Middlesbrough moving forward

Legal and Governance

HEALTH SCRUTINY PANEL

Date:	**Tuesday 23rd March, 2021**
Time:	**4.00 pm**
Venue:	**Virtual meeting**

AGENDA

Please note: this is a virtual meeting.

The meeting will be live-streamed via the Council's Youtube channel at 4.00 pm on Tuesday 23rd March, 2021

1. Apologies for Absence

   Apologies for Absence

2. Declarations of Interest

   To receive any declarations of interest.

3. Minutes - Health Scrutiny Panel - 19 January 2021 — 3 - 6

4. The scrutiny perspective on the Government's health and care White Paper — 7 - 18

5. Health for Wealth - Executive Summary — 19 - 26

   The panel is requested to consider the findings of the Northern Health Science Alliance's report 'Health for Wealth' when establishing its terms of reference for its current review on this topic.

6. Regional Health Scrutiny Update

   The panel is requested to consider an update on the work

recently undertaken by the following regional Joint Health Scrutiny Committee:-

Tees Valley Joint Health Scrutiny Committee – 19 March 2021

7. Chair's OSB Update

The Chair will present a verbal update on the matters that were considered at the meeting of the Overview and Scrutiny Board held on 11 March 2021.

8. Any other urgent items which in the opinion of the Chair, may be considered

9. Date & Time of Next Meeting - Tuesday, 20 April 2021 at 4pm.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Monday 15 March 2021

MEMBERSHIP

Councillors J McTigue (Chair), D Coupe (Vice-Chair), B Cooper, A Hellaoui, B Hubbard, T Mawston, D Rooney, M Storey and P Storey

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Caroline Breheny, 01642 729752, caroline_breheny@middlesbrough.gov.uk

HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on Tuesday 19 January 2021.

PRESENT: Councillors J McTigue (Chair), D Coupe (Vice-Chair), B Cooper, A Hellaoui, B Hubbard, T Mawston, D Rooney and M Storey

ALSO IN ATTENDANCE: C Blair (Director Of Commissioning Strategy and Delivery) (TVCCG) and J Walker (Medical Director) (TVCCG)

OFFICERS: M Adams, C Breheny, J Bowden and L Jones

APOLOGIES FOR ABSENCE: Councillors P Storey

20/2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

20/3 **MINUTES - HEALTH SCRUTINY PANEL - 10 NOVEMBER 2020**

The minutes of the Health Scrutiny Panel meeting held on 10 November 2020 were submitted and approved as a correct record.

20/4 **COVID-19 UPDATE**

The Chair advised that as usual an update on COVID-19 was listed as the first main item on today's agenda and a number of guests were attendance for this item. Guests included the Director of Public Heath (South Tees), the Director of Commissioning, Strategy and Delivery (TVCCG) and the Medical Director (TVCCG).

The Director of Public Health advised that Middlesbrough's rolling 7 day rate (9 – 15 January 2021) was 453 per 100,000 population, which was a 21.5 per cent reduction on the previous rolling 7 day rate (2 – 8 January 2021) of 604 per 100,000. The most worrying slide was the NHS data, which detailed the number of COVID patients currently in hospital in South Tees. The number had doubled in the previous two weeks and there were currently 220 inpatients with COVID at the moment. The panel was advised that at present the Director of Public Health did not have any up to date figures on the vaccination, although he understood that over half of the over 80's in Middlesbrough had been vaccinated.

A number of queries were raised and the following points were made:-

- There were concerns that the COVID rates were again increasing and what potential impact this may have on hospital numbers. South Tees NHS Foundation Trust were rapidly approaching 50 per cent occupancy of COVID patients.
- It was not felt that the return of children to school was a contributory factor in the increase in the number of cases.
- By 24 January 2021 all Care Home staff and residents should have received their COVID vaccine. Over 2,500 staff had received their vaccinations to date.
- Local pharmacies were not currently delivering the vaccine but excellent progress was being made in respect of vaccinating the priority groups.
- All priority groups were being contacted by their GPs and confirmation would be sought that braille correspondence was being used where necessary.
- Positive comments were reported in respect of the way in which GP's had carried out the flu vaccine this year and it was acknowledged that the take up rate had been fantastic.

COVID Oximetry @ Home

The Medical Director at TVCCG advised that agreement had been reached between health

and social care partners to contribute additional funding to the programme. In terms of the virtual ward the provision was focused on two cohorts namely those over 65 that had been in hospital or diagnosed with COVID and those under 65 that had a COVID diagnosis and were clinically vulnerable. At the moment the virtual ward could manage up to 120 patients at any one time. There were 108 patients on the ward. Alongside the Oximetry @ Home service there was also an oximetry ward at James Cook University Hospital and 68 patients were currently being managed through that service, together both of these services were helping to keep people at home.

A number of queries were raised and the following points were made:-

- In terms of any progress on national spray versions of the vaccines further information would be sought. Currently from a local NHS perspective TVCCG was delivering the vaccine in its current format.
- It was anticipated that South Tees NHS Foundation Trust would reach surge capacity later that week and if pressures became too intense there may be a need to stand down certain services. A national agreement had been reached that independent hospitals could be used for priority surgeries and TVCCG was working closely with Ramsey and the Nuffield. However, it was important to note that often the same staff groups were being used and although independent hospitals provided additional physical capacity including theatre capacity it did not necessarily come with additional workforce.
- South Tees NHS Foundation Trust was managing the COVID surge, the winter surge and key pressures around critical care capacity by repurposing staff. However, the elected programme had been significantly scaled back. The majority of routine outpatient appointments and diagnostic appointments had been delivered virtually.
- Clarification was needed as to whether lunch was still being provided to staff at the Trust. Members expressed the view that this was least staff should be provided with to help ensure they were well cared for and supported.
- South Tees NHS Foundation Trust had not spent a significant amount of time harvesting blood plasma and therefore concerns raised recently regarding the efficacy of plasma therapy were not considered to be of real concern. However, a formal response from the relevant clinicians would be sought.
- Numerous innovations had been undertaken to ensure staff at the acute Trust were well supported including the provision of mental health support by TEWV. It was noted that the acute Trust was beginning to see some impact and sickness levels had increased to 6 to 7 per cent.
- It was acknowledged that COVID will be with us for a number of years and there was a need for routine treatments to continue to be provided. The vaccination of those in the priority categories would significantly reduce mortality, however by August / September more consideration would need to be given to what action would be needed to maintain the benefits of the vaccine i.e. how regularly would booster jabs be needed?
- From Easter / late spring the harm caused by COVID would diminish, although many of the other measures including the wearing of face masks, social distancing and use of hand sanitiser would continue.

