DRAFT

Executive **5 October 2010**

Director of Adults, Children and Education

Liberating the NHS

Summary

1. This paper informs Executive of the proposals within the White Paper Liberating the NHS, in particular, those that have most impact for the Local Authority. It seeks agreement to the proposed response to the Government's consultations on the White Paper.

Background

2. The Government launched its White Paper, Equity and Excellence: Liberating the NHS, on 12 July. The proposals within the White Paper in summary are:
    - To offer more choice and control to patients over who provides treatment, and what the treatment should be, in the vast majority of NHS funded service.
    - To provide advocacy and support to help people access and make service choices, and to make a complaint, through HealthWatch England, a new independent consumer champion within the Care Quality Commission, which will take over responsibilities from the Local Involvement Networks (LINks)
    - Performance will be measured through new Outcomes Frameworks. These will set the direction for the NHS, public health and social care. They will be supported by quality standards, to be developed by NICE
    - Local authorities will become responsible for delivering national objectives for improving population health outcomes. This can include local authorities commissioning from providers of NHS care to deliver the outcomes.
    - Council's will become responsible for a ring fenced public health budget. Local Directors of Public Health will be appointed jointly by the local authority and a new national Public Health service.
    - Health and well-being boards will be established by local authorities or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These boards will replace the current statutory functions of the Heath Overview and Scrutiny committess. They will allow local authorities to take a strategic approach and promote integration across health, adult social care and children's services, including safeguarding, as well as the wider local authority agenda. It is not intended that the Local Authority will be involved in day-to-day interventions in NHS servcies
    - An autonomous statutory NHS Commissioning Board will be established. The Board will assess NHS commissioners and hold GP consortia to

account. The Board will be responsible for allocation of resources, and will commission some services including dentistry, community pharmacy, primary ophthalmic services and maternity services.

- Most of the commissioning currently undertaken by Primary Care Trusts (PCTs) will transfer to local consortia of GPs. This will not be voluntary for GPs, and powers and duties will be set out in primary and secondary legislation. Consortia size is not specified, but there is a requirement that they will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. Consortia can choose to buy in support for their commissionign activities, such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management. This could be from local authorities, as well as from other public, private and voluntary sector bodies.
- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.
- All NHS Trusts will be expected to become Foundation Trusts within three years, and so will be regulated by Monitor, the current Foundation Trust regulator.
- There will be no barriers for new suppliers of community health services; employees will be able to transform trusts to an employee led social enterprise, and the cap on the income that foundation trusts can earn from other sources will be abolished.

3. Alongside the White Paper four consultations have been launched.
    - On the outcomes framework
    - On the commissioning arrangements
    - On local democratic legitimacy in health
    - On provider regulation.

4. NHS commissioning in York is currently provided by the Primary Care Trust, NHS North Yorkshire and York, overseen by the Strategic Health Authority. The proposals would see both of these bodies ending by 2013. Commissioning would in future be undertaken locally by a new GP consortium or consortia, which may or may not be based on the current York Health Group consortium. York Health Group covers practices in York, Tadcaster and Easingwold.

Consultation

5. The Government has called for responses to the four consultation papers by 11 October 2010.

6. Both the Healthy City Board and Health Overview and Scrutiny have considered the proposals within the White Paper, and the questions asked within the consultation documents. Both bodies have focussed on the first three papers listed in paragraph 3.

7. Healthy City Board will consider the proposals on 14 September, and Health Overview and Scrutiny on 22 September, and this paper may be updated in response to any views agreed at these meetings.

Options

8. To confirm the proposed response to be sent on behalf of the Council, as outlined in Annex 1, in response to selected questions from the consultation papers.

9. Or to seek changes to this response and agree that the Leader approve a final response.

Analysis.

Key Issues for consideration

10. The proposals contained within the White Paper are significant and wide ranging. To help focus a response on key areas it is suggested that there are five issues that the Council will have a direct interest in:
    a. How the locality for GP commissioning will be defined, and what this may mean for York
    b. The implications for the increased role if LINks become HealthWatch and what this will mean for patient and citizen engagement and involvement
    c. How the Local Authority will exercise the proposed responsibilities for promoting integration
    d. The proposed role of the Health and Wellbeing Boards and what this may mean for the Council's scrutiny role
    e. The implications of public health responsibilities transferring to local authorities

a) GP commissioning and locality definition

11. The consultation on Commissioning for Patients deals with the planned arrangements for the role and functioning of local health commissioning.

