AGENDA ITEM

REPORT TO CABINET

October 2010

REPORT OF CORPORATE MANAGEMENT TEAM

CABINET DECISION

Adult Services and Health – Lead Cabinet Member– Councillor Jim Beall

Response to the Health White Paper *Equity and Excellence: liberating the NHS*

1. Summary

This paper summarises the main points of the Health White Paper and the implications for the Council, as well as incorporating the response submitted to the consultation on behalf of the Council and the Health and Wellbeing Partnership Board.

2. Recommendations

To note the potential implications of the Health White Paper and note the response to the Consultation questions for Stockton Borough Council.

3. Reasons for the Recommendations/Decision(s)

To highlight the direction of travel outlined in the White Paper and note the proposals outlined.
To ensure that Stockton's feedback is included in the national consultation process.

4. Members' Interests

Members (including co-opted Members with voting rights) should consider whether they have a personal interest in the item as defined in the Council's code of conduct (paragraph 8) and, if so, declare the existence and nature of that interest in accordance with paragraph 9 of the code.

Where a Member regards him/herself as having a personal interest in the item, he/she must then consider whether that interest is one which a member of the public, with knowledge of the relevant facts, would reasonably regard as so significant that it is likely to prejudice the Member's judgement of the public interest (paragraphs 10 and 11 of the code of conduct).

A Member with a prejudicial interest in any matter must withdraw from the room where the meeting considering the business is being held -

- **in a case where the Member is attending a meeting (including a meeting of a select committee) but only for the purpose of making representations, answering questions or giving evidence, provided the public are also allowed to attend the meeting for the same purpose whether under statutory right or otherwise, immediately after making representations, answering questions or giving evidence as the case may be;**

- **in any other case, whenever it becomes apparent that the business is being considered at the meeting;**

and must not exercise executive functions in relation to the matter and not seek improperly to influence the decision about the matter (paragraph 12 of the Code).

Further to the above, it should be noted that any Member attending a meeting of Cabinet, Select Committee etc; whether or not they are a Member of the Cabinet or Select Committee concerned, must declare any personal interest which they have in the business being considered at the meeting (unless the interest arises solely from the Member's membership of, or position of control or management on any other body to which the Member was appointed or nominated by the Council, or on any other body exercising functions of a public nature, when the interest only needs to be declared if and when the Member speaks on the matter), and if their interest is prejudicial, they must also leave the meeting room, subject to and in accordance with the provisions referred to above.

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To ensure that Stockton's feedback is included in the national consultation process.

DETAIL

1. The Government published *Equity and Excellence: liberating the NHS*, its health white paper, on 12 July 2010. Following this the Department of Health (DH) launched its public consultation setting out proposals to support this White Paper covering:

    - Commissioning for patients
    - Regulating healthcare providers
    - The review of arms-length bodies

- Local democratic legitimacy in health
- Transparency in outcomes: a framework for the NHS
- Achieving equity and excellence for children.

2. This Cabinet paper summarises the main points of the White Paper and the implications for the Council, as well as incorporating the response submitted to the consultation on behalf of the Council (including health scrutiny) and the Health and Wellbeing Partnership Board.

Summary of Proposals

3. The White Paper represents a significant change in the role of councils and their responsibilities relating to health improvement and the coordination of health and social care.

4. The proposals are focused on four areas:

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

    The details are outlined below:

Putting Patients and Public First

5. The focus of the White Paper is about "shared decision making" supported by additional information and data on all aspects of healthcare. Information will be presented in formats that are easier to understand patient generated information (Patient-Reported Outcome Measures – PROMS), patient experience surveys and real time feedback will be a focus to influence and exert local pressure for service improvement.

6. There are plans to ensure that patients and carers have greater influence and choice in the system. Amongst the proposals there will be an extension of the existing choice arrangements, which will extend choice of provider, expand the any willing provider principle, introduce the choice of named consultant-led team and the right to choose to register with any General practitioner (GP) practice.

7. Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). Local Involvement Networks (LINks) will be rebranded as the Local Health Watch and will ensure that the voices of patients and carers are at the heart of the commissioning process. The Local Health Watch will be funded and accountable to local authorities and be part of the new Health and Wellbeing Boards. At a national level the Health Watch England will provide leadership to local branches and provide advice to national bodies and the Secretary of State. It will be able to propose CQC investigations of poor services based on local intelligence.

Improving healthcare outcomes

8. The current performance regime will be replaced with separate frameworks for outcomes that set the direction for the NHS, for public health and social care. Local authorities will be set national objectives for improving health outcomes but will be able to determine how best to deliver these objectives. A new NHS Outcomes Framework will provide the direction for the NHS which will be translated into a commissioning outcomes framework for GP consortia.

9. The NHS Outcomes Framework will focus on:

    - The effectiveness of treatment and care
    - The safety of treatment and care
    - The broader experience of patients of their treatment and care

10. There will be a range of quality standards developed by the National Institute of Health and Clinical Excellence (NICE), who will set out standards and indicators for patient pathways. 150 new standards will be published by NICE in the first 5 years and some of which will span health and social care.

11. There will be greater emphasis on incentives for quality including the extension of the quality improvement payment framework (Commissioning for Quality and Innovation [CQUIN]), incentives to reduce avoidable readmissions to encourage joined up working between hospitals and social care, and promoting quality in general practice via a new funding model.

Autonomy, accountability and democratic legitimacy

12. The commissioning of most NHS services will be undertaken by local consortia of GP Practices. They will replace the existing Primary Care Trust arrangements and will commission the majority of NHS services with the exception of primary care services, dentistry, community pharmacy, primary ophthalmic and maternity services.

13. A NHS Commissioning Board will allocate NHS resources to GP consortia and support their commissioning decisions. This Board will have 5 main functions:

    - provide leadership for quality improvement of commissioning,
    - promote and extend public and patient involvement and choice,
    - ensure the development of GP commissioning consortia,
    - commission certain services (those not commissioned by the GP Consortia), and
    - allocation of and accounting for NHS resources.

14. Health improvement functions will transfer, by 2013, to local authorities and Local Directors of Public Health will be jointly appointed by local authorities and the new national Public Health Service. A ring-fenced public health budget will be allocated to local authorities to support their public health and health improvement functions. There will be new statutory arrangements for local authorities in the establishment of "health and wellbeing boards" to join up the commissioning of local NHS services, social care and health improvement. They will lead the development of joint strategic needs assessments (JSNA) and build partnerships for service changes and priorities. Health Overview and Scrutiny Committees will be replaced by this Board.

15. The role of the Care Quality Commission (CQC) will be strengthened as a quality inspectorate and will focus on the safety of patients and quality of providers. Its inspection regime will be influenced by a range of sources including information from patients, Health Watch, GP Consortia and the NHS Commissioning Board.

Cutting bureaucracy and improving efficiency

16. There is an expectation that management costs will be cut by 45% by the abolition of PCTs and Strategic Health Authorities, a reduction in the size of the Department of Health and the removal of health related quangos (e.g. National Treatment Agency).

17. There will be a transition period in which the PCT will support the new GP Consortia in developing their commissioning capacity, but there is an expectation that there is a continued emphasis on improvements in quality and productivity. There will be no reduction in the focus on releasing the necessary efficiency savings for reinvestment across the system including a focus on the Quality, Innovation, Productivity and Prevention (QIPP) initiative.

Consultation Process

18. The Department of Health (DH) launched its public consultation setting out proposals to support this White Paper covering:

    - Commissioning for patients
    - Regulating healthcare providers
    - The review of arms-length bodies
    - Local democratic legitimacy in health
    - Transparency in outcomes: a framework for the NHS
    - Achieving equity and excellence for children.