AGREED that the information presented be noted.

20/5 **HEALTH & WEALTH - AN INTRODUCTION**

The Chair reminded Members then when agreeing the 2020/21 Health Scrutiny Panel's work programme, the main topic selected was inclusive growth – alignment of town centre regeneration and health goals**.** A number of representatives had therefore been invited to attend today's meeting to provide a setting the scene presentation in respect of this topic. The expert guests included the Director of Public Health (South Tees) and the Public Health Business and Programme Manager.

The Panel heard that since 2015, Middlesbrough had been identified as the most deprived area nationally (based on proportion of lower super-output areas within the 10% most deprived). The recent Marmot Review highlighted that previous increases in life expectancy in the area had worrying declined or stagnated in the last decade.

Indeed the previous year-on-year improvements in life expectancy observed in Middlesbrough between 2001-2003 and 2011- 2013 had mainly been driven by gains in the affluent wards across the town, with the deprived wards showing very small changes in life expectancy in the last 15 years.

It was explained that in the run-up to COVID-19, a national paradox between growth in employment and GDP, in the face of entrenched poverty, low quality jobs and poor income and living conditions, had cast a light on the unequal distribution of economic progress. Good health was not however just a product of a thriving economy, it was a necessary contributor to it. A recent LGA report highlighted the cost of poor health on the economy, presenting some of the annual costs experienced nationally as a result, this included:

- Over £100 billion a year in productivity lost due to poor health;
- £42 billion a year in workforce costs attached to mental health issues;
- c£4.8 billion a year costs of socio-economic inequality on the NHS; and
- £15 billion worth of sick days

COVID-19 would undoubtedly amplify the economic costs outlined above, with early findings from the crisis additionally pointing to the unequal distribution of the direct and indirect impacts of the virus across socioeconomic lines. Higher number of death from COVID-19 in people living in socioeconomically deprived areas had been observed from as early as May 2020, with some studies suggesting that people residing in poor areas were more than twice as likely to be killed by the virus as those in the richest areas.

In addition to the above, the control measures enforced to stem the virus have had broader implications on income and job security. The IFS has suggested that (excluding key workers) the majority of the people in the bottom tenth of earning distributions, correlate to sectors that have been shut down as a result of COVID. When those who are unlikely to work from home are included within this, it is estimated that job security of c80 per cent of low income earners, have been indirectly affected by the pandemic. As key determinants of health, these impacts were likely to have a significant influence on a person's ability to live a healthy live and would invariably translate to increased risk of premature mortality and morbidity that extended beyond the immediate risk of the virus.

The Public Health Business and Programme Manager advised that Councils and Combined Authorities have a significant role to play in developing inclusive economies. By embracing place-based approaches - that acknowledge the collective role of policy, services and communities in maximising the potential for shared prosperity and growth – shared economic development and public health approaches, can play a critical role in securing a fair and thriving borough.

Six high-level areas of prioritisation in promoting inclusive economies had emerged from the evolving evidence base, these have been outlined below and sit alongside a wider call for improved engagement between economic development functions and public health

- Building a thorough understanding of local issues, to affectively diagnose the challenges and levers to inclusive economic growth and to better understand the impact of growth policies across population groups (e.g. BAME communities);
- Having a long term vision and strong leadership, underpinned by a desire to design local economies that are good for people's health- including rebuilding economies in a way that takes stock of the lessons learnt from COVID-19;
- Building strong citizen engagement to inform priorities and strategies, in a way that builds community momentum and meets local aspirations;
- Capitalising on local assets and using local powers more actively – including

harnessing local government powers to shape economic conditions and capitalising on key assets such as, industrial sector, cultural heritage, natural environment and anchor institutions;
- Cultivating engagement between public health and economic development;
- Providing services that meet people's economic and health needs together.

It was advised that the imperatives outlined above for improved alignment between health and wealth provided a critical starting point for prioritising action at the local government level. It was recommended that the Health Scrutiny Panel consider the high-level actions outlined and incorporate these in their draft terms of reference for the review to ensure that the Council's ability to shape conditions for inclusive economies are fully harnessed and to identify ways in which improved alignment can be achieved between strategies to address health and economic development.

AGREED that the information presented be considered and incorporated as part of the Panel's review on this topic.

20/6 **DRAFT FINAL REPORT - OPIOID DEPENDENCY: WHAT HAPPENS NEXT?**

The Chair requested that this item be deferred and added to the next meeting of the Health Scrutiny Panel agenda given that some pertinent information in respect of this topic was due to be released later this week. An additional meeting would also be arranged in order for this information to be presented to the panel prior to Members considering the Final Report.

AGREED that the item be deferred and an additional Health Scrutiny Panel meeting arranged for 16 February 2021.