12. There is no indication of what a sensible size for a GP consortium would be, or how the geography will be decided, only that there will be local flexibility, with GPs given the opportunity to identify who they wish to join with to form a consortium. The new national Commissioning Body will need to ensure that all GPs are within a consortium. Consortia boundaries will leave no gaps across the country. Locally, there are several options still to be decided upon by our GP partners.

13. One option could be for one or more consortia which are co- terminus with City of York boundaries, although given the nature of patient registrations, it is highly unlikely that our citizens will ever be completely matched by GP surgery patient lists.

14. Another option would be to reflect patients' treatment pathways as the basis for the consortium, and this might suggest a local hospital catchment area could define the locality. In York's case this could mean one or more consortia extending beyond the Council's boundaries and into North Yorkshire, based on the admissions to York Hospital Foundation Trust.

15. In York we have experience of the complexities that result from not having co-terminosity with our health commissioner. Joint commissioning has been slow to be progressed, in spite of good intentions on both sides. Better progress has been made more recently, with a York Adult Commissioning Group leading plans to develop a joint commissioning team and work plan. This has been possible because of a locality focus, based on the City of York boundaries, agreed by NHS North Yorkshire and York (NHSNYY).

16. Working to a wider catchment area in future would mean that NHS commissioners would continue to have to address two JSNAs, and need to work in partnership with two Health and Wellbeing Boards. Governance arrangements are likely to be more complex and opportunities for joint commissioning more complicated to deliver.

17. Discussions are underway to explore these issues with our local GPs and the current Practice Based Commissioning Consortium. We will continue our discussions and seek to help local GPs understand the benefit of being co-terminus with the local authority, whilst ensuring that our partnership work will be protected whatever the final shape of the consortia arrangements

18. However, Members may wish to make representations within the consultation response to urge that GP commissioning Consortia areas be linked more closely to the JSNA and Local Authority boundaries.

19. The following questions within the consultation paper on Commissioning for Patients would offer the opportunity to do this, and a proposed submission is include in Annnex 1:

- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

- Should there be a minimum and/or maximum population size for GP consortia?

- How can GP consortia best be supported in developing their own capacity and capability in commissioning?

- How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

- How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?

- How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

b) Patient and citizen engagement and involvement

20. The consultation on Democratic Legitimacy in Health addresses these issues.

21. Currently LINks promote public and patient involvement and seek views on health and social care services, to feed back to local commissioners. LINks also have an interest in ensuring local commissioners take account of the NHS constitution.

22. LINks are community organisations made up of a variety of individuals and organisations, and are supported by a 'Host', who is commissioned by the local authority. They do not currently provide an advocacy service or support with individual complaints. At present patients access such support this through a range of local advocacy organisations.

23. Local authorities would receive additional funding to commission the additional services. If local authorities are to be able to commission this enhanced service successfully it will be essential that adequate funding is provided.

24. There would not appear to be any reason to oppose the proposals to extend the role of the LINks. The LINKs organisation in York is considered to have made a good start, although it is still a relatively new body. However elsewhere in the country, concerns have been raised about the effectiveness of LINks.

25. Providing a single point of contact for patients and customers needing support in dealing with health and social care organisations would appear to be in line with our own ambitions to simplify contact and access arrangements.

26. Taking on the additional responsibilities for advocacy and complaints could provide the organisation with a broader access to views on services, however these will, by definition, primarily be from those who have experienced a difficulty. Clear expectations about the separation of responsibilities might help to avoid the engagement and participation element of the work being overly influenced by the complaints and advocacy.

27. Taking on an advocacy role could also impact on other local advocacy organisations, and could put at risk some of the more specialist support that is available to more vulnerable groups and those with special communication needs. A requirement to work in collaboration with other advocacy groups might be helpful therefore.

