LIBERATING THE NHS: LOCAL DEMOCRATIC LEGITIMACY IN HEALTH BMA SUMMARY (ENGLAND)

Background
On 12 July 2010 the Secretary of State for Health Andrew Lansley released a White Paper on health reform entitled Equity and Excellence: Liberating the NHS setting out an ambitious agenda for the NHS for the next five years.

As part of the White Paper consultative process Liberating the NHS: Local democratic legitimacy in health was released on 22 July 2010. This joint Department of Health (DH) and Department for Communities and Local Government consultation provides further information on proposals to increase local democratic legitimacy and accountability in health, through an enhanced role for local government. Responses to the consultation document are due by **11 October 2010.**

Introduction

- **In the new system, local authorities will have an enhanced role in four areas:**
    - Leading joint strategic needs assessments (JSNA)[1] to ensure coherent and coordinated commissioning strategies;
    - Supporting local voice and the exercise of patient choice;
    - Promoting joined up commissioning of local NHS services, social care and health improvement; and
    - Leading on local health improvement and prevention activity.
- This will provide the opportunity for local areas to further **integrate health with adult social care, children's services and wider services such as housing.**
- **Local authorities will lead the process of JSNA** across health and local government services and promote joint commissioning between GP consortia and local government.
- GP consortia and the NHS Commissioning Board will be responsible for making health care commissioning decisions, informed by the JSNA.
- The Government would encourage local authorities to take the NHS Constitution into account when influencing NHS commissioning decisions.
- The Government will work with the Local Government Association to understand the potential benefits of place-based budgets through the Spending Review period. The possible application of these approaches to cross-cutting areas of health spending that require local partnerships will be examined.
- **Elected local councillors and local authorities will have an enhanced role**, in order to boost local democratic engagement.

CHAPTER 2 – Strengthening public and patient involvement

This chapter puts forward proposals for creating a more responsive NHS by strengthening public and patient involvement.

- Structures for local public and patient involvement have been subject to numerous changes.
- **The Government intends to build on the current statutory arrangements, to develop more powerful and stable infrastructure in the form of local HealthWatch**, **which will act as local consumer champions across health and care.**
- **Local Involvement Networks (LINks) will become the local HealthWatch.**

[1] A joint strategic needs assessment is an assessment of the health and wellbeing needs of the population in a local area and since 2007 it has been a statutory duty for primary care trusts and local authorities to undertake one.

It is proposed that local HealthWatch be given additional functions and funding. Like LINks, they will:

- Promote patient and public involvement;
- Seek views on local health and social care services which can be fed back into local commissioning; and
- Continue to take an interest in the NHS Constitution.

It is proposed that **HealthWatch perform a wider role, so that they become more like a "citizen's advice bureau" for health and social care.** Therefore it is proposed they are granted additional specific responsibilities, matched by additional funding for:

- **NHS complaints advocacy services**. This is currently a national function of the NHS, exercised through a DH contract for the Independent Complaints Advocacy Service. It is proposed that this responsibility is devolved to local authorities to commission through local or national HealthWatch; and
- **Supporting individuals to exercise choice e.g. helping patients choose a GP practice.**

Local authorities have a vital role in commissioning HealthWatch arrangements.

- They will continue to fund HealthWatch, and contract for their services. Local authorities have an important responsibility, set out in statute, for discharging these duties, and holding local HealthWatch to account for delivering services that are effective and value for money.
- They will ensure that the focus of HealthWatch activities are representative of the local community.
- **In the event of underperformance, a local authority should intervene; and ultimately re-tender the contract.**
- **Local HealthWatch would still be able to report concerns about the quality of the provision of local NHS or social care services to HealthWatch England,** in order to inform the need for potential regulatory action, independently of its host local authority.
- **HealthWatch England will form a statutory part of the Care Quality Commission (CQC), the quality regulator for health and social care.** This role for HealthWatch will be underpinned by continued rights to visit provider organisations**.**

CHAPTER 3 – Improving integrated working

The Government has stated that 'Liberating the NHS' is designed to strengthen integration in a number of ways including:

- **Giving people more choice**. This includes choice of treatment and care not just choice of provider;
- **By extending the availability of personal budgets** in the NHS and social care, with joint assessment and care planning;
- **The development of NICE quality standards across patient pathways**;
- **Through the CQC as an inspectorate of essential quality standards**, that span health and social care;
- **Through payment systems being used to support joint working** – for example the proposals around payment by results and hospital readmissions;
- **Through freeing up providers to innovate and focus on the needs of the people using services rather than the needs of a top-down central bureaucracy**. For example, by proposing to remove the constraints on foundation trusts to enable them to augment their NHS role, by, for example, expanding into social care.

