Agenda Item No. 11

Meeting of the Cabinet – 27th October 2010

Report of the Interim Director of Adult Social Services

Equity and Excellence in Health – Liberating the National Health Service (NHS) – The NHS White Paper

Purpose of Report

1. To provide Cabinet with a summary of the NHS White Paper *'Equity and excellence in health, liberating the NHS'* and highlight the implications for local government. A 'hard' copy of the White Paper and a related consultation document 'Local democratic legitimacy in health' have been placed in the Members Room and on the Committee Management Information System (CMIS). Other relevant documentation is also available at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

Background

2. The NHS White Paper represents a major restructuring, not just of health services but also of councils' responsibilities in relation to health improvement, and co-ordination of health and social care.

3. The main focus of the White Paper is the aspiration to put patients first through greater choice, involvement and control and a more important role for clinicians in deciding on health priorities. It wants to give a greater focus on improved health outcomes to replace process-led targets. It sees greater accountability as key with improved local autonomy and democratic legitimacy through the development of GP commissioning consortia, working in partnership with local authorities.

4. The Government state that they want 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 and there will be "no bail-outs for organisations which overspend public budgets".

5. A national NHS Commissioning Board to oversee commissioning and to champion improvement and patient involvement in health services will be established. At a local level, the development of General Practitioner (GP) commissioning consortia and the creation of the NHS Commissioning Board

will pave the way for the abolition of Strategic Health Authorities (SHAs) in 2012/13 and Primary Care Trusts (PCTs) in 2013.

6. Decisions on treatment and care will pass directly to groups of GPs who will be responsible for around £80 billion of NHS resources per annum. It is anticipated that there will be around 500-600 GP commissioning consortia across England and all GPs will be required to join a consortium. Each consortium will have to be of sufficient size to manage financial risk and to commission services jointly with local authorities. The NHS Commissioning Board will be responsible for holding consortia to account for their use of NHS resources.

7. These consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty of patient and public involvement.

8. GPs in Dudley have already been working on developing their previous arrangements and have now come together as a Borough-wide GP consortium in readiness for these changes.

9. Patients will be given greater choice of provider, including the right to choose to register with any GP, and greater involvement in decisions about their care. There will be better information for patients and carers, a wider range of on-line services and new ways for patients and clinicians to communicate.

10. All providers and commissioners will have a legal duty to provide accurate and timely data. Patients will have control over their health records and will be able to share them with other organisations, such as patient support groups and patient advocates.

11. The White Paper reiterates the Government's commitment to extending choice through a roll-out of personal budgets for health.

12. The White Paper seeks a stronger focus on improved health outcomes, rather than meeting central targets. The first step towards this will be the new NHS Outcomes Framework which will include a set of national outcome goals, against which the NHS Commissioning Board will be accountable.

13. The outcomes will focus on clinical effectiveness, patient safety and patient experience of their care. The DH will be publishing a separate consultation document on the development of national outcome goals. The outcome framework will be supported by quality standards developed by the National Institute for Health and Clinical Excellence (NICE).

<u>The Role of Local Authorities</u>

14. New roles and resources for local councils are planned in the White Paper. These are outlined in more detail in one of several supplementary consulation papers produced by the Department of Health – 'Local democratic legitimacy in health', which refers to an enhanced role for local government and elected

Members. PCT public health improvement functions will be transferred to local councils after the abolition of PCTs in 2013. Local Directors of Public Health will be jointly appointed by LAs and the national Public Health Service.

15. Dudley already has a jointly appointed Director of Public Health who is a member of Corporate Board, so is well placed to respond to arrangements for the employment of public health teams. The responsibilities of the local Director of Public Health will be clarified in due course.

16. A ring-fenced public health budget will be allocated to Councils to support their public health and health improvement functions.

17. Councils will be required to establish "Health and Wellbeing Boards" to join up the commissioning of local NHS services, social care and health improvement. This will allow local authorities to take a strategic approach on promoting integration across health and adult social care. The White Paper also suggests that this will include children's services (including safeguarding) and the wider local authority agenda.

18. Under our current partnership arrangements, there is already a Dudley Health and Well-Being Partnership which can provide a basis for further development. The proposals concerning children's services are likely to require further deliberation. An extension and simplification of powers to enable joint working between the NHS and local authorities are also proposed building on work already done in Dudley using pooled budgets e.g. in learning disability services.

19. In the context of creating the Health and Well Being Board, the White Paper also suggests replacing Health Overview and Scrutiny Committees - in Dudley, the Health and Adult Social Care Select Committee - by including scrutiny in the remit of the Health and Well Being Board but this is currently subject to consultation.