28. Annex 1 contains a proposed response to the following questions:

    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?

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

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

    <u>c) Promoting integration</u>

29. The consultation on Democratic Legitimacy in Health addresses the proposed role of local government in promoting integration and joint working.

30. The current arrangements under Section 75 of the NHS Act set out optional partnership arrangements for service led collaboration between health bodies and the local authority. Currently there is only limited use of these partnership arrangements, both nationally and locally.

31. In York there is a Section 75 agreement and pooled budget for Drugs and Alcohol commissioning. We have a partnership agreement, but no pooled budget for the provision of mental health services for working age adults, and the Children's Trust provides some joined up commissioning.

32. In July 2010 the Executive Member for Health and Adult Social Services agreed a joint vision for older people's services, developed with these two health partners, as a foundation for future joint commissioning.

33. Work is now under way to develop joint commissioning arrangements with NHS North Yorkshire and York (NHSNYY) and the York Health Group (YHG), for adults service. Whilst the White paper will mean plans will need to be reviewed, it is anticipated that this development will continue. This could put York in a good position to consider any opportunity to be an early adopter of any changes, should our health partners wish to consider this option.

34. Locally in York we already have a positive model of the Healthy City Board. It mirrors the proposals for the health and well being board, bringing council members and officers, the Primary Care Trust, Practice Based Commissioners LINk and other partners together. The Board addresses both adults and Children's issues, and has worked alongside the Children's Trust (the YorOK Board). We have positive relationship with our Primary Care Trust and GP Commissioning Consortium

35. It has to be recognised that this has not, to date, led to extended integration of services.

36. The Government is asking whether giving local authorities a statutory role to support joint working on health and well being will encourage more integration, and whether it should therefore be a requirement to have a Health and Wellbeing Board.

37. Statutory powers to support joint working would emphasise the importance of partnership work, but partnership working requires commitment from all partners, and cannot be driven by just one organisation.

38. Of the nine strategic partnerships within the city two currently have statutory powers. These are the Safer York Partnership and the Children's Trust. There is no evidence that the statutory nature of these two partnerships makes it any easier to ensure integration, and although it does give a focus to the potential to pool funding it does not guarantee that this will happen.

39. The barriers to further integration in York include the impact of the financial risks of pooled budgets, with both the health and social care economies not in balance, and the complexities in governance due to the lack of co-terminus boundaries. Our current work to develop more joined up commissioning includes a commitment to understand the total budget for key areas of service in York, a commitment to develop a single work plan which addresses our shared

objectives, and the continuation of the Adult Commissioning Group as a forum for managing the various governance arrangements of all partners.

40. It is suggested that Members may wish to respond to the consultation that greater integration is unlikely to be achieved without:

- mechanisms within pooled budget arrangements to better manage risk,
- toolkits to help show benefit attribution across the whole system
- co terminous boundaries which will support more joined up governance arrangements

41. Annex 1 contains proposed responses to the following questions within the consultation on democratic legitimacy :

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

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

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

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?

d) Establishment of Health and Wellbeing Boards

42. The consultation on Democratic Legitimacy in Health also addresses the proposals for health and wellbeing boards.

43. The proposed functions of the health and well being boards are:

- To assess the needs of the local population and lead the joint strategic needs assessment.
- Promote integration and partnership including joined up commissioning plans
- To support joint commissioning and pooled budgets where all parties agree this makes sense
- To undertake a scrutiny role in relation to major service redesign

44. Membership is proposed to include: The local authority Leader or Directly Elected Mayor, representatives from social care and NHS commissioners (both GPs and the new NHS Board) and champions from local government and patient voice. Representatives from the new HealthWatch and from the new local Authority led public health service would be included in this. The elected members of the local authority would decide who chairs the Board

45. In effect the proposals are to bring together the current responsibilities of the Local Strategic Partnership (our Health City Board) and the Overview and Scrutiny Committee. The proposals would therefore impact on both the current Strategic Partnership arrangements and the governance arrangements for the Council.

46. The expectation is that by developing a partnership approach there would be an opportunity for the local authority to influence the GP consortia commissioning plans, and for the GP consortia to influence the public health plans of the local authority.

