Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM:

HEALTH SCRUTINY PANEL

4 OCTOBER 2010

EQUITY & EXCELLENCE – LIBERATING THE NHS CONSIDERATION OF THE HEALTH SCRUTINY PANEL'S FINAL RESPONSE

PURPOSE OF THE REPORT

1. To present a DRAFT Response to the NHS White Paper, for the Panel to consider, amend where appropriate and endorse for submission to the Department of Health.

RECOMMENDATIONS

2. That the Health Scrutiny Panel considers the DRAFT Response to the White Paper, makes amendments where desired and ultimately endorses the response, for submission to the consultation process.

CONSIDERATION OF REPORT

3. The Panel will recall that at a meeting on 9 September 2010, consideration was given to the recently published *Equity & Excellence – Liberating the NHS* and the supporting documents. The Panel expressed a strong interest in submitting a formal response to the consultation process and expressed some clear views for inclusion in the response.

4. As such, the following DRAFT response has been prepared, for consideration by the Health Scrutiny Panel. In consultation with the Chair, all Councillors have been invited to attend the meeting today and contribute to the debate, which will assist the Panel in considering its final response.

5. Following the debate at the meeting today and any amendments felt necessary, the DRAFT response will be submitted to the Department of Health's consultation process. The Draft Response is at Appendix 1, for the Panel's attention.

BACKGROUND PAPERS

6. Please see DRAFT Consultation Response – marked as Appendix 1.

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Appendix 1

Equity & Excellence – Liberating the NHS
Draft response to the White Paper and supporting documents

Dear Secretary of State

1. The purpose of this letter is to submit the Middlesbrough Council Health Scrutiny Panel's response to the current consultation on the recently published White Paper *Equity & Excellence – Liberating the NHS* and its supporting documents.

2. In the view of the Panel, the White Paper contains some positive developments and The Panel welcomes the commitment to the core principle of the NHS - available to all, free at the point of use - based on need and not ability to pay. Some developments, however, provide cause for concern.

3. The Panel would like to express concerns over the notion of General Practice having ultimate control over local commissioning budgets and question the current level of expertise within the General Practice community, to effectively identify need and commission services.

4. Accepting, however, that General Practice will take a central role in commissioning in the near future, the Panel would emphasise the need for GP Consortia to have full access to all relevant management support to assist in those decisions. The management allowance needs to take account of this need. The Panel also feels that General Practice will be required to enhance its skills and knowledge of wider parts of the NHS, that it has not had a great deal of exposure too. This is especially the case given that GP Consortia will soon be making commissioning decisions on such matters. The Panel would have particular concerns regarding mental health and the use of non-clinical interventions e.g. talking therapies and debt advice. It is absolutely crucial that GP Consortia are sufficiently aware of other options to clinical interventions, where appropriate.

5. Further, it is crucial that 'rank and file' GPs feel sufficiently empowered to raise service gaps if they feel they exist. It is the Panel's hope that when such concerns are raised, the Consortia would recognise that it is their clear responsibility to look at commissioning additional services, if the evidence is supportive and not to simply continue 'as was'. By way of example, the Panel has identified through its work, clear opportunities to improve earlier diagnosis for cancers and end-of-life care. Those opportunities will only be taken if GPs are able to understand the needs of their patients and be prepared to develop whole services and not just clinical responses. The Panel has considerable experience to indicate General Practice has not always been able to grasp that non-clinical work can be as crucial as purely clinical interventions. The Panel would also point to good examples from our own Social Care Dept of areas of service such as support for Carers and Respite Care. By no means is Carers Support a purely clinical intervention, although it performs a crucial role. Without understanding the whole person and their domestic environment, GP Commissioning will only ever be a partial solution.

6. The Panel would point out that Commissioning is also about stimulating activity and there is the opportunity to use commissioning to develop local service provision. The Panel has had some experience of this in the field of Patient Transport, where the development of a community transport scheme can save money, develop community capacity and help people back into work. Still, it requires some developmental work on behalf of the Commissioners as the ideal service isn't always immediately ready to become operational.

7. If there is an exaggerated medical perspective these can be overlooked so there is a need within consortia to have different perspective, that includes patients and the third sector.

8. The Panel is pleased to see the increased role for local government in the promotion of public health and the delivery of public health services, although clarity is required as to the level of resources available for local government to take up this work. The Panel also welcomes the increased involvement of local government in the co-ordination of health and social care services and the stronger involvement in setting of strategy.

9. The Panel does, however, express a strong concern over the scrutiny role envisaged for the Local Health & Wellbeing Board. The Panel is of the view that it is not acceptable that the Health & Wellbeing Board will be involved in setting local health strategy and then become involved in the scrutiny of proposals, when reconfiguration plans occur, which are a direct result of that health strategy. In this sense, the Panel feels that it would be better that a degree of separation remains and a previously uninvolved party, such as a Scrutiny Panel, considers reconfiguration plans.

