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AGENDA ITEM: 5

HEALTH SCRUTINY PANEL

9 SEPTEMBER 2010

RESPONDING TO THE WHITE PAPER
EQUITY & EXCELLENCE: LIBERATING THE NHS

PURPOSE OF THE REPORT

1. To formally make the Health Scrutiny Panel aware of the publication of a new White Paper, pertaining to the NHS' structure and operation, entitled *Equity & Excellence: Liberating the NHS*.

2. To seek the views of the Health Scrutiny Panel as to whether it would like to submit a formal response to the consultation being handled by the Department of Health.

RECOMMENDATIONS

3. That the Health Scrutiny Panel notes the information presented.

4. That the Health Scrutiny Panel considers whether it would like to formulate and submit a formal response to the consultation, as a Panel.

CONSIDERATION OF REPORT

5. As the Health Scrutiny Panel will be aware, the Department of Health published a White Paper on 12 July 2010, pertaining to the NHS structure and operation, which sets out HM Government's policy proposals for the NHS. Hereafter, the White Paper entitled *Equity & Excellence: Liberating the NHS*, will be referred to as the 'White Paper'.

6. The White Paper is a comprehensive document and sets out, in detail, proposals relating to the NHS' structure and operation. It is not intended to set out the full detail of the White Paper in this briefing report, although this covering report will pick out the major aspects of the White Paper, which Members may wish to consider. A copy of the White Paper is attached (at Appendix 1) for the Panel's attention.

7. The White Paper was published on 12 July 2010 and is the principal document outlining the Government's intentions, subject to parliamentary approval, for significant reforms to the NHS. It is, in turn, supported by set of documents, which are intended to provide more detail over key areas of NHS operation. Those documents are entitled *Regulating healthcare providers*, *Commissioning for Patients*, *Increasing Democratic Legitimacy in Health*, *Transparency in Outcomes – a framework for the NHS*. Of the supporting documents, *Increasing Democratic legitimacy in health* is the most relevant to the work of local authorities, elected members and specifically the work of Health Overview & Scrutiny Committees, including this Panel.

8. There is a section later in this report outlining the major aspects of *Increasing Democratic legitimacy in health*, although it is prudent to first consider the primary document, namely the White Paper.

Equity & Excellence: Liberating the NHS

9. The Panel will be aware that the White Paper has attracted a significant amount of publicity since its publication on 12 July 2010. For the benefit of the Panel, the following paragraphs attempt to pick out the key points for Members to be aware of. A full copy of the White Paper is appended to this covering report, at Appendix 1.

10. Arguably the most significant aspect of White Paper is the creation of GP Consortia, which will become the principal commissioning apparatus of the local NHS. The White Paper does not specify the precise nature of a GP Consortium, nor does it contain any detail about the likely geographical size or optimum number of practices. GP Consortia will receive a place-based budget, set by the National Commissioning Board, to which GP Consortia will be answerable. Set out below is a list, taken directly from page 28 of the White Paper, of the intended functions of GP Consortia:

The role of GP commissioning consortia

- *We envisage putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.*

- *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 be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. 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.*

- *The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and*

may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.

- *GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.*

- *A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. We envisage that the NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia, and we envisage a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary.*

- *GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.*

- *GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.*

- *GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.*

- *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.*

- *We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.*

- *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.

- *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. Through its local infrastructure, HealthWatch will provide evidence about local communities and their needs and aspirations.*

11. GP Consortia will, therefore, take over the vast majority of functions currently carried out by Primary Care Trusts (PCTs), with PCTs' remaining responsibilities regarding public health being transferred to local authorities. As such, the White Paper outlines the Government's intention to abolish PCTs, by the end of March 2013. In addition to PCTs, the White Paper also outlines the Government's intention to abolish Strategic Health Authorities (SHAs). Depending on consultation outcome and parliamentary processes, the Government's indicative timetable is laid out below(this can be found at page 30 of the White Paper) :

- *a comprehensive system of GP consortia in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs;*
- *following passage of the Health Bill, consortia to take on responsibility for commissioning in 2012/13;*
- *the NHS Commissioning Board to make allocations for 2013/14 directly to GP consortia in late 2012; and*
- *GP consortia to take full financial responsibility from April 2013*

12. Despite their approaching abolition, the White Paper is clear that PCTs and SHAs will be expected to play a full role in the transitional arrangements, ensuring that GP Consortia are in a position to take up their envisaged role. The precise nature of that support and the role to be played in the transitional period will require more work. It may be a topic that the Panel would like to become involved in considering.