20. Local Involvement Networks (LINks) will be replaced by 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.

21. HealthWatch would have a wider remit than LINks to provide complaints advocacy and supporting customers in accessing/ choosing services and making a complaint. Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). It will have the power to propose CQC investigations of poor services, based on local intelligence.

22. National objectives for local councils will be set though the Public Health Service for improving population health outcomes and Councils will determine how best to secure these objectives.

23. Providers of health services will also be subject to a twin licensing role. Monitor will become the economic regulator for all health and social care providers with responsibility for: promoting competition; regulating prices for NHS services; and supporting the continuity of services if services have become unviable. The Care Quality Commission will remain and focus on quality assurance for all health and social care, both public and private.

Summary

24. The NHS White Paper proposals place a clear emphasis on promoting joint working and integration between local authorities and the health system in planning commissioning and delivering services as well as holding the health and social care system to account locally.

25. The Council in consultation with the health and Well-being Partnership has sent a detailed response to Department of Health as part of the consultation process on the White Paper. A copy of this response is attached at Appendix A.

26. The Government plans to publish a further White Paper on Public Health in the autumn and will bring forward proposals for the future vision of adult social care in 2010.

27. The proposal to remove health scrutiny powers from Councils, whilst still subject to consultation, implies a challenge to ensure a strong element of democratically accountable oversight of health services in the proposed Health and Well Being Board arrangement. Local Elected Members will have interest in ensuring services are responsive to the needs of their communities.

Finance

28. Whilst major re-structuring of the NHS with implications for Local Authorities is envisaged in the NHS White Paper, there are no immediate financial consequences for the Council.

Law

29. There are no immediate legal implications rising from this report although the changes proposed will be made through new primary legislation. A Bill to enact the White paper provisions will be published in the autumn.

Equality Impact

30. An Initial Equalities Impact Assessment of all the proposals has been carried out by the government.

31. The White Paper also states that local authorities and boards will need to ensure that the health and wellbeing of all groups within the local population are taken into account in carrying out their work.

32. The aims and objectives of the White Paper can be seen as contributing to the equality agenda in its pursuit of improving care for all. This implies a challenge to ensure that services meet the needs of all sectors of the community to make this an even greater reality in Dudley.

Recommendation

33. It is recommended that:

- Cabinet note the publication of the NHS White Paper and Dudley's response to the consultation.
- Cabinet comment on any aspect of the proposals for future planning and development of health and care services in the Borough.
- Cabinet agree that a seminar for Members on the White Paper is arranged before the end of the calendar year.

Richard Carter.

……..

Richard Carter
Interim Director of Adult Social Services

Contact Officer - Brendan Clifford – Assistant Director DACHS

APPENDIX A

DUDLEY COUNCIL RESPONSE TO THE NHS WHITE PAPER

We welcome the key principle behind the reforms "no change about me without me" and support the new plans which will allow patients to have a greater degree of choice over which GP practice they register with, regardless of where they live.

Through our own experience however, we are well aware that people want quality services closer to home and that choice for older and vulnerable people has been the most difficult to deliver, the ability to "vote with their feet" is not one which will be available to large numbers of GP patients. We feel that the closer integration of health and social care will enable a greater delivery of choice to a wider range of patients.

GP's having responsibility for commissioning care for their patients and managing NHS budgets is an untrodden path for most GP's. Whilst it should result in services being more closely aligned with patients needs, many GP's are hesitant in embracing this and are not armed with the skills needed. The pace for change for GP's is extrememly ambitious and carries considerable risk. For it to be achieved will depend on appropriate support being put in place as well as close working with partner agencies. We feel that access to support and a recognition by the primary care commissioners of the role of Local Authorities in prevention and early intervention are key to timely delivery of the aspirations enshrined within the White Paper.

Older patients form a large majority of NHS patients, GP's will need to work closely with their commensurate local authorities in effectively preventing ill health, providing support following a hospital discharge and pulling together complex packages of care. There is increasing pressure on the NHS currently in dealing with structural reforms and with GP's needing to manage huge budgets, the needs of patients in receiving quality services must remain paramount.

The Government's commitment to ending age inequalities across the NHS by 2012 is one we wholly support.

Response to Liberating the NHS: Local Democratic Legitimacy in Health

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

On balance we feel that LHW should be a membership body with a prime remit of linking the public with service commissioners. An organisation that would be able to pull together the views of other participation groups including, we assume, GP consortia to provide a coherent font of public expectation and needs.

Its scrutiny role should include ensuring that the NHS Constitution is maintained and a place on Health and Wellbeing Boards will ensure a bottom up strategy is achievable.

A minor point but with their role with Health and Social Care is 'Health Watch ' the right term? Also what will their link be with HW England could this confuse its governance link with Local Authorities?