47. Under the new proposals GP consortia will be required to work in partnership with local authorities, but will also be able to choose from where they receive any support, that they may need in their commissioning activity, and will be able to use private services. The documents make it very clear that the local authority will not be involved in day to day work with NHS, although it also makes reference to joint commissioning between GP consortia and local authorities.

48. The proposed health and well being board is not therefore proposed as a joint commissioning body but as a strategic partnership board. A question that has been raised by others is whether the model of strategic partnership working will be effective, if key investment decisions are still taken elsewhere in partner organisations.

49. Questions have also been raised about changing the authority of scrutiny committees and the potential for confusion between the roles of the Health and Wellbeing Board and scrutiny committees. Whilst a really strong partnership should be able to challenge the constituent partners, the independence and separation of powers of a scrutiny committee would be lost. This raises questions as to the accountability of the Board and, if the local authority representation is at an Executive Member level, it also raises the issue of what influence other members can have on the health agenda.

50. Annex 1 contains a proposed submission in relation to the following questions relating to the Health and Well being Board:

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

    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?

    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?

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

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

    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)?

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

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?

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?

e)Transfer of Public Health responsibilities to local authorities

51. There is only currently only outline on the proposals for local authorites to take on public health responsibilities and a separate White Paper is due in December which will provide more detail.

52. Public health services currently take responsibility for health improvement, health promotion and health protection. Health protection may become the responsibility of a national public health body.

53. The local authority already plays a significant role in health improvement, and promotion with housing, education and access to sport and leisure being key determinants of good health and well being. The Council is already jointly responsible for the production of the JSNA, with Public Health.

54. It would appear therefore to make good sense to transfer public health responsibilities to the local authority. Such an arrangement should enhance our ability to understand the health and wellbeing needs of our community as we gain the skills and data available to our public health colleagues. It would also provide closer access to clinical and professional guidance on best practice to deliver health improvements, and will enhance the authority with which the Council works to promote joint and integrated working with GP consortia to ensure the right service are commissioned to provide cost effective interventions.

55. Given that Public Health budgets are often small, it is not yet clear what resources will actually transfer to Councils, alongside the new responsibilities

56. It is worth noting that within the consultation on the proposed outcome framework for the NHS it is planned that a separate framework will be developed for both public health and social care. Details of these frameworks is not yet available, but it is anticipated that the principles will be the same as for the NHS.

57. One concern that has been raised is that although there is a commitment to joint responsibility for outcomes across the system separate frameworks will work against an joined up approach to performance management and delivery of outcomes.

58. There are no specific questions within the consultation regarding the proposed transfer of public health, but there is an opportunity to make any other comments and Members may wish to highlight budget issues

Corporate Objectives

59. The White Paper will impact on the Council's objectives in respect of:

A Healthy City – we want to be a city where residents enjoy long healthy and independent lives. For this to happen we will make sure people are supported to

make healthy lifestyle choices and that health and social care services are quick to respond to those that need them

Implications

Financial

60. There are no financial implications for the Council at this stage

Human Resources (HR)

61. There are no immediate HR implications for the Council within the consultations, but if the proposals are accepted there will be issues related to the transfer of Public Health staff.

Equalities

62. The Government has undertaken its own Equality Impact assessment on these proposals

Legal

63. There are no legal implications flowing directly from the consultations and this report. However, the implementation of the Government proposals will have a range of implications particularly relating to staffing and governance issues.

Crime and Disorder

64. There are no crime and disorder implications

Information Technology (IT)

65. There are no immediate IT implications at this stage

Property

66. There are no property implications at this stage

Risk Management

67. There are no risks that require registration in the council's risk register in relation to the proposed submission to the Government's consultations.

Recommendations

68. It is recommended that Executive approves the responses in Annex A, and that further reports are provided on the detailed implications and opportunities as they become known.

Reason: To ensure that York's views are made known, and to enable the authority to review the implications of major change in more detail.

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Report Approved ☐ **Date**

Wards Affected: **All** ✔

For further information please contact the author of the report

Annex

Annex 1 Draft response to consultations of Liberating the NHS White paper