20/7 **OVERVIEW & SCRUTINY BOARD - AN UPDATE**

The Chair advised that on the 18 December 2020 the Overview and Scrutiny Board had considered two call-ins. The first had been in relation to the decision taken by the Executive on 24 November in respect of Nunthorpe Grange Farm: Disposal – Church Lane. After hearing evidence from all parties an issue was raised that required legal advice. The Board agreed for the meeting to be reconvened at a later date once the Monitoring Officer and Section 151 Officer had had the opportunity to provide that advice. The reconvened OSB meeting was scheduled to be held on 29 January 2021.

The second call in related to residual waste collections. Unfortunately owing to a technical issue the meeting could not be held. However, as the decision was subsequently reversed by the Executive there was no need for the meeting to be rescheduled.

On the 14 January 2021 the Overview and Scrutiny Board considered updates on the following:-

- The Executive Forward Work Programme;
- Middlesbrough Council's Response to COVID-19;
- An update from the Executive Member for Adult Social Care and Health;
- The Strategic Plan and Quarter Two Outturn Report;
- The Teeswide Safeguarding Adults Board Annual Report;
- All Scrutiny Chairs.

AGREED that the update be noted.

“Integration and innovation: working together to improve health and social care for all”

The scrutiny perspective on the Government’s health and care White Paper

Contact information: Ed Hammond, Deputy Chief Executive

Ed.hammond@cfgs.org.uk

Date: 19 February 2021

This is a paper primarily intended for local government scrutiny practitioners, to set out some of the principal components of the Health and Care White Paper, to highlight particular issues with respect to the health scrutiny function, and to set out how we suggest Government’s proposals be amended.

About Centre for Governance and Scrutiny

CfGS is a social purpose consultancy which social purpose consultancy and national centre of expertise. Our purpose is to help organisations achieve their outcomes through improved governance and scrutiny. CfGS exists to promote better governance and scrutiny, both in policy and in practice. We support local government, the public, corporate and voluntary sectors in ensuring transparency, accountability and greater involvement in their governance processes.

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1. Background to the White Paper

The last major restructure and reorganisation of the NHS in England (in 2013) involved the creation of clinical commissioning groups (CCGs) and a national service commissioning system overseen by NHS England. In respect of local accountability, the main change was the establishment of Local Healthwatch to replace Local Involvement Networks (LINks). In respect of overview and scrutiny functions, the law remained largely unchanged, although new Regulations were laid to consolidate and update existing powers. CfGS produced guidance on the operation of these powers in 2014. Since 2016/17 the NHS in England has been on a path towards increased integration and partnership working – between NHS bodies, and between NHS bodies and others, such as local councils.

This began with the establishment of "sustainability and transformation partnerships" (STPs), and has accelerated with the piloting of "integrated care systems" (ICSs). The development of this agenda has been guided by the NHS Long Term Plan[1].

ICSs are partnerships between a range of organisations that meet health and care needs to co-ordinate, plan and deliver services. ICSs and the integration agenda that they serve is based on a description of health and care activity happening at three levels within a locality[2]:

- System level. Covering a wide geographical area with populations circa 1 million to 3 million, in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale;
- Place level. Covering populations circa 250,000 to 500,000 people, and usually coterminous with a local authority area; places are served by a set of health and care provider connecting to services provided by councils, hospitals and voluntary organisations. This is the level at which CCGs currently sit and in the 2013 reforms were the focus of commissioning decision-making;
- Neighbourhood level. Covering populations circa 30,000 to 50,000, served by groups of GP practices (known as "primary care networks" or PCNs) working with community service providers.

The White Paper proposes to place ICSs on a statutory footing and to make a range of structural, and other changes, at place and neighbourhood level.

The White Paper is in part derived from reform ideas developed by and with NHS staff and other health and care professionals; it also draws on institutional learning from the health service's experience dealing with COVID-19.

[1] NHS England and NHS Improvement (2018), "NHS Long Term Plan": https://www.longtermplan.nhs.uk/online-version/overview-and-summary/

[2] NHS England and NHS Improvement (2019), "Designing integrated care systems (ICSs) in England": https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

2. Executive summary: main provisions on scrutiny and local accountability

Overall the White Paper envisages a further drawing up of power and accountability for health and care services to the Secretary of State.

Accountability systems at the local level are being reduced, and replaced by broad powers by the Secretary of State to take action and to directly intervene in local services. Significant power and responsibility will now rest at the system level – the level at which statutory integrated care systems (ICSs) will operate.

The White Paper is notable for what is not covered as much as what is. For example, there is little on plans for more meaningful engagement with local people – we expect that the main focus on structures is because of the need to focus on the content of imminent, forthcoming legislation, but it is still a concern. Furthermore, despite the focus on partnership working, it appears to be partnership working on the terms of the NHS as an institution, rather than thinking about how working in partnership will need to involve substantial changes to prevailing organisational cultures in NHS bodies.

The White Paper is best seen as part of a jigsaw which includes the NHS Long Term Plan and the various extant, and forthcoming, pieces of secondary legislation and statutory guidance relating to health and care (including Government's long-awaited plans for social care). It gives us a sense of the whole picture and the rough look of what we can expect when it is complete, but perhaps not enough to make more than a general judgement.

That said, from a structural and cultural perspective, if the White Paper's proposals are translated into legislation without substantial change (and if fundamental new material on engagement, culture and accountability are not, in fact, forthcoming), we are concerned that a reduction in local accountability, and the drawing of increased intervention power into DHSC and the Secretary of State, will make the design and delivery of services more remote and less relevant to local people's needs. This may be exacerbated by the drawing of commissioning up to the system level.

National political accountability is essential for a national health service. If the Secretary of State does consider that these proposals for enhanced intervention should be taken forward, we think that they should be complemented by evidence-gathering and scrutiny arrangements at a local level – this is not a case of either/or. We do not consider that national and local systems of accountability are in tension. We lay out below some areas where we think local accountability, through health scrutiny, can sit in support of national accountability with the Secretary of State.

There are a number of proposals where we have concerns, and/or where we feel a stronger role for local scrutiny should be built in.

