APPENDIX C

WAVERLEY BOROUGH COUNCIL

EXECUTIVE – 5 OCTOBER 2010

Title:

RESPONDING TO THE HEALTH WHITE PAPER –
EQUITY AND EXCELLENCE: Liberating the NHS

[Portfolio Holder: Cllr Robert Knowles]
[Wards Affected: All]

Summary and purpose:

The purpose of this report is to outline the main features of the Health White Paper, *Equity and Excellence: Liberating the NHS* and to comment on the implications for local authorities and Waverley in particular, together with Member responses to the consultation.

How this report relates to the Council's Corporate Priorities

This report relates to the Council's Corporate Priority: **Improving Lives** – Improving the quality of life for all, particularly the more vulnerable within our society.

Equality and Diversity Implications:

There are no direct equality and diversity implications arising from this report. The Government White Paper makes it clear however that equality of provision and access to services is an important aspect of the proposals.

Climate Change Implications:

There are no direct climate change implications arising from the report.

Resource/Value for Money implications:

There are no direct resource implications arising from the report.

Legal Implications:
There are no legal issues arising from this report.

Introduction

1. The Health White Paper, *Equity and Excellence: Liberating the NHS,* was published on 13 July 2010 and was followed by four separate papers on key elements of the proposals
   - **Transparency in outcomes**: a framework for the NHS – sets out how the Secretary of State for Health will hold the NHS to account for improving healthcare outcomes through a new NHS Outcomes Framework.

- **Increasing democratic legitimacy in health** – proposes giving local authorities a greater role in supporting patient choice, taking on local public health improvement functions and promoting more effective NHS, social care and public health commissioning arrangements.
- **Commissioning for patients** - proposals for local consortia of GP practices in charge of commissioning services supported by a new NHS Commissioning Board
- **Regulating healthcare providers** – outlines proposals on foundation trusts and the establishment of Monitor as an independent economic regulator for health and adult social care.

2. Consultation responses on these four areas must be submitted by 11th October 2010. A report on the proposed health service reforms has been considered by the Healthcare Special Interest Group and a response has been prepared by members of this group. Their comments are set out in Annexe 1.

Health White Paper - *Equity and Excellence: Liberating the NHS*

3. In the Health White Paper the Government sets out a vision in which the Department of Health (DH) very deliberately steps back from top-down control of the NHS and power is devolved to frontline clinicians and patients; and thus the NHS is ‘liberated’ from bureaucracy and political control. The proposals continue the separation of commissioning and provider functions.

4. The headline components of the White Paper are:

    - an NHS Commissioning Board to be established which will look after commissioning healthcare with NHS funds working with the GP consortia. The Secretary of State will contract with the NHS Commissioning Board to achieve specified outcomes in return for its budget.
    - a new National Public Health Service will be created.
    - Strategic Health Authorities (SHAs) and PCTs will be abolished
    - GP consortia will be created which will commission services (with some exceptions) from healthcare providers from any sector.
    - Local authorities to be given a strengthened role to direct public health policy and to oversee commissioning in partnership with GP consortia.
    - Local Involvement Networks (LINks) will become local HealthWatch, an independent consumer champion within the Quality Care Commission. They will be funded by and be accountable to local authorities.
    - A strengthened regulatory system comprising Monitor (currently the independent regulator for NHS foundation trusts) and the Care Quality Commission whose role will cover both health and social care.
    - A Cancer Drug Fund will operate from April 2011 and will support patients to get the drugs their doctors recommend.

5. The DH will retain a largely strategic role in relation to the NHS. However, the Secretary of State will keep political control of the outcomes of all hospital reconfigurations that local government politicians refer to him, which may conflict with local commissioning decisions.

6. Having shed much of its NHS responsibilities, the DH will have a new focus on improving public health, tackling health inequalities and reforming adult social care. A Public Health white paper is due by the end of the year, which will set out plans to establish a Public Health Service.