13. As mentioned above, GP Consortia will become the principal commissioners of services for any given locality, although some services will be commissioning at a regional or national level, by the NHS Commissioning Board. The NHS Commissioning Board will set place-based budgets for GP Consortia and hold GP Consortia to account for their impact. The following is the role of the NHS Commissioning Board, as envisaged by the White Paper (this can be found on page 31 and 32 of the White Paper):

The role of the NHS Commissioning Board

The Board will have five main functions:

1. Providing national leadership on commissioning for quality improvement:

- *setting commissioning guidelines on the basis of clinically approved quality standards developed with the advice of NICE in a way that promotes joint working across health, public health and social care;*
- *designing model contracts for local commissioners to adapt and use with providers;*
- *designing the structure of tariff and other financial incentives, whilst Monitor will set tariff levels;*
- *hosting some clinical commissioning networks, for example for rarer cancers and transplant services, to pool specialist expertise;*
- *setting standards for the quality of NHS commissioning and procurement;*
- *making available accessible information on commissioner performance; and*
- *tackling inequalities in outcomes of healthcare.*

2. Promoting and extending public and patient involvement and choice:

- *championing greater involvement of patients and carers in decision-making and managing their own care, working with commissioners and local authorities;*
- *promoting personalisation and extending patient choice of what, where and who, including personal health budgets; and*
- *commissioning information requirements for choice and for accountability, including through patient-reported measures.*

3. Ensuring the development of GP commissioning consortia:

- *supporting and developing the establishment and maintenance of an effective and comprehensive system of GP consortia; and*
- *holding consortia to account for delivering outcomes and financial performance.*

4. Commissioning certain services *that cannot solely be commissioned by consortia, in accordance with Secretary of State designation, including:*

- *GP, dentistry, community pharmacy and primary ophthalmic services;*
- *national specialised services and regional specialised services set out in the Specialised Services National Definitions Set; and*
- *maternity services.*

5. Allocating and accounting for NHS resources:

- *allocating NHS revenue resources to GP consortia on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability;*
- *managing an overall NHS commissioner revenue limit, for which it will be accountable to the Department of Health; and*
- *promoting productivity through better commissioning.*
- *The Board would not have the power to restrict the scope of the services offered by the NHS.*

14. The National Commissioning Board's mandate would come from the Secretary of State for Health.

15. The White Paper has significant implications for local government. Local Authorities will inherit the public health responsibility from Primary Care Trusts, including the receipt of a dedicated public health budget and jointly appointing a Director of Public Health with a newly formed national Public Health Service. Arguably the most significant proposal of the White Paper for local government, however, is the suggested creation of a Local Health & Wellbeing Board (LHWB). The precise function of the LHWB has not been confirmed as yet, although so far the White Paper envisages a scenario where the LHWB takes on a co-ordinating and integrating role, ensuring that health and social care services become more integrated. It is also suggested that the LHWB will be able to endorse or reject GP Consortia's Commissioning Strategy, with the National Commissioning Board serving to resolve such disputes in the final act.

16. The White Paper provides a list of anticipated local government functions as outlined below, (which can be found on page 35 of the White Paper)

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- *Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;*

- *Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and*

- *Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.*

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

17. As is touched upon above, it is also proposed that the LHWB would take on the statutory responsibility to address statutory consultations major reconfigurations or service design.

18. Another significant development relating to local authorities is the creation of *HealthWatch,* which is described as evolving from LINks and developing its role to become a local healthcare watchdog and 'consumer champion'.

Local Democratic Legitimacy in health

19. In the subsequently published *local democratic legitimacy in health*, *Healthwatch's* responsibilities are outlined in much further detail, with a series of questions seeking responses. This document is appended to this report at appendix 2. *Local Democratic legitimacy in health* describes Healthwatch as a:

"powerful new consumer champion, commissioned by local authorities, but located within the Care Quality Commission"[1].

20. It is described as a function that Local Involvement Networks will 'evolve' into[2], although in reality, Healthwatch will have more powers and more areas of responsibility than LINks currently have and are intended to become a kind of 'citizens advice bureau' for health, providing a "sign-posting function". As such, Healthwatch represents a development and advancement on what LINks currently offer. It is also proposed that LINks will receive additional support and additional funding for[3]:

- *NHS complaints advocacy services. Currently, this is a national function for the NHS, exercised through a Department of Health contract for the Independent Complaints Advocacy Service. We propose that this responsibility is devolved to local authorities to commission through local or national HealthWatch, so that they can support people who want to make a complaint.*

- *Supporting individuals to exercise choice, for example helping them choose a GP practice. Giving patients and users the right to choice, and greater information, is essential, but it is not always sufficient to enable everyone to exercise it. Local Health Watch will have a key role in offering support to those that need it.*

21. The document goes on to say that local authorities will have an enhanced role in addressing the health needs of their populace and the planning of health services. *Local Democratic Legitimacy in Health* outlines (on page 3) four areas of greater influence for local authorities in relation to health as:

- *leading joint strategic needs assessments (JSNA)[1] 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*

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[1] Please see paragraph 9, on page 2.
[2] See paragraph 15, page 4.
[3] See paragraph 17, page 4.

- *leading on local health improvement and prevention activity.*

22. *Local Democratic Legitimacy in Health* describes how local authorities will be expected to take on a convening role, which will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing and tackling crime and disorder.