<u>Health scrutiny powers in general</u>

The White Paper proposes the creation, as part of the ICS, of two linked bodies whose powers will be found in statute – the ICS "NHS body" and the ICS Health and Care Partnership. Powers around health scrutiny should relate to:

- Both of these bodies;
- NHS trusts;
- Health and Care Partnership bodies insofar as their functions relate to providing services relating to the ICS and its priorities.

This might include:

- Building scrutiny into the "duty to collaborate";
- Requiring the agreement between ICSs and local scrutiny functions on modes of communication and engagement – reflecting the fact that in different areas, to meet different needs, different models of health scrutiny might be necessary. This will also allow councillors to plan to focus their attention on those matters of greatest public contention, adopting a more targeted approach to their work. It will also provide for the ICS to provide support and resources for necessary joint scrutiny, and to facilitate working between ICS scrutiny, place-based health scrutiny, local Healthwatch and place-based scrutiny of HWBs and the delivery of public health priorities;
- Providing for ongoing information sharing with scrutiny, where information is gathered through the work of the ICS.

This framework would support some of the other changes that we describe below. In particular, we consider that a failure by an ICS to meet expectations on these points in relation to a substantial variation could precipitate a referral to the Secretary of State.

The White Paper does not say much about how the ICS will develop its overall priorities and its priorities for commissioning. If the legislation includes the development by the ICS of a statutory plan to reflect the content of the NHS Mandate, we think that there should be an expectation of scrutiny involvement in the delivery of this plan – proportionate, directed, but designed to give both local people and the Secretary of State the assurance that such plans align both with national priorities and local need. Scrutiny can bring support, and constructive challenge, to the development of these plans. We anticipate that the development of these plans would involve wide consultation and public participation and that local scrutiny would provide a mechanism for scrutiny to facilitate this participation.

Scrutiny engagement in specification

The streamlining of the commissioning of clinical services will arguably lead to more focused and responsive services. Commissioning will however need to be informed by high quality specification of services. Where services are being commissioned at the system level for the first time, the need for accurate intelligence on local need is particularly important.

We think that provision needs to be built into primary legislation or Regulations to give scrutiny a formal role in providing support to the way that services being commissioned are specified. This provides a complement to the planning role we describe above, to the generalised place-based scrutiny which we describe in the section below, and the substantial variation powers which we also describe below.

Movement of health scrutiny activity from place level to system level.

Although we know that ICSs will in future be coterminous with local authority boundaries, they will cover wide geographical areas, raising the possibility that councils will be expected to establish joint scrutiny arrangements on a standing basis.

It remains to be seen whether health scrutiny powers will be abolished for all NHS bodies other than ICSs or whether scrutiny of individual trusts, and commissioning focused at the place-level, will still permit authority-specific health scrutiny. We think the presumption remains that place-based scrutiny of NHS services, and services delivered by partners, should continue – supportive of new formal scrutiny arrangements at system level and a new approach to appropriate scrutiny engagement with PCNs.

A continuation of health scrutiny at the place level has benefits, because:

- It benefits from the existing presence of structural arrangements, and resources, to deliver it, as well as from the insight of local elected politicians who are anchored to that “place”;
- It reflects the fact that in unitary areas, a considerable amount of planning activity is still to be undertaken at place level – such as the convening of HWBs, the development of JSNAs and the operation of local Healthwatch. In two-tier areas ICSs may map to county areas but may cover a larger geographical footprint;
- It reflects the fact that services are likely to be experienced by local people at neighbourhood and place level, with the system level being relevant for large-scale planning but not for the granular understanding of local services which are a necessary pre-requisite for that planning;
- It means that system-level scrutiny – where necessary – can be managed in a way that is proportionate and relevant to (for example) individual commissioning arrangements rather than the assumption being made that all ICS scrutiny needs to engage with the whole ICS area.

Whatever happens, any system-wide guidance will need to engage with the resourcing and management challenges associated with the joint scrutiny committees which would need to be established to give effect to meaningful scrutiny at the ICS level.

The removal of the power of referral

We note that while it is not proposed that scrutiny’s power to review plans for substantial variation is removed, it is proposed to remove its power of referral to

the Secretary of State – a vital longstop which is central to local accountability of health services.

This is framed as a "tidying up" measure to avoid duplication between health scrutiny and the new broader powers being given to the Secretary of State to direct and intervene in reconfigurations. We are dubious whether the granting of enhanced powers directly to the Secretary of State is a sensible response to the challenge of complex reconfigurations but even if it is, we think that health scrutiny can provide vital insight to the Secretary of State on these matters, allowing them to use their powers proportionately.

We think that the referral power should remain, but that it should be cast in the following light:

- A local scrutiny function should be able to refer a matter of local concern on a proposed ICS-led substantial variation at a number of points in the development of such a proposal – for example:
    - Where scrutiny considers that a proposal for change is not in accordance with the NHS Mandate or the ICS's overall plan for the area;
    - Where scrutiny considers that an ICS proposal is not being designed in accordance with the "duty to collaborate";
    - Where scrutiny considers that plans to consult and engage local people are inadequate.

  These reasons are framed to reflect the focus of the White Paper on collaboration and partnership working. Here, scrutiny can act as a local, independent voice to establish whether the ICS HCP is working effectively, and can identify where poor relationships place the delivery of major proposals in jeopardy. We describe this as a "partnership enter and view"[3] responsibility.

- Importantly, we think that these powers of referral should primarily sit at the design stage – far earlier than they currently apply – and that they should be designed to provide "early warning" to the Secretary of State of where emerging problems might exist, in order to ensure that the SoS receives consistent and high quality information, and to ensure that they can use their powers proportionately and in a way that is less likely to be subject to challenge.

The rest of this paper is devoted to a more detailed exploration of some of the components of the White Paper.