19. A member's seminar session was held in August to outline the proposals and discuss the key issues. The Health and Wellbeing Partnership held an extra-ordinary meeting to review the key points and Health Scrutiny undertook its own internal review of the White Paper. In addition there were various internal meetings with officers and attendance at regional

events that has helped shape and influence the comments that have been collated.

20. A summary of the issues/ responses is attached (**Appendix 1 - 5**) which has been submitted in line with the DH deadline of the 11 October 2010.

Local Issues

21. The Health White Paper signals a significant period of change for the Local Authority and NHS. This is in parallel to challenging financial constraints in both areas. The management of the transition period will be critical in "skilling up" the GP Consortia to manage their new functions, transferring of health improvement functions/ personnel to the Local Authority and reshaping pathways to enable efficiencies to be released and ensure that quality of care is maintained.

22. The Public Health White Paper is anticipated in December 2010 and will consult on further details around the expectations and arrangements for the public health transition to the Local Authority.

FINANCIAL IMPLICATIONS

23. The White Paper proposes that the NHS will release £20 billion of efficiency savings by 2014 which will be reinvested to support improvements in quality and outcomes. As part of the proposed White Paper for Public Health funding transfer to the Local Authority as part of ring fenced budgets. A full assessment of the implications would need to be undertaken when there is clarity about the precise expectations for this budget.

LEGAL IMPLICATIONS

24. Not applicable

RISK ASSESSMENT

25. Not applicable

COMMUNITY STRATEGY IMPLICATIONS

26. The Sustainable Community Strategy (Shaping Our Future) for Stockton-on-Tees 2008-2021 sets out the vision and key improvement priorities for the local area. Stockton on Tees Council Plan 2008-2011 sets out directives aimed at helping create a sustainable community in which residents and local organisations play an active role in developing and maintaining their own environment and society. 'Being healthy, improved access to integrated services, improved health and emotional wellbeing, improved quality of life, increased choice and control, and leadership' are key objectives in the Borough.

EQUALITIES IMPACT ASSESSMENT

27.Not applicable

CONSULTATION INCLUDING WARD/COUNCILLORS

28.A councillor briefing session was held in August where there was an opportunity to discuss and feed into the consultation questions. The health and wellbeing partnership undertook a facilitated session to consider the White Paper which has representation from Councillors and scrutiny committee. This has fed into the consultation responses detailed above.

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Background Papers

Ward(s) and Ward Councillors:

A Policy Update Briefing session has been undertaken

Property

Not applicable

Appendix 1 - Response to "Local Democratic Legitimacy in Health"

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

We welcome the continued strengthening of the role of LINKs to a HealthWatch function. The current LINKs arrangements have been helpful in collaborating with scrutiny on service issues, undertaking specific areas of work and providing feedback from the local population on health issues.

However, within Stockton we have a concern that the LINKs is subject to further changes and has not had time to "bed in" with current arrangements. The widening of the role will require significant capacity building. We need to ensure that they have the skills, support, funding and infrastructure to undertake this formal role.

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

Whilst there are some synergies to take forward complaints advocacy and support roles in exercising choice and control there needs to be careful thought about the existing infrastructure that is in place via LA contracts to support advocacy arrangements (and even wider into Mental Capacity?).

The arrangements need to avoid duplication of arrangements and confusion for individuals.

The actual service name "Health Watch" has been identified as confusing for service users as its role is anticipated to be wider than health.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

We need to learn the lessons from the commissioning arrangements put in place for LINKs and understand how to these can be incorporated into any future commissioning arrangements for Health Watch. There could be required a re-tendering process to commission this new service.

There is lack of clarity of the actual scope and responsibility for Health Watch – for example will Health Watch support/ review both Children and Adult services? How wide are Health Watch's powers?

In moving to a more outcomes based approach we need to consider what outcomes Health Watch will deliver.

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

The process for pooling of budgets remain complex.

Reorganisations often do not acknowledge existing joint arrangements so this can be detrimental in taking forward further integrated working.