The existing framework provided in legislation[2] sets out optional partnership arrangements for service-level collaboration between local authorities and health related bodies. The arrangements include:
- Lead commissioning (with PCTs or local authorities leading commissioning services for a client group on behalf of both organisations);
- Integrated provision (for example care trusts); and
- Pooled budgets.

- **The take up of the current flexibilities to enable joint commissioning and pooled budgets has been relatively limited**. It has tended to focus on specific service areas, such as mental health and learning disabilities.
- The full potential of joint commissioning remains untapped.
- **GP commissioning consortia will have a duty to work with colleagues in the wider NHS and in social care to deliver more integrated care**.
- **The Government believes that there is scope for stronger institutional arrangements within local authorities, led by elected members, to support partnership working across health and social care**.
- Local authorities' skills, experience and existing relationships present them with an opportunity to bring together the new players in the health system, as well as to provide greater local democratic legitimacy in health.

The Government believes that there is scope for stronger institutional arrangements within local authorities, led by elected members, to support partnership working across health and social care, and public health:
- One option is to leave it up to NHS commissioners and local authorities to devise their own local arrangements.
- **The Government proposes establishing a statutory role within each upper tier local authority to support joint working on health and wellbeing**. This would provide duties on commissioners to participate and provide a high level framework of functions.
- **Another way to enhance roles and responsibilities is through a statutory partnership board such as a health and wellbeing board** – established within the local authority. If health and wellbeing boards were created, requirements for such a board would be minimal, with local authorities having freedom and flexibility as to how it works in practice.

Functions of health and wellbeing boards
The primary aim of the health and wellbeing boards would be to promote integration and partnership working across the NHS, social care, public health and other local services and improve democratic accountability. The Government proposes that statutory health and wellbeing boards would have four main functions:

1. To assess the needs of the local population and lead the statutory joint strategic needs assessment;
2. To promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
3. To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and.
4. To undertake a scrutiny role in relation to major service redesign.

- There would be a statutory obligation for the local authority and commissioners to participate as members of the board and act in partnership on these functions.
- Responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia.

[2] Section 75 of the NHS Act 2006.

- **Health and wellbeing boards would give local authorities influence over NHS commissioning and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.**

Operation of health and wellbeing boards

- **The Government anticipates that statutory health and wellbeing boards would sit at the upper tier of local authority level.**
- **However, the boards would want to put in place arrangements to discharge their functions at the right level**. In two-tier areas boards may want to delegate the lead for some functions to districts or neighbourhoods.
- Health and wellbeing boards would have a lead role in determining the strategy and allocation of any local application of place-based budgets for health.
- Health and wellbeing boards would have an important role in relation to other existing local partnerships e.g. vulnerable adults and children's safeguarding.
- **To reduce bureaucracy, local authorities may want to use the proposed health and wellbeing boards to replace current health partnerships** where they exist.
- If these proposals are taken forward, appropriate arrangements to support the full package of reforms in London will have to be made with links between the borough boards and the Mayor.

Membership of health and wellbeing boards

- **The boards would bring together local elected representatives** including the Leader or Directly Elected Mayor, social care, NHS commissioners, local government and patient champions.
- Directors of Public Health would also play a crucial role.
- The elected members of the local authority would decide who chaired the board.
- **The board would include both the relevant GP consortia and representation from the NHS Commissioning Board** (where relevant issues are being discussed).
- The Government would specify both parties' duty to take part in the partnership in legislation.
- Health and wellbeing boards could agree joint NHS and social care commissioning of specific services e.g. mental health services.
- A local representative from HealthWatch will have a seat on the board.
- Local authorities may also want to invite local representatives of the voluntary sector and other relevant public service officials to participate in the board.

