**HEALTH AND WELL-BEING SCRUTINY COMMITTEE 13th October 2010**

**EQUITY AND EXCELLENCE: LIBERATING THE NHS WHITE PAPER – UPDATE REPORT**

**REPORT OF THE CHIEF EXECUTIVE**

## 1. Purpose of Report

1.1 The purpose of this report is to provide members with an update in relation to the 'Equity and Excellence in Health, liberating the NHS white paper' and its associated consultation papers.

## 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 Health White Paper 'Equity and Excellence – Liberating the NHS' was open for consultation until 5th October.

2.3 The five supplementary papers are out for consultation until 11th October, under the overall heading Liberating the NHS

- Transparency in outcomes: a framework for the NHS – proposals for performance standards
- Local democratic legitimacy in health – the role of Local Authorities, Health and Wellbeing Boards, HealthWatch
- Commissioning for patients – the establishment of GP commissioning consortia and the demise of PCTs
- Regulating healthcare providers – the proposed regulatory role for 'Monitor'
- Report of the arms-length bodies review – the merger or abolition of health related quangos including the Appointments Commission

2.4 At an informal meeting held on 1 September members discussed the NHS White Paper and the consultation questions. The consultation responses were endorsed at the Scrutiny Committee held on 15 September. The comments were submitted to the North East Regional Joint Health Scrutiny Committee on 16 September and the collective regional scrutiny response is attached.

## 3. Healthy Accountability Forum - Local Democratic Legitimacy in Health

3.1 Sunderland Health Overview and Scrutiny was represented at a CfPS meeting of Health Scrutiny Chairs and scrutiny officers on 20th September in London. The discussion was focused on 'How might transparency and accountability be achieved in the Health White Paper proposals?'

3.2 The facilitated debate followed an introductory briefing from Ed Moses of the Department of Health White Paper Team, and Alyson Morley, Senior Policy Analyst for the Local Government Association on the implications of the white paper for local government, and focussed on GP Commissioning, Health and Wellbeing Boards, Health Improvement and HealthWatch.

3.3 For the final panel discussion, Ed Moses and Alyson Morely were joined by Andrew Larter, Deputy Director Local Government and Regional Policy, Department of Health; Dr Hugh Annett , Director of Public Health, Bristol; Ivan Rudd, Chief Executive, Ipscom, GP-Led Commissioning Consortia for Ipswich Community; Steve Holmes, Performance Assessment Manager London, Care Quality Commission and Frances Blunden Senior Policy Manager , NHS Confederation.

3.4 The focus of the Forum was on four aspects of the white paper where existing health scrutiny has experience to contribute to the development of the detail and implementation of GP commissioning, Health Improvement, and the creation of HealthWatch and Health and Wellbeing Boards.

3.5 Ed Moses from the Policy Unit at the DoH described the White Paper proposals as a radical simplification of the NHS so that it becomes more resilient, transparent, patients are placed at its centre; and outcomes are improved. His briefing introduced the White Paper as a whole, but was primarily intended to promote discussion and consideration of the issues. He focussed on commissioning for patients and increasing democracy and legitimacy in health to be achieved by GP Commissioning Consortia, responsible for commissioning local services; an autonomous NHS Commissioning Board, responsible for commissioning other services such as primary medical services, dentistry and community pharmacy; all NHS Trusts will become Foundation Trusts or be part of a Foundation Trust with staff having a greater say in how they are run; and a new role for local authorities.

3.6 The local authority role will be to support local strategies for NHS commissioning and integration of NHS, social care, and public health services; leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies; supporting local voices, and the exercise of patient choice; promoting joined up

commissioning of local NHS services, social care and health improvement; leading on local health improvement and prevention activity. Health and Wellbeing Boards would be created to set the local direction of health services and as part of this they would absorb the powers currently given to HOSCs.

3.7 Alyson Morley briefed the forum on the emerging response of the Local Government Group (formerly LGA) based on five tests:

- Do the proposals build on existing experience and good practice?
- Do they support an area-based approach?
- Do they support a person-centred approach?
- Do they ensure accountability to local communities?
- Do they ensure that public resources are directed to the areas of greatest need?