Some national targets may be focused on metrics which do not leave organisations the flexibility to tackle their issues to meet local needs.

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

GP Consortia need to be involved and engaged with integrated arrangements and need to be able to see services beyond their GP Practice.

Where savings are achieved how do we ensure that the benefit is realised across both health and care?

There can be issues in the differences in NHS and councils accounting regimes – the Local Authority has greater flexibility to plan over a 3 year timeframe which is not mirrored in the NHS and can lead to a "short term" outlook.

The shift to commissioning approaches rather than councils as providers may be a challenge. Support from ADASS/DCS and various programmes of work could help refine and focus this shift but needs to be in the context of democratic accountability.

There are concerns that some services, such as mental health and learning disabilities may not be seen across the continuum of health and social care requirements. This needs to be considered.

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

Arrangements within Stockton are mature and so joint working is the "norm" within the locality – but understand where the statutory powers may be helpful in taking forward health and wellbeing arrangements in other areas.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Local arrangements may give local solutions however a statutory element does give a level of "kudos" and focus for all partners to contribute. It may be necessary to have statutory powers to ensure engagement of GP Consortia. This may be important where there may be additional complexity where GP Consortia may span more than one Board.

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

Yes - we welcome the enhanced role of the Board and its function. However there needs to be clarity about the links with other functions e.g. Children Trust Boards

The second bullet is narrow in its definition as there are a number of "wider determinants" of health that could be considered e.g. housing and economic regeneration.

There needs to be greater clarity about how the needs assessments might be translated into specific commissioning plans within GP Consortia. There could be a danger of disconnect as it is not clear about the precise nature of how this might work. How will the Board connect effectively with the GP consortia's commissioning plans?

There needs to be a mechanism for the NHS Commissioning Board to check the connectivity with Boards and GP Consortia and to ensure that the JSNA is actually impacting on commissioning decisions. There is a concern that the GP consortia focus on the hospital end of the service and new public health service considers the wider determinants with the consequence that there is limited interchange between the two. GPs will need to engage with the JSNA processes.

There could be tensions in balancing the national requirement of the health service with the local democratic processes. The key factor will the role of the JSNA in determining local need and influencing this at a national level.

There needs to be clearer language around the roles and responsibilities of the Board – throughout the document "promote", "ensure" and "duties of partnership" are used.

There is no clarity about some of the clinical governance arrangements and responsibilities with which organisation? It is not clear how Safeguarding will sit within the new arrangements.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

There is already a range of guidance on the JSNA arrangements – the recent world class commissioning assessments may identify further best practice and support and could be a useful tool to support further development of these functions.

It may be helpful to consider what support for GP Consortia may be required in their new roles and taking forward the wider aspects of health and care so that they can contribute effectively here.

The role of health care information and intelligence is important in the development of the JSNA.

It is important that in any transition arrangements there are clear joint working arrangements and protocols for information sharing, supporting the needs assessment and other programmes of work.

There may need to be training programmes put in place to support the development of these Boards and to ensure clarity of roles and responsibilities – this should be locally determined.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

The duty to cooperate has been dropped but in many areas the function will remain – so there needs to be clear links around the CTB and H&WBB.

Equally important will be the role and function of the LSCB and their accountability.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Within Tees there are already Tees wide work plans that operate across LA boundaries – with the proposed changes to the management infrastructure it will be necessary to maximise these specific work streams on a Tees wide basis. In addition, some work may be best undertaken on a Regional basis and there needs to be flexibility to enable this to happen with oversight from each locality board or the ability to consider lead arrangements.

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

Will Health Watch be the patient champion function or is it envisaged that there will be other representatives? We need to ensure that patients are not seen as token representatives or have "single issue" focus.

It would be appropriate for portfolio leads for health and care/ children's and young people to be a representative within the membership of the Board.

GP Consortia need to actively contribute to the Board arrangements.