[3] "Enter and view" is the legal power held by Healthwatch to direct observe local health services; our suggestion is a strategic complement to this operational power of oversight.

3. Main components

Integration

This is the first of the three main areas of policy focus in the White Paper.

Integration is the name usually given to the creation of joined-up care arrangements across the health and care system. A number of different providers and organisations are responsible for relevant services at a local level – the goal of integration is to ensure that those services are aligned and that they complement each other, and that patients and others have a seamless experience in using them.

Government proposes to integrate services through the legislation in two main ways:

- Integration within the NHS. In part, this will be delivered by putting ICSs on a statutory footing through the creation of both an ICS "NHS body" responsibility for the day-to-day running of ICS services and a wider ICS Health and Care Partnership to facilitate integration. It is unclear from the White Paper whether the Partnership will be a distinct and separate statutory body. There is more than a little of a "strategic health authority[4]" flavour to the way that the White Paper describes the ICS NHS body.
- Greater collaboration between the NHS, local government and other bodies. The NHS and councils will be given a "duty to collaborate" with each other; this will be through the operation of the Health and Care Partnership. It is unclear whether this duty to collaborate will essentially amount to a power for the Partnership, or the ICS NHS body, to "direct" other partners to take action in line with a statutory plan of some kind. The White Paper also promises action on data sharing and "digital transformation", although these are matters where the NHS has a decidedly chequered past[5].

The system will support place-based commissioning but commissioning itself will no longer occur at "place" level. This is being used as an opportunity focus health scrutiny activity at system level, rather than at place level – which we explore in more detail below. This shift upwards of the commissioning powers and the

[4] SHAs were bodies established to provide strategic leadership at a regional level in the NHS, and operated between 2003 and 2013. A useful historical perspective can be found in Edwards N and Buckingham H (2020), "Strategic health authorities and regions: lessons from history" Research report, Nuffield Trust: https://www.nuffieldtrust.org.uk/research/strategic-health-authorities-and-regions-lessons-from-history

[5] The experiences of NHS Connecting for Health (https://en.wikipedia.org/wiki/NHS_Connecting_for_Health) have presumably been learned by those designing new systems.

governance systems which underpin them raise significant questions around patient focus, local insight and local accountability.

Existing arrangements for Health and Wellbeing Boards will continue, and the existing requirements to produce a Joint Strategic Needs Assessment (JSNA), at place level, will continue. However, the context for that work will look very different, and local authorities and other partners operating at this level will presumably have less freedom to act, with commissioning happening at system level. This will have an impact on scrutiny too.

Removal of "transactional bureaucracy"

This is the second of the three main areas of policy focus in the White Paper.

This includes the removal of the oversight role of the Competition and Markets Authority (CMA) over certain aspects of the system. It involves connected changes to the National Tariff, new rules about the creation of new NHS trusts (alongside an assurance that a change to the provider landscape is not being sought), and the removal from statute of local education and training boards (LETBs), whose general functions will continue.

It also involves a wholesale change to the mechanisms by which providers will be chosen to deliver clinical services. Existing arrangements – including section 75 of the Health and Social Care Act, which was particularly controversial at the time of that legislation's enactment – are being repealed.

In its place will sit a new provider selection regime, in which the need for competitive tendering will be removed under certain circumstances, and in which commissioners will be under a duty to act in the best interests of "patients, taxpayers and the local population" when making decisions about arranging healthcare services.

This envisages the significant streamlining of certain procurement and commissioning arrangements, particularly where an existing specialist NHS provider already exists.

Scrutiny, specification and procurement

We have long felt that there is an active role for health scrutiny not in formal involvement in procurement, but in assisting in the specification of new commissioner arrangements. Where commissioners will be under a specific duty to "patients, taxpayers and the local population", elected councillors will have important insight to share on where need may lie, at all levels. We think that statutory guidance associated with this duty should put in place an expectation that for certain clinical commissioning plans, health scrutiny should be consulted.

Accountability and responsiveness

This is the third of the three main areas of policy focus in the White Paper.

NHS England and NHS Improvement are already functionally merged; legislation will formalise this, as well as providing for a merger with Monitor and the NHS Trust Development Authority (which currently form a part of NHSI).

This will bring with it accountability changes for NHS England – in particular, greater powers of intervention by the Secretary of State. The exact scope of these powers of intervention are not set out; there is an expectation that they will apply at national level and that they would not provide the Secretary of State with the power to direct NHS organisations at a local level.

This will be facilitated by a new, rolling NHS Mandate (replacing the annual Mandate process which currently exists). The Mandate is the mechanism by which the Secretary of State sets targets and expectations of the NHS. A rolling mandate will presumably allow ongoing dialogue and negotiation – and possibly informal direction – by the Secretary of State. The White Paper insists that the rolling nature of the Mandate will not impact on existing Parliamentary scrutiny arrangements, but this is moot – the absence of a formal procedure to develop a "new" Mandate will make it more challenging for Parliament to exert oversight at an appropriate time and in a proportionate way.

Scrutiny and the referral power

For scrutineers, the part of the White Paper which will cause most concern is that which relates to reconfiguration intervention.

The local authority referral power for substantial variations in NHS services usually sits with a health overview and scrutiny committee. If councillors consider that consultation has not been adequate, proposals can be referred to the Secretary of State, who may ask that the Independent Reconfiguration Panel consider the issue.

The White Paper proposes the abolition of the IRP and the removal of the power of a local authority to make a referral to the Secretary of State. It proposes the creation of a new, more generalised power for the Secretary of State to intervene, which does not need to be triggered by local action.

The White Paper suggests that the local referral power is being removed to reduce the risk of "duplication" – we do not accept the characterisation that a national power of intervention, and local scrutiny, somehow sit in tension.

