powers to support the integration agenda. There needs to be a formal arrangement underpinning joint working rather than relying on good relationships and good will. Within this statutory framework the Council should be free to commission joint services that are appropriate to the needs to the community.

10.4 The government proposes that Councils should establish health and well-being boards, to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs. In time it is likely that health and well-being boards will determine the strategy for allocation of the health elements of place based budgeting.

10.5 The four main functions of the health and well-being board would be:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment.
- To promote integration and partnership across areas, including promoting joined up commissioning plans across the NHS, social care and public health.
- To support joint commissioning and pooled budget arrangements where all parties agree this makes sense.
- To undertake a scrutiny role in relation to major service redesign.

10.6 The Council and commissioners partners would be under a duty to cooperate with the health and well-being Board. Responsibility and accountability for commissioning decisions, will be with the NHS Commissioning Board and GP consortia. However, the proposal is that through the Board, the Council and commissioners would have influence over each other.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 10.5?

Comments from the informal Scrutiny Committee

It is appropriate that the new Board will have a scrutiny role in its decision making process however with regard to the proposal to remove health oversight and scrutiny powers from Councils, the loss of the independence of scrutiny of decisions is a concern.

Suggested response:

It is appropriate that the board should have the first three functions however the fourth function requires independence and should be with the existing model of Overview and Scrutiny.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Suggested response:

We support use of best practice to support the health and wellbeing boards in the knowledge that many councils and local partnerships already have very similar structures to improve co-ordination and collaboration on health improvement and addressing health inequalities.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Suggested response:

We note the proposal to join-up the work of the new arrangements with Children's Trusts. The government will need to provide further clarity on this, as we are aware that the government is currently proposing significant changes to the role and responsibilities of Children's Trusts, including changing the requirement to have one. If this proposal proceeds we would wish to see a formal arrangement between the board and trust and overview and scrutiny to ensure transparency of decision making and public accountability.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

10.7 It is proposed that the membership of health and well-being boards will consist of councillors, social care, NHS commissioners and local government and patient champions, with councillors determining who should chair the board. The Councils' Director of Pubic Health, will have a major role in advising the board. It is also expected that GP consortia and Health Watch representatives will be given seats on the boards.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 10.7?

Suggested response:

We agree that where Boards are established, membership should consist of a range of people, including those with clinical and health improvement expertise. However, we feel that the membership of Boards should not be prescribed in law, rather that the local authority, should have the flexibility to determine what is the most appropriate Board membership for their local area.

We also feel that councillors should have the majority seats on the Board, given that they alone, have a democratic mandate to ensure services meet the needs of their constituents and local users of health services.

There would be a need to avoid inordinately large Health and Wellbeing Boards. It is difficult to envisage how decisions would be made in a Board with a large number of members of differing powers, some democratically elected and some not. Membership could be better if restricted to a core group of members, with equal and full voting powers. Others mentioned in the consultation document could be regular attendees and/ or called as witnesses as and when required.

Given the role that Health Watch members will have in championing the voice of patients and advocating on behalf of complaints, we feel that the proposed role for them, would mean that they are better suited to becoming more involved with the work of Overview and Scrutiny committees, helping to ensure that they maintain a degree of independence from those taking commissioning decisions and developing strategy.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Suggested response:

Commissioners should engage with the Council's health overview and scrutiny function on a frequent and regular basis, to ensure significant changes to services are largely in the interest of health and social care services for the area. This should limit disputes in the first place, but if there is any dispute, this should be left for local authorities to determine with its partners how to resolve them.

10.8 If a health and wellbeing board was created within a local authority, it would have a new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services. To avoid duplication, the government proposes that the statutory functions of the Overview and Scrutiny Committee to refer matters to the Secretary of State or to be consulted on major changes to services, would transfer to the health and wellbeing board.

10.9 The consultation paper further states that public scrutiny is an essential part of ensuring that Government and public services remain effective and accountable. It helps to achieve a genuine accountability for the use of public resources. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Suggested response:

We do not support this arrangement. Health Overview and Scrutiny Committees have made a real difference in championing the public interest and challenging health commissioners and providers to deliver better health services. The scrutiny of health services must be transparent and have a strong element of democratically accountable oversight, independent of the health service, in order to ensure that it is responsive to the local public's needs. Health Overview and Scrutiny should work alongside the new board and retain the powers to be effective, such as a formalised call-in of decisions arrangements.

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Suggested response:

Overview and Scrutiny committees should retain their statutory health scrutiny powers. The need for local democratic accountability through, locally elected non executive members, independent of those commissioning or developing services, is even more important in the context of health and well being boards leading local health improvement work and in the context of commissioning decisions being taken by executive members, council officers and GPs. Removing these powers from Overview and Scrutiny committees would lead to confusion as what the role of Overview and Scrutiny is in scrutinising health issues and would could potentially mean that the health functions of the Council would be the only area of Council activity that non-executive members on Overview and Scrutiny Committees cannot comprehensively scrutinise.

If it is decided to proceed with these proposals, then we would welcome full clarity from the government about the continued role of Overview and Scrutiny Committees in scrutinising health issues. We would also welcome the flexibility, to be able to ensure that non-executive members can have a role in the work of health and well-being boards.

10.10 Questions 17 and 18 are general question on the proposals.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

Q18 Do you have any other comments on this document?

Suggested response:

The proposals must include clear and transparent accountability arrangements to local communities, which build on existing accountability rather than creating new structures. It remains to be seen how effective the new Board will be at holding the new GP consortia to account; although there will be more local authority involvement, the current role of Overview and Scrutiny Committees will go and this leaves a void in public accountability.

We are pleased to see the recognition that Councils are the best placed body to lead health improvements in their local area and that Council's will need additional resources to deliver this work.

Local authorities and their partners should be left to lead and manage health services, in accordance with local need. Indeed Councils should be free to commission joint adult social care and health services teams, providing holistic services around patients' needs.

If the government decides to proceed with a national outcome framework, then it should not be too prescriptive and should not cover too many issues, as health and well-being board's need to be free to address local issues.

5. Conclusion

5.1 The Committee is asked to endorse the suggested response for submission as part of the formal consultation.

6. Background Papers

Equity and Excellence in Health, liberating the NHS white paper
Commissioning for patients – consultation paper
Regulating healthcare providers – consultation paper
Transparency in outcomes – consultation paper
A framework for the NHS and local democratic legitimacy in health – consultation paper

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