23. *Local Democratic Legitimacy in Health* also discusses the precise nature of the local authority's role in the planning and provision of local health services and the level of current integration that currently exists. It describes how, in the view of the Government, the full potential of joint commissioning and partnership working (between the NHS and local government) remains untapped. It expresses the view that there is scope for stronger institutional arrangements, within local authorities, led by elected members, to support partnership working across health and social care, and public health. It also states how "local authorities' skill, experience and existing relationships present them with an opportunity to bring together new players in the health system, as well as to provide greater local democratic legitimacy in health"[4]

24. The Paper describes how one option is to leave it up to NHS Commissioners and local authorities as to whether they want to work together and should they so wish to devise their own local arrangements. The Government prefers the option of specifying the establishment of a statutory role, to support joint working on health and wellbeing.

25. Local Democratic Legitimacy in health also contains more details around the nature and function of the proposed local health & wellbeing boards. It describes how the "primary aim of the health & wellbeing boards would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability". Local Health & Wellbeing Boards are also envisaged to have a "lead role in determining the strategy and allocation of any local application of place based budgets for health". It is proposed that such boards would have four main functions[5]:

- *to assess the needs of the local population and lead the statutory joint strategic needs assessment;*

- *to promote integration and partnership across areas, including through 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; and*

- *to undertake a scrutiny role in relation to major service redesign*

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[4] Please see paragraph 24, page 7.
[5] Please see paragraph 30, page 8.

26. As is mentioned above, it is proposed that the local health and wellbeing board will adopt a scrutiny role, when it is necessary to consider service reconfigurations or substantial variations. This would mean a transfer of Health Scrutiny's powers regarding statutory consultations, to the LHWB. The LHWB would also inherit the current statutory power of referral regarding disputed reconfigurations. The document outlines a continuing, if different, role for Overview & Scrutiny in considering the impact and actions of the local health and wellbeing board.

27. Relating to the scrutiny of service reconfigurations, the Department of Health also published a letter and guidance on service reconfiguration on 29 July 2010[6] (Appendix 3). It describes four important principles to be satisfied when considering a service reconfiguration. Those four principles are:

- *support from GP commissioners;*
- *strengthened public and patient engagement;*
- *clarity on the clinical evidence base; and*
- *consistency with current and prospective patient choice*

28. The letter also makes reference to the fact that current guidance and legislation pertaining to Overview & Scrutiny's involvement in reconfigurations will remain in force and the powers of Overview & Scrutiny in that regard remain intact. At this stage, it is not clear from the documentation as to whether this is an interim step until local health and wellbeing boards are established, or whether this represents a more permanent re-stating of the role of Overview & Scrutiny in considering reconfigurations. It would be prudent to keep this matter under review as the situation develops.

Responding to the Consultation

29. Despite its status as a White Paper, *Equity & Excellence: Liberating the NHS,* is open to consultation and comments invited, to be received by 5 October 2010. *Local democratic legitimacy in health* has a deadline for comments of 11 October 2010.

30. The Panel is asked to note the contents of this briefing paper and specifically, to consider whether it wishes to submit a response to the consultation process for *Equity & Excellence: Liberating the NHS* and/or *Local Democratic legitimacy in health*.

31. It may be that the Panel wishes to submit a response, constructed around the questions in the consultation document. Alternatively, it may be that the Panel may wish to submit a 'freehand' response to the documents, concentrating on making comment on the areas of priority for the Panel.

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[6] Please see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf

32. The Panel is asked to discuss the documents appended and consider whether it would like to make a formal response and if so, the nature of that response. Following a discussion by the Panel, support officers will prepare a draft response based on those discussions and the instructions received from the Panel. That draft response will then be presented to the Panel for comment, amendment and approval, which will then be sent to the consultation responses addresses, in time to meet the deadline.

33. In addition to submitting responses to the consultation, the Panel is asked to note the significant changes to the local NHS' planning and operation that are contained within the White Paper and its supporting documents. It is clear that General Practice will have a central role in the commissioning of services and that the relationship between local government and General Practice will be crucial. It may be that the Panel wishes to start establishing links with General Practice, seeking to understand how the new role is envisaged and how PCTs are playing their role in the 'transition phase'. This could be a theme of work for the rest of the 2010/11 municipal year and beyond, although this is ultimately a decision for the Panel. Nonetheless, it would be prudent for the Panel to ensure that the White Paper and its ramifications, is an important element in its thinking for the foreseeable future.

BACKGROUND PAPERS

Appendix 1 – *Equity & Excellence: Liberating the NHS*, © Department of Health, published 12 July 2010.
Appendix 2 – Liberating the NHS: Local Democratic Legitimacy in Health © Department of Health, published 22 July 2010.
Appendix 3 – Dear Colleague Letter – Service reconfiguration, Gateway Reference number: 14543, dated 29 July 2010.

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