10. As the White Paper and supporting documents suggest, a scrutiny power should remain to ensure adequate oversight of the activities and conduct of the Local Health & Wellbeing Board. The Health Scrutiny function in Middlesbrough has been very successful in influencing service developments both independently and along with our neighbours in a Joint Scrutiny Committee context. A very recent example of this is the securing of additional General Practice provision in an area, which it became clear to the Panel, was significantly 'under-doctored'. It is precisely the role of Scrutiny Panels as previously uninvolved, elected local representatives which allows proposals to benefit from scrutiny, as a 'fresh set of eyes'. When relying upon evidence, Overview & Scrutiny's consideration of reconfiguration proposals is of great benefit to the local population. The Panel does not feel that it is beneficial for public services that the architects of a strategy 'scrutinise' the implications of the strategy, as is proposed in the White Paper. The Panel would ask how likely a Health & Wellbeing Board would be to critically appraise its own thinking.

11. The Panel understands that the transfer of Public Health duties to local authorities will involve taking on responsibility for clinical functions currently delivered by the Health Protection Agency, operations such as immunisation programmes and infection outbreak control. The Panel is concerned whether

Local Authorities currently have the expertise to deliver them. The Panel would welcome more information about the resource and precise nature of public health functions that would come to local authorities, as a matter of some urgency, to enable local authorities to plan.

12. On the topic of Healthwatch, the Panel has expressed concern that Local Involvement Networks (LINks) do not currently have the capacity to deliver the services and functions envisaged of Healthwatch. As such, a great deal of capacity building would be required to deliver on the Healthwatch ambition. The Panel would be keen to hear more detail as to how the Department of Health envisages delivering that capacity and expertise. The Panel does not feel it is accurate to suggest that LINks can essentially evolve into Healthwatch. Healthwatch, as envisaged, is a much more comprehensive function and will probably require a re-tendering exercise to ensure that adequate support functions can be commissioned. In addition, the funding for LINks ends in March 2011, yet Healthwatch is not envisaged to be 'up and running' until 2012. As such, there is a year without funding, which the Panel would question how central government expects LINk activity to be maintained.

13. Accepting that GP Commissioning will become a fundamental aspect, the Panel would express a strong interest in hearing much more detail around how GP Commissioning Consortia will be put together and the intended size and structure of Consortia. The Panel feels that Consortia with a clear link to local authority boundaries would be the best option, whether that would be co-terminous with individual local authorities or covering more than one. This would also assist in making the Joint Strategic Needs Assessment easier to prepare and work towards. The Panel feels that there should be an ability for an organic coming together of LAs and Consortia to jointly commission, where it makes sense to do so. Further, the Panel would like to hear how GP Commissioning Consortia will be accountable to the community they serve, as well as being answerable to the NHS Commissioning Board in Whitehall.

14. The Panel would also like further detail around the question as to how firm General Practice's duty to co-operate with partners would be and what exactly would happen if there were a disagreement between a local authority and a Consortium.

15. The Panel is also unclear as to what will happen to assets, such as buildings, which are currently owned by PCTs. When PCTs are abolished, those buildings should remain either in public use, or should they be sold, capital receipts should benefit local health services. Some clarification on this point would be welcome.

16. The Panel notes that there is significant coverage in the White Paper and supporting documents about provider development and building on the 'any willing provider' concept. The Panel would counsel against an unqualified adoption of the concept and would point to possible unintended consequences. The Panel is well aware that in the acute sector, cross subsidising of services take place, where 'profit yielding' areas of service

support other areas where a Trust may ‘make a loss’. If commissioners apply an all too simplistic interpretation of ‘competition by price’, the Panel would suggest that new entrants would may enter the market and ‘cherry pick’ their preferred areas of service provision, without the large overheads of a tertiary centre. It is a matter of great concern to the Panel that a diffusion of service providers, selected purely on cost basis, would pose huge risks to the viability of acute centres.

17. The Panel would like the Department of Health to outline how exactly, it expects GP Consortia to advance work to reduce health inequalities in their communities.

18. Finally, the Panel would like to highlight that Wanless and others have shown that NHS inflation is higher than the general rate and that demographic change, new drugs and technologies also drive costs within the NHS. The Panel is concerned that the plans to deliver savings of £15 - £20bn, with expectations of 5% pa efficiency savings within trusts, do not take sufficient note of the coming pressures on the health care system. NHS funding that matches inflation will deliver funding well below the historical trend. The share of GDP spent on Health will fall back well below the average in Europe.