7. Local authorities will pick up the current PCT responsibilities for local health improvement and they will employ a Director of Public Health (jointly appointed with the Public Health Service). Local Directors of Public Health will be responsible for a ring-fenced public health budget which will be allocated, according to relative population need. Given the relative health of the Surrey and Waverley populations, this may lead to further constraints on health provision in the Borough.

8. The DH will continue its role in setting adult social care policy with an emphasis on seeking to break down barriers between health and social care funding to encourage preventative action. Adult social care will be the subject of a consultation later in the year with a white paper in 2011 to establish a sustainable legal and financial framework for adult social care. The DH will establish a commission on the funding of tong-term care and support within a year.

9. The future strategy for the NHS is built around 4 principles:

   - Putting patients and public first
   - Improving healthcare outcomes
   - Autonomy, accountability and democratic legitimacy
   - Cutting bureaucracy and improving efficiency

Putting patients and public first

10. The government aims to make shared decision making the norm - *"no decision about me without me"*. Patients will have access to the information they want so as to make choices about their care. There is a major commitment to extending patient choice into new areas of the NHS. This includes the right to choose to register with any GP practice with an open list; choice in diagnostic testing; choice in care for long-term conditions; extended maternity choice and choice of named consultant-led team for elective care. Patients will be asked to rate hospitals and clinical departments according to the quality of care they receive.

11. Much of the White Paper assumes the development of active and informed health consumers who are able to make use of the choices being made available to them to take control of their healthcare. There is a firm belief in the role that feedback from patients, carers and staff can play in informing patient and carer choice, as a driver for improving standards of care, and encouraging providers to be more responsive.

12. Whilst it sounds as though it ought to be a positive step, many people are likely to find that they are overwhelmed by a raft of information that they may not understand, and will have the additional worry of whether they have chosen the 'right' treatment plan or consultant. In rural areas the choice of GP is often limited by geographic exigencies and difficulties in transport.

13. LINks (Local Involvement Networks) are the bodies currently designated to give the public a stronger voice in how their health and social care services are delivered. LINks are run by local individuals and groups and independently supported. Under the new arrangements, it is proposed that there will be a new national body – HealthWatch England – to act as the independent consumer champion, located within the Care Quality Commission. LINks will become the local Healthwatch, commissioned by the 'local authority'.

14. Local HealthWatch will be funded by and accountable to local authorities who will be responsible for ensuring that local HealthWatch are operating effectively and for putting in place better arrangements if they are not. It is a potential concern that the ability of HealthWatch to fulfil their functions of providing advocacy services for patients, for example, may be constrained by the level of funding provided in the current financial climate.

Improving healthcare outcomes

15. In order to achieve 'world-class' health outcomes the government are proposing to establish a framework of outcomes rather than process targets to achieve their objectives of reducing mortality and morbidity, increase safety and improve patient experience. The NHS will be held to account against these clinical and evidence-based outcome measures. The NHS Outcomes Framework will focus on three domains of quality
    - The effectiveness of the treatment and care provided to patients – measured by clinical outcomes and patient-reported outcomes;
    - The safety of the treatment and care provided to patients; and
    - The broader experience patients have of the treatment and care they receive.

    There will be separate Outcomes Frameworks issued for public health and social care and it will be up to local authorities to determine how best to achieve these.
16. The Government hopes that by creating a culture of open information, active responsibility and challenge it will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire will not go undetected in the future.

17 The role of the National Institute of Clinical Excellence (NICE) will be expanded to develop quality standards for social care, as well as clinical pathways of care. The Health Bill will put NICE on a firmer statutory footing securing its independence and core functions, but there is some concern about it conflicting with the operation of the Cancer Drug Fund.

18 The DH proposes to revise the system of payments within the NHS in order to incentivise results, including a new dentistry contract with a focus on improving quality, achieving good dental health and increasing access to NHS dentistry.