3.8 She welcomed the proposals for the transfer of Public Health back to local government describing it as 'coming home', reminding scrutiny practitioners that local government was brought into being to tackle the great public health challenges of the nineteenth century. She also welcomed health and wellbeing boards and urged local authorities not to wait but to set up shadow boards as soon as possible to enable a smooth transition of responsibilities.

3.9 Finally, she expressed the LGG's strong support for the retention of HOSCs and separation of executive and scrutiny in health. Her questions, to be echoed in all discussions later were how the transition was to be managed; the nature of the public health role; how transparency and accountability were to be achieved, and not least, resourcing, with a brief reference to Total Place, now referred to as place-based budgets.

3.10 The four topic based facilitated discussions made it quite clear that at its best, scrutiny, in the independent format of the last ten years, has shared the vision of the White Paper – it is patient and public centred, takes an integrated view of the determinants of health, joined up, and well informed. It has demonstrated that it has a role to play in informing commissioning and monitoring progress against the Joint Strategic Needs Assessment. It has also given voice to local interests and sought community involvement in times of major change in both primary and secondary care.

3.11 The potential for Health and Wellbeing Boards to deliver joined up health and social care was welcome, and a statutory requirement for the establishment of the boards would be preferred. There is also concern for how to manage successful and practical transition from a culture of central regulation to local initiative. The role of elected members, if any, on the Health and Wellbeing Boards is not clear, but the main concern is the conflict of interest created by transferring scrutiny powers to the board.

3.12 HOSCs have matured and have ten years experience in an environment of perpetual change. The strongest case for the continuation of HOSCs comes from the significant contribution of vast numbers of topic based reviews to commissioning strategies and reducing health inequalities. There was widespread concern among participants that the proposal to merge current health scrutiny powers into Health and Wellbeing boards will be the end of this level of accountability to the local community, and that the scrutiny function will be diluted by conflict of interest as well as capacity constraints. The proposals to merge HOSC scrutiny powers into Health and Wellbeing Boards runs totally counter to the classic philosophical arguments for the separation of executive and scrutiny.

3.13 Some forum members held the view that currently many LINks appear to model their role on Overview and Scrutiny and are perceived to want to work in a similar fashion to HOSCs. In fact, where LINks are successful the role is complementary, with LINKs able to connect more consistently and deeply with patients and public, become experts in specialist areas, and provide evidence and insight to HOSCs when required. The full realisation of the LINk as a link to specialist patient groups and the voluntary sector is still unfulfilled in many places, or so it would appear from the experiences described at the Forum.

3.14 There is considerable concern how LINks will transform in to HealthWatch and serious work on this is only just beginning. There have been problems in some areas with LINks, which HOSCs would not want replicated, around hosting arrangements, the realisation of the role of Links, and lack of public engagement in the LINK. Links/Healthwatch have the potential to reflect the multiple voices of the public in an idiom the public feel most comfortable in, and need to be supported by, not in competition with, the HOSC in fulfilling their role. There are enough high performing LINks to carry forward good practice in to HealthWatch.

3.15 Historically relationships between HOSCs and GP commissioners has been as variable as with the LINks. Partly the relationship of HOSCs with PCTs has often hindered building constructive relationships directly with GPs. Currently HOSCs would like to see the statutory nature of their relationship with PCTs transferred to GP consortia. Without this GP consortia may find it difficult to demonstrate their accountability to the community and miss out on the useful contribution scrutiny can make to commissioning. Where scrutiny of GP commissioning has previously been undertaken, or GPs have been involved in topic based reviews, the mutual learning that has resulted has been constructive and can be carried forward as a model.

3.16 If a key outcome from the Health and Wellbeing Boards is the reduction of age-old silo working practices, and place-based budgeting without the need for complex legislation, the full transfer of Public Health functions to local authorities, unlike the current joint appointments, should accelerate this process. The foundation of the Joint Strategic Needs Assessment

(JSNA) is already in place, but will the new focus on outcomes change the way scrutiny performs its work, or encourage more topic based reviews and emphasise work on reducing Health Inequalities?

## 4. Conclusion

4.1 The event provided useful discussion to inform the next steps for HOSCs in responding to the consultation, and interpreting those consultation responses and taking part in the implementation of specialist aspects of the reforms.

4.2 The Committee is asked to note the update report and receive further updates on the white paper developments.

## 5. 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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