We have some reservations as to the extent of patient awareness and knowledge of the NHS Constitution and therefore question if this would be an effective use of Healthwatch

resources as they presently stand. In view of the proposed changes to provider services, how valid will the current Constitution be in the future? An alternative possibility is that the Care Quality Commission is better placed to formerly assess delivery against expectations – as part of current APA process - on a more formal basis.

Q2: Should local Health Watch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

We would recommend against complaints advocacy as this would take up considerable time managing and diminish their main purpose of being the eyes and ears of the public.

LINks staff tend to work from one discrete location within the area they represent. We therefore question whether L HW would have the infrastructure/facilities to provide the services as envisaged as accessibility at key provider points would be critical to its success. Taking on such a role would be dependant upon the scale of the proposed transfer of funds to LAs, which is not made explicit in the document.

Q3: What needs to be done to enable local authorities to be the most effective commissioners of local Health Watch?

Developing a national contract of clear accountability lines and deliveries would ensure that a post-code approach would be avoided. This could be cemented by making LHW's statutory bodies accountable to LA's.

We assume a level of appropriate funding will be available to ensure quality services are procured and supported. Clear outcomes will need to be specified to test performance. This should be accompanied though a clear prospectus and the option of re-tendering the contract in the event of under-performance.

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

New performance indicators should be designed to measure the effectiveness of the board rather than aimed at individual agencies so that partners dl not aim to achieve their target to the detriment of partner agencies overall outcomes?

We would also welcome greater flexibility in the ability to transfer budgets between systems by reducing the distinction between what is a health need and a social need to ensure better outcomes for recipients.

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

Pay scale differentials, terms of condition, pensions etc all limit the likelihood of fully integrated models of working. The outcomes from integrated care site projects would provide strong evidence of where further freedoms and flexibilities could be developed, although local differences would negate these as catch all solutions.

Clear outcomes and the express requirement to work together.

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

Yes, this will create a uniform approach and ensure a consistent way of working.

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?

We agree with the proposal which should also enable flexibility to recognise localism agenda's.

Q8: Do you agree that the proposed health and wellbeing boards should have the main functions described in paragraph 30?

The listed functions are strong ones, which we would support fully. The proposals to undertake a scrutiny role may prove difficult to execute.

Q9: Is there a need for further support to the proposed health and well being boards to carry out aspects of these functions, for example information on best practice in undertaking JSNAs?

We welcome the lead health improvement role for LAs and integrating adult social care and NHS services in their local area. To be effective, they should be given maximum flexibility in configuring commissioning structures and management of those services. As such we strongly feel commissioning strategies by GP consortia, should be agreed by local authorities – through the board - helping ensure health, health improvement and adult social care are properly joined-up.

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?

We note currently government is proposing significant changes to the role and responsibilities of Children's Trusts. At the time of this response we can only comment that the proposals seem to be complementary.

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?

Most areas have significant experience of working regionally and sub-regionally as well as joining up services with other agencies. We do not envisage this being a concern.

Q12: Do you agree with our proposals for membership requirements set out in paragraph 38 – 41?

It is crucial, where boards are established, that they have clinical and health improvement expertise. LAs should be given flexibility to determine most appropriate board membership according to local circumstances - not be prescribed. We also feel that elected councillors should have a significant representation, if scrutiny is to be transferred to boards so that democratic oversight of health services ensures a responsive health service. However we feel it will be difficult to see how decisions will be made with large membership. Perhaps the board could report to a core group of members, with equal voting powers. Others could attend as expert witnesses as required.

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

Regular engagement between commissioners, Local Authorities, health and wellbeing boards' and overview and scrutiny function (or which ever democratic oversight of health services) to ensure significant changes to services are largely in the interest of health and social care services for the area.

Development of substantial variation/dispute resolution procedures. Disputes could be referred to Health Watch England or DH for mediation/arbitration might be an appropriate mechanism, health scrutiny framework can be adapted here.

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)?

We feel there is a need for local democratic oversight of health services independent of NHS through locally elected non-executive members, independent of commissioners.

The role of the boards in undertaking health OSC will require a clear national mandate in order for it to be effectively delivered, providing the LA's with this role through the board or to continue through the OSC is essential in ensuring the commissioners as well as the powerful F.T's work together to support health and well-being.

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

By inclusion of genuine lay members/ non-executives to the board. This would ensure that where there is an overwhelming political majority within an authority that the board would have an infrastructure to challenge itself. Without that the only solution for the dissatisfied is to take an issue national.

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?

National consistency is essential so the 'prescription' needs to be within legislation. CQC monitoring to ensure health services are open to and respond to challenge.

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?

The proposals imply a challenge to ensure the services meet the needs of all. Local Authorities will need the commitment of resources required to engage with traditionally hard to reach groups and communities. This will enable access to information about services, which will need to be resourced adequately by government taking into account local needs.