19 The proposals for the NHS Outcomes Framework include the five 'domains' that have been identified as covering the range of healthcare outcomes that the NHS is responsible for delivering:

Domain 1: Preventing people from dying prematurely.
Domain 2: Enhancing quality of life for people with long-term conditions.
Domain 3: Helping people to recover from episodes of ill health or following injury.
Domain 4: Ensuring people have a positive experience of care.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

Autonomy, accountability and democratic legitimacy

20. This section of the White Paper sets out the proposals that have the greatest impact at a local level in terms of how healthcare services are commissioned and the role of local authorities. The proposals in the White Paper are developed in the two

supporting documents *Commissioning for Patients* and *Local Democratic Legitimacy.* The Healthcare SIG have prepared a response to these specific papers and these are set out at Annexe 1 to this report.

21. The Government will devolve power and responsibility for commissioning services to GPs and their practice teams working in consortia. Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement. GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

22. GP consortia will not commission primary care contracts from their constituent GP practices. These will be held with the NHS Commissioning Board. The NHS Commissioning Board will also be responsible for commissioning maternity services. It has been suggested that this has been withheld from GP consortia because of a political commitment to retaining hospital maternity services, but it may be strongly challenged as the Health Bill is debated later in the year.

23. GP consortia will be able to decide which commissioning activities they undertake themselves and which they buy in from external providers. It seems inevitable that many of the analysts, commissioners and procurement experts currently working for PCTs will end up working directly for GP consortia, or working for private sector or social enterprise businesses to provide this support. The duty on GP consortia to work in partnership with local authorities may promote more joint commissioning of health and social care services than has happened to date, with county/unitary authorities able to provide the commissioning and procurement expertise.

24. To support GP consortia in their commissioning decisions a statutory NHS Commissioning Board will be established. It will be free from day-to-day political interference. It will help standardise best practice, for example improving discharge from hospital, reducing delays prior to operations and enabling community access to care and treatments. The Board will hold GP consortia to account for their performance and quality and will allocate and account for NHS resources. The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia.

25. GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.

26. GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process.

27. The headlines in this section, commissioning being put into the hands of GPs, and the strengthening of local democratic involvement, appear to be positives. However, there are a number of issues with the proposals that may affect the implementation and operation of the new arrangements.

28. One of the aims of the White Paper has been to 'liberate' the NHS from political micro-management. The DH will still retain the ability to override local clinical decisions on hospital closures; and will take on responsibility for appointment of non-executive directors. There is also an issue around the extent to which this freeing of the NHS from the control of the DH actually reduces the accountability of the Secretary of State. Currently, the 'last resort' for members of the public, or local councillors, is to lobby their MP about healthcare issues (e.g. closure of community hospital beds); and MPs have the right to raise these issues with the Secretary of State. In future, MPs may be directed to the NHS Commissioning Board for a response.

29. It is important to note that it is GP consortia – not GP practices – that will have commissioning powers. GP practices are private sector businesses; GP consortia will be statutory bodies. All GP practices will have to belong to a consortium, whether they want to or not. GPs' reactions to the proposals have been very mixed with some very enthusiastic and others very opposed to being forced to take on roles far beyond their clinical training.

30. The geographical focus for GP consortia is not being prescribed and it is expected that some may be based on existing Practice Based Commissioning (PBC) groups, e.g. the cluster of 10 GP practices in Waverley that make up Waverley PBC*. The geographic focus will have to be large enough to make sensible commissioning decisions, however, so Waverley PBC may decide to group with the Farnham PBC cluster and/or the Guildford PBC cluster. However, the Farnham PBC cluster may more logically look towards a consortium including Farnborough and Aldershot GP practices, which raises issues about how local democratic oversight is achieved where consortia cross local authority boundaries, and where services are needed or provided over a wider area.

    *Binscombe Medical Centre; Chiddingfold Surgery; Cranleigh Medical Practice; Grayshott Surgery; Haslemere Health Centre; Hurst Farm Surgery; The Mill Medical Practice; Springfield Surgery; Witley & Milford Medical Centre; Wonersh Surgery .

31. It is unclear how either the NHS Commissioning Board or GP consortia will derive their democratic legitimacy. The Coalition Agreement had proposed directly-elected members to sit on PCT Boards, but now PCTs are to be abolished and GP consortia will have a duty to work in partnership with their local authority. However, there is no requirement for GP consortia to include any elected members on their boards – or, indeed representatives of any other healthcare services, such as nurses – and some commentators expect this to be challenged in the Health Bill. The danger of prescribing a widely representative membership for GP consortia boards is that the result recreates a PCT in all but name.