There may need to be greater focus on how the Boards might engage "effectively with local people and neighbourhoods" – locally our existing partnership arrangements have attendance from the Area Partnerships to ensure that local issues can be considered.

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

It would be helpful to have an agreed arbitration process set out in the terms of reference of each Board. The likely issues of dispute will be funding and reconfiguration of services so need to be mindful of the need to have a robust process. It may be possible to build on existing local processes.

Within paragraph 46 the consultation states that "the health and wellbeing would have an important role in enabling the NHS Commissioning Board to assure itself that GP consortia are fulfilling their duties in ways that are responsive to patients and public" – it would be helpful to understand how this might be undertaken to inform how disputes processes could operate.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

There are genuine concerns about the removal of OSC and the dual role of the Board to set the local health strategy and then become involved in the scrutiny of proposals when reconfiguration plans occur. There needs to be a degree of separation.

If OSCs are removed there would need to be some consideration of where OSCs have undertaken pro-active, in-depth review work at the local, Tees, and region-wide level to the benefit of the Borough and the wider North East. This would also be lost in proposed arrangements.

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

We have identified the following:

- Mature working relationships key
- Clear roles and responsibilities
- Appropriate support arrangements from democratic services/ officer level capacity
- Escalation arrangements clear at the outset

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions?
To what extent should this be prescribed?

We feel that there needs to be a separation of scrutiny function with the boards as outlined in Q14.

It would be helpful to understand what external assessment might take place from other agencies e.g. CQC/ Public Health Service/ NHS Commissioning Board?

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

All proposals for the development of Health and Wellbeing Boards should include equality and diversity statements within the Terms of Reference. As part of the commissioning plan processes there should be equality impact assessments undertaken

Q18 Do you have any other comments on this document?

The Public Health White Paper is also key to Local Authorities perspectives on the next steps. Stockton welcomes the shift of health improvement to the Local Authority but needs to understand the expectation of the function and the related resource that will follow. The budget allocation needs to reflect our local challenges around health inequalities.

Appendix 2 - Response to "Transparency in outcomes – a framework for the NHS"

The document is focused on NHS outcomes rather than a health and wellbeing framework and more work needs to be undertaken to tie in the broader public health and social care dimensions. However the "partnership" approach is not fully embraced examples such as 2.19 highlight which organisation is accountable, rather than consider how are partners collectively accountable.

The use of Quality Standards seems key to balance out the reliance on the indicators – we need to shift reliance on being able to count everything and there is a place to articulate "this is what good quality care looks like and it you are doing this all the evidence suggests you will improve outcomes"

Q1 Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?

The NHS Outcomes Framework provides a clear focus for measures that the NHS can influence. At this stage measures for Public Health and Local Government has not been published and so we need to ensure that there are clear linkages made across health and care systems to ensure that there is no perverse incentives or gaming of the system. It would be helpful to have sight of the total range of outcomes frameworks to assess them together.

In terms of "delivering more equitable outcomes and reducing health inequalities" the framework alone may not deliver this – as there needs to be tie in with the broader care and wellbeing agenda.

We welcome the clear principle "working in partnership…where required". However the focus is stated around "other public services" this could exclude working with other sectors such as the community and voluntary sector and third sector which may be appropriate.

Q2 Are there any other principles which should be considered?

The shift to a more focused outcome based approach is still relatively new and as such we need to be mindful of a proportionate approach in developing the future performance indicators. We need to target efforts around outcome based measures but be clear about avoiding creating overly bureaucratic systems. This should be reviewed regularly to ensure that as measures do "evolve" (as set out in the key principles) they are not adding a further burden.

In addition the use of proxy measures (para2.33) is appropriate for this new and developing field however these measures may not be for the short term.

Q3 How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

Without the publication of the Public Health Measures it is difficult to assess.

Q4 How can we ensure that where outcomes require integrated care across the NHS, public health and / or social care services, this happens?