The challenge which the White Paper identifies – of referrals coming late in the process – are by and large caused by NHS bodies designing and deploying sub-optimal approaches to engagement both with the public and with local scrutiny arrangements. In a cultural sense, late referral and inadequate consultation of the public at large are closely connected, and speak to deficiencies within NHS bodies at a local level.

The siting of an ongoing power of intervention with the Secretary of State involves the acceptance of a new of arguments, all of which are contentious:

- That the Secretary of State will be able to maintain meaningful oversight of substantial variations being delivered across England;
- That the Secretary of State will be in a position to make a dynamic assessment on:
    - The substantive impact of those changes;
    - The adequacy of consultation and engagement mechanisms being undertaken, as they are being undertaken;
    - The considerations and weighting being given by ICS staff on matters relating to consultation response and design.

The amount of active oversight required by DHSC under these circumstances seems extraordinary, particularly considering that the development of ICSs will by definition involve a substantial shift in commissioning arrangement which will inevitably lead to variations in services.

If the Secretary of State wants to widen their powers to allow for ongoing engagement with substantial variations rather than waiting for the triggering of their powers of intervention by the existing referral power, that suggests a role for local scrutiny to inform that process, and to ensure that the way the Secretary of State uses their powers is proportionate and not subject to challenge. Scrutiny can (and has, in the past) draw together evidence from local people and – because it is led by local elected politicians – have specific credibility and legitimacy in assessing need, both around substantive proposals and the consultation being carried out to support them.

We think that an expansion in local scrutiny powers to provide more generalised oversight on change proposals – a kind of "partnership enter and view" power – would provide a complement to the exercising by the Secretary of State of these powers at a national level, with intelligence and insight being fed up to DHSC to support those Ministerial activities.

Additional powers

There are a number of further powers and changes set out in the White Paper.

Adult social care

The White Paper suggests a range of structural changes which do not address the fundamental challenges raised by professionals and politicians about the ongoing sustainability of social care services. Government has still to publish its proposals for sustainable funding for social paper, despite a Green (and/or White) Paper having been pending for some time.

Where the White Paper does suggest change is in greater oversight for local authorities in carrying out their social care duties, and a new power for the Secretary of State to intervene "in exceptional circumstances" where CQC determines that duties are not being fulfilled. Here we think that some integration of scrutiny's powers in this national oversight would be proportionate.

Other powers

The White Paper makes changes to the Secretary of State's powers on direct payments, discharging arrangements, technical changes to the operation of the Better Care Fund, and the operation of public health at a national level.

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nhsa
Northern Health Science Alliance
A Health Partnership for Northern England

Health for Wealth

Building a Healthier Northern Powerhouse for UK Productivity

Foreword

The vision for the Northern Powerhouse was built in the knowledge that if we harnessed the potential of the great cities of the North we would be increasing the economic strength of the United Kingdom. The North's cities and towns led the Industrial Revolution and their decline has seen a marked shift downwards into lower wages compared to the South, with lower productivity.

Henri Murison, Director of the Northern Powerhouse Partnership

Linking up Liverpool, Manchester, Sheffield, Leeds, Hull and Newcastle with high-speed, integrated transport systems and cutting-edge digital connectivity would allow those cities to collaborate and contribute more than the sum of their parts, creating a single market. Only with this joined-up approach could the sluggish productivity of the Northern Powerhouse be stimulated and allow our businesses to thrive.

Transport is a vital component of the Northern Powerhouse, with Northern Powerhouse Rail (NPR) promising the world-class transport network our commuters, families and businesses deserve. Reducing journey times, enhancing capacity and increasing frequency are all compelling reasons to build the network, but potentially more important is the opportunity for economic growth NPR would create. Reversing decades of stagnation takes time, but opening up new labour markets and opportunities for our young people would have a transformational effect.

In addition, our businesses need access to the skilled workforce they need to embrace the digital revolution, embedding emerging technology such as robotics, AI, 3D printing and VR into everything they do.

Our education system requires major interventions, as set out in our Educating the North report, particularly tackling entrenched disadvantage leading to our children falling behind their peers in other parts of the country.

Until now health has not had the profile it should have in the Northern Powerhouse, despite its undoubted importance.

Life expectancy is on average two years lower in the North than the South, and there is a productivity gap between the Northern Powerhouse and the rest of England of £4 per-person-per-hour. In this report, led by the Northern Health Science Alliance (NHSA), the link between the two is set out across the North for the first time.

People in the North are more likely to leave work due to sickness than those in the South, and when they leave they are less likely than those in the South to go back into work. This report, put together by leading academics from six Northern universities, shows that ill health in the North accounts for over 30% of the productivity gap with the rest of England. What's more, the report's findings show that the NHS allocated budgets explain over 18% of this productivity gap.

Importantly, improving health in the North could reduce the existing gap in GVA of £4 per-person-per-hour between the Northern Powerhouse and the rest of England by up to £1.20. Improving health in the North increases the whole country's productivity.

To tackle the poor health and increase productivity in the Northern Powerhouse we need proportional interventions to the scale of the opportunity from those who can drive it forward: industry, central and local government.

The Mayor, Andy Burnham, a former Labour Health Secretary, will now be able to fully integrate health and social care utilising health devolution. Newcastle University was funded to create the National Centre for Ageing which can have an impact across the North, and in Leeds the presence of NHS Digital and a major cluster of health data businesses is of global significance.

From Liverpool to the new Mayor of the North of Tyne to be elected in May, health should be the next major transfer of power which government offers pro-actively, and without it, unlocking productivity and our economic potential will be held back.

The economic arguments for the Northern Powerhouse are ignored at the United Kingdom's risk. We need to strengthen our country's economic performance in every way we can, particularly when we leave the European Union.

The businesses of the Northern Powerhouse require a healthy, productive workforce. Addressing ill health would support a workforce which is fit and able, and – allied with improved connectivity, education and skills – could create the right conditions for a thriving Northern Powerhouse.