32. Local authorities are to be given an enhanced role in health, in particular over the following areas:

    - **Leading joint strategic needs assessment (JSNA) to ensure coherent and co-ordinated commissioning strategies** - production of a JSNA has been a statutory duty of PCTs and (upper tier) local authorities since 2007. With the abolition of the PCTs, the responsibility falls entirely to the local authority. The JSNA will inform commissioning decisions of GP consortia and the NHS Commissioning Board, and promote joint commissioning between GP consortia and local authorities.

    - **Supporting local people and exercise of patient choice through arrangements for local HealthWatch** - which is envisaged as being a 'citizen's advice bureau' for health and social care, including responsibilities for NHS

complaints advocacy services and supporting individuals in exercising choice in healthcare (e.g. choosing a GP practice).

- **Promoting joined up commissioning of local NHS services, social care and health improvement** - the new arrangements are intended to promote and support joint commissioning and pooled budgets. GP consortia will have a duty to work in partnership with the wider NHS and social care to deliver higher quality care, a better patient experience and more efficient use of NHS resources.

  The Government is minded to complement this by establishing a statutory role in each upper tier local authority to support joint working on health and wellbeing. Local Health & Wellbeing Boards are envisaged, to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The Health & Wellbeing Board would take on the statutory scrutiny role in relation to major service redesign that is currently exercised by Health Overview & Scrutiny Committees. Local authorities would still need to have suitable scrutiny arrangements for the Health & Wellbeing Boards, and for health improvement policy.

  Health & Wellbeing Boards are expected to sit at upper tier local authority level. In the only reference to two-tier areas in the White Paper, it is acknowledged that Boards might want to delegate the lead for some functions to districts (or neighbourhoods) to ensure that they are discharged at the right level in relation to the needs of diverse areas, and that democratic representatives below the upper tier can contribute.

  Membership of the Health & Wellbeing Board is envisaged as including local elected representatives; local authority directors for social care, public health and children's services; NHS commissioners (GP consortia and NHS Commissioning Board); HealthWatch representatives; voluntary sector representatives; and other public service officials as considered relevant.

- **Leading on local health improvement and prevention activity** - responsibility and funding for local health improvement will transfer to local authorities from PCTs. Local authority leadership for public health improvement will be complemented by the creation of a National Public Health Service (PHS). Local Directors of Public Health will be appointed jointly between local authorities and the PHS. They will have a ring-fenced health improvement budget allocated by the PHS to be used to deliver local and national priorities, reporting to both the local authority and the Secretary of State through the PHS.

Cutting bureaucracy and improving efficiency

33. The Government are proposing that the NHS should realise up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes. They propose to reduce NHS management costs by more than 45% over the next four years, freeing up further resources for front-line care. They also propose to 'delayer' and simplify the number of NHS bodies and radically reduce the DH's own NHS functions.

34. The principal ways identified for cutting bureaucracy are:

- PCTs and Practice Based Commissioners to be replaced by GP consortia.
- Strategic Health Authorities to be abolished.

- Reduction in DH's NHS functions.
- Review of Arm's Length Bodies; abolition of organisations that do not need to exist; streamline functions that need to continue and tight control over costs and scope of continuing arm's length bodies.
- Cull of data returns.
- Simplification of bureaucracy of medical research.
- Reduction in central budgets for consultancy services and advertising.

35. Improvements in efficiency are expected to be achieved through reducing bureaucracy, and changes to expand patient choice, payment incentives, partnership working, implementation of best practice, etc.

36. While some of these actions may well save money and improve efficiency, it is hard to believe that significant numbers of PCT staff will not end up working in or for GP consortia in commissioning, procurement and contract management functions. Similarly, the SHA has been given the responsibility of implementing the necessary changes in commissioning over the next 2-3 years. It will be for the NHS Commissioning Board to decide what presence, if any, it needs regionally, but given the range of responsibilities it will have, there is a danger that as SHAs are statutorily abolished they become the local offices of the statutorily commissioned NHS Commissioning Board. The proposed 45% cut in NHS management costs seems optimistic.