We need to ensure that the Health and Wellbeing Board has a clear sphere of influence – we would expect the Board to be able to show progress against a range of performance indicators (across health and local authority) and be able to demonstrate joint plans to credibly address any performance issues. It would be helpful to understand how the NHS Commissioning Board/ CQC might assess these joint arrangements including the local performance approach.

Where the National Support Team has developed toolkits, an assessment of the locality could be against some of these methodologies to review the joint working arrangements for example preventing excess winter deaths/ winter warmth initiatives.

Q5 Do you agree with the five domains that are proposed as making up the NHS Outcomes Framework?

The domains seen comprehensive but need to be seen in the context of other outcome measures that have not been published (See response to Q1).

There are additional questions within this consultation document however they are more technical in nature and have not been responded to specifically in Stockton's submission.

Appendix 3 - Response to Commissioning for Patients

Within the consultation document there are a range of questions posed – Stockton has responded to the general direction of travel outlined in the White Paper.

The plans for GP Consortia to take responsibility for the majority of the NHS Commissioning budget will require a clear transition plan. There is a significant learning curve for these organisations to address their commissioning responsibilities. There are concerns that the new Consortia cannot do everything that the existing PCTs have undertaken, especially with the reduced management resource. There will need to be serious consideration of what does not need to be done.

We recognise that there are ongoing discussions about the size and geographical coverage of GP consortia but would highlight that there needs to be acknowledgement of Local Authority boundaries and the GP contribution to the Health and Wellbeing Boards will be critical to enable local influence and democratic accountability.

The focus of health inequalities needs to be a high priority for GP Consortia and with the future financial regime there are concerns that “short termism” may prevail. GPs need to understand the role of and contribution that the Local Authority can make in addressing the wider determinants of health. Tools and techniques such as the National Support Team work on Health Inequalities may be valuable in providing additional support for GPs on this issue.

It is acknowledged that the transition period will be resource intensive and there are concerns that many existing plans and developments may not be progressed due to inertia.

There are concerns the plans could fragment commissioning arrangements, in particular, some of the current joint commissioning arrangements in Stockton may be unpicked.

The relationship between patients and GPs could change when GPs are responsible for budgets. In addition the ethos of the NHS may be diluted if significant functions are outsourced to private sector organisations.

There are responsibilities for the GP Consortia to challenge poorly performing member practices which could be difficult and sensitive. But peer support and challenge could be a valuable tool to address this issue. The concern was for consistent engagement and involvement of GPs in supporting schemes that may be beneficial for patients, especially in supporting lifestyle issues and education of patients.

There is an emphasis on involving patients via existing mechanisms such as practice patient participation groups. Local Authorities also have well developed engagement and consultation arrangements that should be considered as part of the range of tools that Consortia could access.

Appendix 4 - Response to Achieving equity and excellence for children

This document was released in mid September but with the same consultation response deadline. As such, detailed consultation and consideration of the questions has not been able to be sought. Some general comments have been collated as part of the general engagement processes.

There is a role for Health Watch in ensuring the voice of Children and Young People is fed into the commissioning of services. This is a new role which the existing LINks organisations do not formally undertake. Additional resources will be required to reflect these functions.

One of the principles highlighted is the ability to show that services are tailored with the needs of young people and children in mind. The "You're Welcome" programme offers some excellent approaches for services and is a valuable quality marker. (Albeit this programme needs to be made more user friendly and less bureaucratic).

There will need to be clear links and connections with the Health and Wellbeing Board and the Children's Trust Board function which may remain. It is helpful that the arrangements will be for local determination.

The document identifies that there are key issues for local organisations to work together to safeguard children and young people and protect them from harm. GP consortia will become members of the LSCBs and escalation of concerns would be via the Health and Wellbeing Boards. There will need to be strong clinical leadership to support this role and clear training and development plans for lead representatives.