Overview and scrutiny function

- Overview and scrutiny committees (OSCs) currently scrutinise health service changes and the ongoing planning, development and operation of services, and hold the NHS to account by:
    - Calling NHS managers to give information and answer questions about services and decisions locally;
    - Requiring consultation by the NHS on proposals for major health changes; and,
    - Referring contested service changes to the Secretary of State.
- **To avoid duplication, the Government proposes that the statutory functions of the OSC would transfer to the health and wellbeing board.**
- This would strengthen the overview that local authorities have on health decisions and bring in the voice of the local HealthWatch.
- Having a seat on the health and wellbeing board gives HealthWatch a stronger formal role in commissioning decisions than currently exists for LINks.
- The Government will work with local authorities and the NHS to develop guidance on how best to resolve disputes locally, so that they are only referred on in exceptional cases.
- It is proposed that the health and wellbeing board will 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 the public.

- If health and wellbeing boards have significant concerns about substantial service changes an attempt should be made to resolve this locally.
- **The boards would be expected to take account of the need to deliver services more efficiently, and of the wider quality, innovation, productivity and prevention (QIPP) agenda.**
- **The board may choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel.**
- There will still need to be a dispute resolution system beyond the local level for exceptional cases.
- **Where the dispute is unable to be resolved, the health and wellbeing board would have the power to refer the commissioning decision to the NHS Commissioning Board.**
- **If the issue relates to a decision made by the NHS Commissioning Board (e.g. in relation to maternity services) the health and wellbeing board may choose to refer it directly to the Secretary of State.**
- **If the NHS Commissioning Board is satisfied that the correct procedure has been followed but the health and wellbeing board still has significant concerns about the issue they will have a statutory power to refer cases to the Secretary of State.**
- The Secretary of State would then consider the NHS Commissioning Board's report alongside the reasons for referral, seeking advice from the Independent Reconfiguration Panel.
- In the context of the new regulatory framework, the Secretary of State for Health's involvement will be subject to independent decisions made by regulators - Monitor, and the CQC - for example on the basis of patient safety.
- Local authorities will need to assure themselves that they have processes in place to adequately scrutinise the functioning of the health and wellbeing boards and health improvement policy decisions.

CHAPTER 4 – Local authority leadership for health improvement

This chapter sets out the Government's vision for local authorities to have a stronger influence on the health outcomes for their local area.

- **Responsibility and funding for local health improvement will be transferred to local authorities when PCTs are abolished.**
- In practice, this would mean that **services such as smoking cessation would be funded from the resources transferred to the local authority but treatment for patients with impaired lung function through smoking would be funded from resources allocated to GP consortia by the NHS Commissioning Board.**
- **Local authority leadership will be complemented by the new national Public Health Service (PHS),** which will aim to integrate and streamline health improvement and protection bodies and functions, including an emphasis on research, analysis and evaluation.
- The PHS will have powers in relation to the NHS in order to manage public health emergencies. The NHS Commissioning Board will have a role in supporting the PHS to ensure the NHS is resilient and able to be mobilised as appropriate during any emergency.
- **The local authority will play a role in national campaigns aiming to improve or protect public health or provide population screening**, tailoring campaigns to the needs of the local population.
- **Local Directors of Public Health will be jointly appointed by local authorities and the PHS and will have a ring-fenced health improvement budget allocated by the PHS.**
- **There will be direct accountability to both the local authority and, through the PHS, to the Secretary of State.**
- The Secretary of State, through the PHS, will agree with local authorities, the local application of national health improvement outcomes. Local authorities will determine how best to secure these outcomes.

- Health improvement will be aligned with future arrangements for outcomes in local government and in particular with the approach to social care outcomes.

Timeframe
2012 - Subject to legislation, health improvement functions will transfer to local authorities and statutory partnership functions will be formally established.

However, if the idea receives support the Departments of Health and Communities and Local Government will support local authorities to establish shadow arrangements with the PCT, emerging GP consortia and LINks in 2011.

Consultation Questions

1. 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?
2. Should local HealthWatch take on the wider role as outlined with responsibility for complaints advocacy and supporting individuals to exercise choice and control?
3. What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?
4. What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?
5. What further freedoms and flexibilities would support and incentivise integrated working?
6. Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?
7. 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?
8. Do you agree that the proposed health and wellbeing boards should have the main functions as described?
9. 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 JSNAs?
10. 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?
11. 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?
12. Do you agree with our proposals for membership requirements of health and wellbeing boards?
13. What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?
14. 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)?
15. How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?
16. 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?
17. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they [the proposals] can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?
18. Do you have any other comments on this document?