Implementation and Timetable

37. Many of the changes proposed in the White Paper require primary legislation. The Health Bill will be introduced to Parliament in the autumn. The majority of reforms are planned to come into effect in April 2012 such as the Health and Wellbeing Boards, the NHS Commissioning Board, Public Health Service with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities and Health Watch. The Strategic Health Authorities will be abolished in 2012/13 and the PCTs will go from April 2013.

38. The Chief Executive of the NHS has already written to all NHS Chief Executives setting out how SHAs will lead the change process (including their own abolition) regionally. SHAs have been advised to engage local authority colleagues in the transition, and one of the principles of the implementation process is co-production – implementation must be designed and decided in partnership with the NHS, Local Authorities and key stakeholders.

Conclusions

39. Whilst there is a strong emphasis on partnership working with local authorities to provide local democratic accountability in the provision of health services, this appears to be a role designated for upper tier (county/unitary) local authorities. As currently set out, the scope for participation by districts and boroughs in this process appears to be limited and at the discretion of the upper tier Health & Wellbeing Boards.

40. The Government do recognise however the 'convening' role of local government to integrate health with adult social care, children's services and wider services including disability services, housing and tackling crime and disorder. They also give a commitment to work with the Local Government Association to understand the potential benefits of place-based budgets through the Spending Review period. They will look at the potential application of these approaches to cross-cutting areas

of health spending that require effective partnerships with local authorities and other frontline organisations, for example older people's services.

41. However, it is important that a case is made, through consultation responses and other channels, for Borough and District elected members to have an appropriate level of representation in partnership arrangements, relative to the configuration of GP consortia within the county, or they will continue to be effectively excluded from discussions and decisions about commissioning and delivery of healthcare services and public health improvements. One of the consultation questions asks *"Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?"* Is it more likely to secure involvement of all bodies, including Waverley if it was statutory?

42. The areas of involvement at Waverley with the health service are various, from housing and disabled adaptations to elderly services and from leisure provision to environmental health. The experience of many people trying to keep an elderly parent or relative in their own home is often a complicated and frustrating one having to deal with a complicated set of agencies including their GP, Adult Social Care, Waverley, if disabled adaptations are necessary and perhaps Careline services. This is an area which could be improved by more effective integrated services.

43. Unlike some other Surrey districts Waverley is still a provider of social housing including provision of housing for the elderly, those with mental health issues and other disabilities. A previous white paper in 2006 on community services recognised the contribution housing makes to people's well-being. It also identified a need for a continued shift towards prevention and improved lifestyles. From a commissioning point of view it will be important to have a link with Health & Wellbeing Boards to ensure the right amount of specialist housing is provided. Likewise for Day Centre services. The implications for other services may be clearer when the Public Health Service paper is published.

44 There is clearly a stated enhanced role for local authorities in public health which is welcome, with direct responsibility and funding (allocated to local Directors of Public Health) for improving the health of local communities, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity. Waverley's community development work has an important role to play in this area.

45 Waverley is predominantly rural and with that comes its own particular challenges especially in terms of the least well-off, the disadvantaged and the most vulnerable. Transportation issues are a major issue in terms of access to health and health improvement and will need to be considered as a strategic issue by the Health and Wellbeing Board.

Recommendation

It is recommended that the Executive:

1. notes the report and agrees the responses to the consultation attached at Annexe 1.
2. engages with local GP consortia in the Borough to identify areas of common interest in meeting the wider needs of the community.

Background Papers

White Paper - Equity and Excellence: Liberating the NHS (Dept of Health, July 2010)
Liberating the NHS: Commissioning for Patients (Dept of Health, July 2010)
Liberating the NHS: Transforming Outcomes (Dept of Health, July 2010)
Liberating the NHS: Local Democratic Legitimacy in Healthcare (Dept of Health, July 2010)
Liberating the NHS: Review of Arm's Length Bodies (Dept of Health, July 2010)

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