Appendix 5 – Overview and Scrutiny Response

Stockton Health Select Committee (HOSC)

NHS White Paper

Consultation Response

Submitted for inclusion in Stockton's Health and Wellbeing Partnership response

The Committee's comments are focussed upon the operation of the proposed Health and Wellbeing Boards, the future of health scrutiny, and the role of HealthWatch.

Health and Wellbeing Boards and health scrutiny

The Committee agrees with the proposal to use statutory powers to underpin the requirement for joint working and co-operation by partners with the Health and Wellbeing Board (HWB). There is still a need for clarity on the role of the HWB, and it will be important to keep the balance between local flexibility with regard to how it operates, and the need for the duties and powers that would be necessary to enable it to function effectively.

The Committee agrees with the proposed functions of the Health and Wellbeing Board, with the exception of the scrutiny role in relation to major service re-design. The Committee has serious concerns about the transfer of any scrutiny powers from Health Overview and Scrutiny Committees to Health and Wellbeing Boards.

The Board's responsibilities in relation to influencing commissioning, health improvement, the reduction of health inequalities and social care, will be incompatible with a scrutiny role and would lead to blurred accountability.

Currently, health scrutiny is effective as it makes use of the ability of elected Members to reflect the views and concerns of the people they represent. Health and Wellbeing Boards will need to be accountable for their actions and although the proposed membership of Health and Wellbeing Boards includes elected Members (presumably executive Members), these will be in the minority compared to the other proposed members.

The Committee believes that the retention of the full range of scrutiny powers by an independent health scrutiny forum would represent the best way forward in terms of ensuring that local accountability is maintained, and that there is a clear separation between those who are commissioning and influencing health services, and those whose duty it is to hold them to account.

This independence built into existing arrangements has already proven to be valuable. The Independent Reconfiguration Panel has used the reports of

health scrutiny committees when making recommendations on major service changes (for example, when considering the location of consultant-led maternity services in the North Tees area).

There needs to be further clarity in relation to the accountability of GP Consortia (whether to HWBs or independent health scrutiny forums), and the accountability of locally based services that have been commissioned on a national basis.

A separate scrutiny function would also provide a forum for the local resolution of disputes, both in situations where partners on the HWB could not agree on, for example, shared goals and priorities, and also in relation to major service re-designs.

In addition to providing a forum for responding to NHS proposals, since its introduction health scrutiny has enabled non-executive Councillors to undertake a wide range of pro-active investigations into issues of local concern. For example, Stockton's Health Select Committee has produced well-received reports on local alcohol services, and ensuring access to NHS dentistry provision. Many of these reviews have identified recommendations aimed at reducing health inequalities and the Committee believe that the ability to undertake this work should be maintained. It has been demonstrated that NHS commissioners have been able to use the evidence that has been gathered when designing services, and providers have been able to benefit from an extra level of assurance as to the quality of their services.

Health Watch

It is proposed that the HWB will include membership from the local Health Watch. This would have the benefit of ensuring that the voice of the public and patient is heard directly by those influencing the provision of services. However, unless careful consideration is given to the operation of the Board (for example, with regard to voting rights) Health Watch's ability to act as the independent 'consumer' voice could be compromised, and there is a danger of blurred accountability, similar to the situation with health scrutiny.

The Committee notes the concerns voiced by Stockton LINk in relation to the formation and operation of local Health Watch, and agrees that this is an issue that will require further consideration. The Health Watch proposals represent a significant change to patient and public engagement, at a time when there has as yet been no national evaluation of the effectiveness of LINks, which were themselves only established in 2008.

LINks as currently constituted do not have the capacity to undertake additional responsibilities, especially in relation to complaints advocacy and the provision of advice and information. The volunteer base would need support that would be commensurate with the additional services that it would be commissioned to provide. In addition, the future Health Watch must be able to ensure that it is able to keep a focus on both health and social care matters.

The Committee is also keen to be assured that during the transition period, high standards of patient care will be maintained, and there will continue to be opportunities for robust patient and public involvement.