Government, as it looks to allocate additional NHS spending, here has the evidence needed for how that investment can also be financed sustainably through increased productivity in the Northern Powerhouse. Spending more on health here, through more efficient devolved arrangements will close the gap in fiscal terms of what the North contributes to the UK economy, generating increased revenues for the Treasury to make the NHS in the long term more financially sustainable nationally for decades to come.

Executive Summary

60 Second Summary

There is a well-known productivity gap between the Northern Powerhouse and the rest of England of £4 per-person-per-hour. There is also a substantial health gap between the Northern Powerhouse and the rest of England, with average life expectancy 2 years lower in the North. Given that both health and productivity are lower in the Northern Powerhouse, the NHSA commissioned this report from six of its eight university members (Newcastle, Manchester, Lancaster, Liverpool, Sheffield and York) to understand the impact of poor health on productivity and to explore the opportunities for improving UK productivity by unlocking inclusive, green, regional growth through health improvement. Our report shows the importance of health and the NHS for productivity in the Northern Powerhouse. So, as it develops its post-Brexit industrial strategy, central government should pay particular attention to the importance of improving health in the Northern Powerhouse as a route to increased wealth.

Key findings

- Productivity is lower in the North
- **A key reason is that health is also worse in the North**
- Long-term health conditions lead to economic inactivity
- **Spells of ill health increase the risk of job loss and lead to lower wages when people return to work**
- Improving health in the North would lead to substantial economic gains
- **Improving health would reduce the £4 gap in productivity per-person per-hour between the Northern Powerhouse and the rest of England by 30% or £1.20 per-person per-hour, generating an additional £13.2 billion in UK GVA**

Productivity is lower in the North

A key reason is that health is also worse in the North

Long-term health conditions lead to economic inactivity

Spells of ill health increase the risk of job loss and lead to lower wages when people return to work

Improving health in the North would lead to substantial economic gains

30% of the £4 per person per hour gap in productivity (or £1.20 per hour) between the Northern Powerhouse and the rest of England is due to ill-health. Reducing this health gap would generate an additional

£13.2bn in **UK GVA**

Summary of Detailed Findings

- Health is important for productivity: improving health could reduce the £4 gap in productivity between the Northern Powerhouse and the rest of England by 30% or £1.20 per-person per-hour, generating an additional £13.2 billion in UK GVA
- **Reducing the number of working age people with limiting long-term health conditions by 10% would decrease rates of economic inactivity by 3 percentage points in the Northern Powerhouse**
- Increasing the NHS budget by 10% in the Northern Powerhouse will decrease economic inactivity rates by 3 percentage points
- **If they experience a spell of ill health, working people in the Northern Powerhouse are 39% more likely to lose their job compared to their counterparts in the rest of England. If they subsequently get back into work, then their wages are 66% lower than a similar individual in the rest of England.**
- Decreasing rates of ill health by 1.2% and decreasing mortality rates by 0.7% would reduce the gap in gross value added (GVA) per-head between the Northern Powerhouse and the rest of England by 10%.
- **Increasing the proportion of people in good health in the Northern Powerhouse by 3.5% would reduce the employment gap between the Northern Powerhouse and the rest of England by 10%**
- So, given the relationship between health, health care and productivity in the Northern Powerhouse, then in order to improve UK productivity, we need to improve health in the North.

Increasing the NHS budget by

10%

in the Northern Powerhouse will decrease economic inactivity rates by 3 percentage points

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Challenges

Key

Although these findings demonstrate the scale of the health and economic challenges facing the Northern Powerhouse, they also provide a blueprint to overcome the problem: in order to improve UK productivity, we need to improve health in the North. However, there are challenges which need to be addressed:

- Expenditure on public health and prevention services has always lagged behind spend on the treatment of existing conditions. In 2017/18 in England, £3.4 billion was spent by local authorities on public health. This was dwarfed by Department of Health and Social Care spend of over £124 billion, the vast majority of which went on hospital-based treatment services. Public health budgets are estimated to experience real-term cuts averaging 3.9 per cent each year between 2016/17 and 2020/21.
- **Austerity presents a real challenge for Northern agencies to implement approaches to improving health. Local authorities have faced disproportionally larger cuts and reductions in social welfare since 2010 have also had more of an impact in the Northern Powerhouse.**
- Exiting the European Union is a challenge for the NHS in terms of the supply of highly skilled workers. Uncertainties over post-Brexit NHS and local authority public health budget settlements are also a challenge for planning prevention and health and social care services particularly in the Northern Powerhouse.
- **Health research funding in the UK is heavily concentrated in the so-called 'golden triangle': London, the South East and the East of England receive over 60% of funding. This is exacerbated by the fact that the Northern Powerhouse's strengths are in applied health research, for which there is high need in the region but much less funding available nationally and regionally.**
- Uncertainty around the effectiveness of public health interventions means that more applied research is needed to develop, pilot and evaluate and scale-up interventions to improve health – particularly in areas of high need such as the Northern Powerhouse.
- **Green and Inclusive Growth is required given the well-documented threats posed by climate change. It cannot be the case of 'business as usual' for an industrial strategy to increase productivity in the North, innovation is required to ensure carbon-free growth. Growth in the North also needs to be socially inclusive - reaching all places in the region and people from all social backgrounds.**

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60%

of funding. This is exacerbated by the fact that the Northern Powerhouse's strengths are in applied health research, for which there is high need in the region but much less funding available nationally and regionally.

Recommendations to Central Government

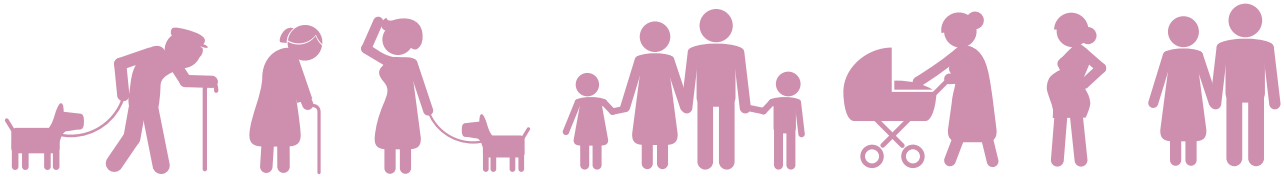
As it develops its post-Brexit industrial strategy, central government should pay particular attention to the importance of health for productivity in the Northern Powerhouse. Specifically, we make four key proposals to central government:

1) To improve health in the North by increasing investment in place-based public health in Northern Powerhouse local authorities.

2) To improve labour market participation and job retention amongst people with a health condition in the Northern Powerhouse.

3) To increase NHS funding in the Northern Powerhouse – to be spent on prevention services and health science research.

4) To reduce economic inequality between the North and the rest of England by implementing an inclusive, green industrial strategy.



Recommendations to Northern Powerhouse Local and Regional Stakeholders

We make four key proposals to Northern Powerhouse local and regional stakeholders:

1) Health and Wellbeing boards and the emerging NHS integrated care systems should commission more health promotion, condition management and prevention services.

2) Local enterprise partnerships, local authorities and devolved Northern regions should develop locally tailored 'health-first' programmes in partnership with the local NHS and third sector providers.

3) Local enterprise partnerships, local authorities and devolved Northern regions should scale-up their place-based public health programmes across the life course: 'starting well', 'living well' and 'ageing well'.

4) Local businesses should support job retention and health promotion interventions across the Northern Powerhouse workforce and Northern city regions and Northern NHS integrated care systems should lead by example.

Figure 1.4: An English Journey – life expectancy for men along the East Coast, Great Western and West Coast Mainlines

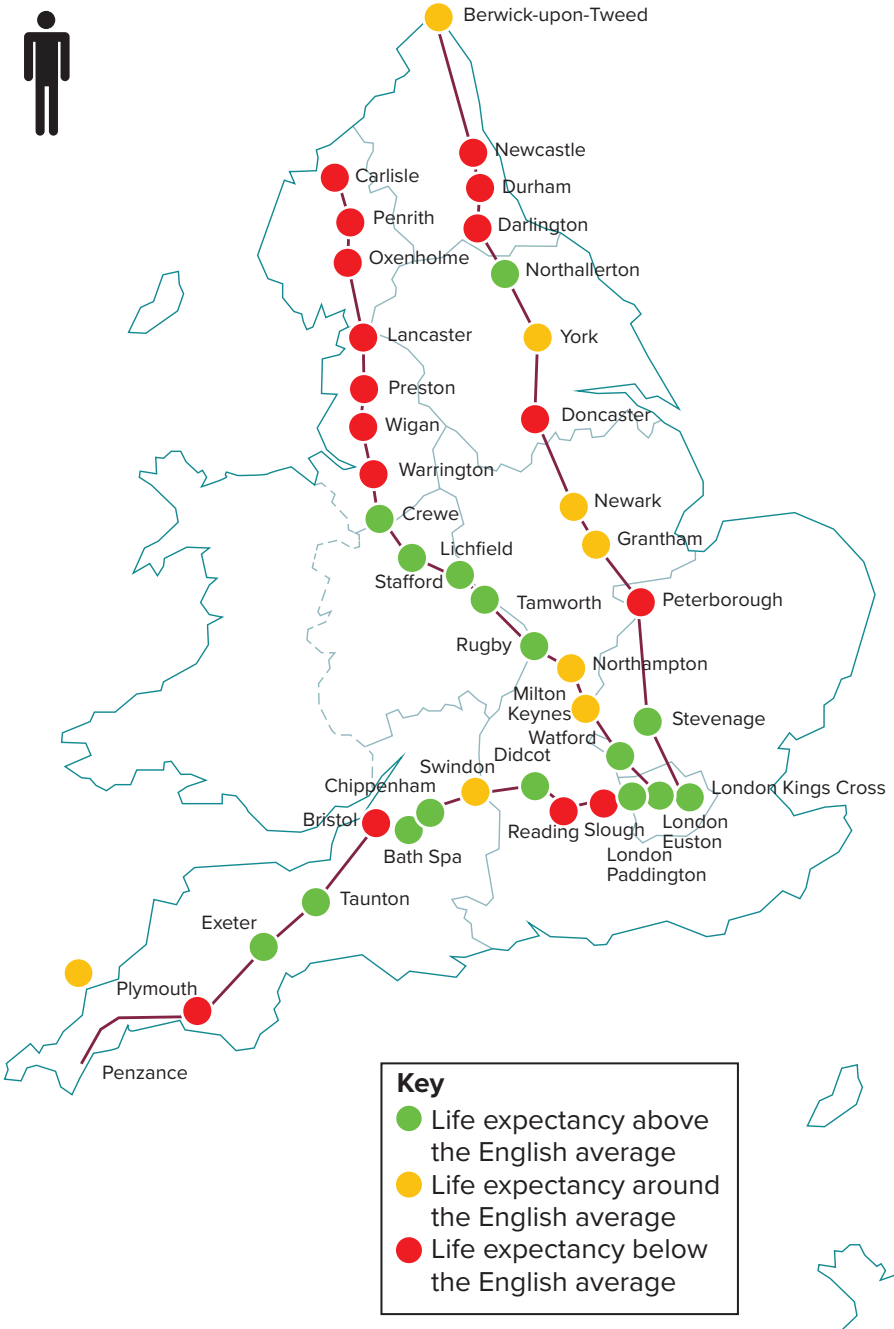


Figure 1.5: An English Journey – life expectancy for women along the East Coast, Great Western and West Coast Mainlines

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