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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

DATE: THURSDAY 16 SEPTEMBER 2010
TIME: 3.00 PM
PLACE: WARSPITE ROOM, COUNCIL HOUSE

Committee Members–
Councillor Ricketts, Chair
Councillor Coker, Vice Chair
Councillors Bowie, Delbridge, Gordon, Dr. Mahony, Mrs Nicholson, Dr. Salter and Viney

Co-opted Representatives-
Margaret Schwarz (NHS Plymouth Hospitals Trust), Chris Boote (Plymouth LINk)

Any Member other than a Member of the Cabinet may act as a substitute member provided that they do not have a personal and prejudicial interest in the matter under review.

Members are invited to attend the above meeting to consider the items of business overleaf.

Members and Officers are requested to sign the attendance list at the meeting.

BARRY KEEL
CHIEF EXECUTIVE

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

PART I (PUBLIC COMMITTEE)

AGENDA

1. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

Members will be asked to make and declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. HEALTH WHITE PAPER CONSULTATION (Pages 1 - 8)

The panel will consider a response to the consultation on the Health White Paper Equity and excellence: Liberating the NHS.

4.1. White Paper Presentation

The panel will receive a presentation on the White Paper “Equity and Excellence: Liberating the NHS” with focus on the consultation paper “Liberating the NHS: Local Democratic Legitimacy in Health”.

4.2. Feedback on proposals from NHS Plymouth

4.3. Feedback on proposals from NHS Plymouth Hospitals Trust

4.4. Feedback on proposals from General Practioners

4.5. Feedback on proposals from Plymouth Adult Social Care

4.6. Feedback on proposals from UNISON

4.7. Feedback on proposals from the Local Involvement Network

4.8. Feedback on proposals from the Children's Trust

5. PANELS RECOMMENDATIONS FOR RESPONSE

The panel will consider its response to the consultation documents.

6. EXEMPT BUSINESS

To consider passing a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve(s) the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000

PART II (PRIVATE COMMITTEE)

MEMBERS OF THE PUBLIC TO NOTE
that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.

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Prepared by the Director for Public Health

Summary of the NHS White Paper

Commissioning of health services will be done by GP Commissioning Consortia (with the exception of 'essential service', public health and health promotion). Government intention is that these Consortia will be established in shadow form by the end of 2011.

GP Commissioning Consortia will be able to commission services from any willing provider.
There will be a new national commissioning organisation, the NHS Commissioning Board, which will oversee Consortia commissioning and commission essential services. This will be established in shadow form as a special health authority in April 2011 with a view to being fully established by April 2012.

A new public health service is expected to be in place by April 2012 (details to be announced in a White Paper later in 2010), possibly in shadow form by 2011.

PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health jointly appointed with the new national Public Health Service. The Department of Health will create and allocate a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

Strategic Health Authorities will be abolished in 2012.

PCTS will be abolished from 2013 as GP Consortia take on fuller commissioning responsibilities.

A new advocacy organisation, called HealthWatch, will be set up by April 2012. This will be a statutory department of the Care Quality Commission (CQC), which champions service users across health and social care and will enhance the role of the local authority in promoting choice and complaints advocacy.

The NHS White Paper, and its contents, has not yet been approved and legislated so some of the above details are liable to change. The NHS Bill, expected to be introduced to Parliament in Autumn 2010, will firm up some of these details and their confirmed date for implementation. At the moment, the proposed dates to implement the changes start in 2011 and will take until 2015 to complete.

Background

The NHS White Paper "Liberating the NHS" sets out transformational plans for radical restructuring and transfer of NHS responsibilities to both the Local Authority and as yet, largely unformed GP Commissioning Consortia. These plans are described in more detail in two key papers "Liberating the NHS: Commissioning for Patients" which sets

out the roles for proposed GP Commissioning Consortia and "Local Democratic Legitimacy in Health" which sets out new roles for the Local Authority. The latter paper is part of what the Government sees as the practical application of localism within the NHS, pushing power away from Whitehall out to those who know best what will work in their communities. The new proposals for the NHS have a strong emphasis on a strengthened market economy in the NHS and reintroduces the notion of 'any willing provider'.

Unusually the White Paper is subject to consultation as it contains many proposals that were not included as part of the Coalition Government's separate party manifestoes nor the original coalition plan. The consultation period finishes 5th October 2010.

"Local Democratic Legitimacy in Health" Summary

Elected councillors and Local Authorities will have a new role in ensuring the NHS is responsible and answerable to local communities. It is expected that for the first time in forty years, there will be real local democratic accountability and legitimacy in the NHS. Local Authorities will be expected to set up Health and Well Being Boards, commission 'HealthWatch' - the replacement for LINks, a new way for patients and the public to shape health services as part of their new responsibility for ensuring local voices are heard within the health service and patients are able to exercise genuine choice. Local Authorities will also significantly take the lead in improving local public health, for the first time since 1974.

In this new role, Local Authorities will be assessing local needs, promoting more joined up services, and supporting joint commissioning. This builds on the existing work that is already in place in Plymouth by joining up services to improve local health and social care at locality level and should help ensure a closer working relationship between health and other Local Authority responsibilities, such as housing and environmental health. This means that patients who need the help of both health and social care services can expect to get much more coherent, effective support in future.

National Changes and Responsibilities

The intention of Government is to remove 'political interference' from the NHS by setting up an independent national **NHS Commissioning Board** which will retain national accountability for the NHS but with 'less scope for day-to-day political interference'. This NHS Commissioning Board will be responsible for:

- Allocating and being accountable for NHS resources.
- Ensuring a comprehensive system of GP Commissioning Consortia is in place across the NHS including setting budgets for GP Commissioning Consortia and holding them to account for the outcomes they achieve and for financial performance.

- Developing commissioning guidelines, model contracts and tariffs for GP Consortia.
- Holding the contracts for the services that 29,000 GPs provide themselves (and also for dentists, pharmacists and opticians).
- Providing national leadership on commissioning for quality improvement.
- Promoting and extending public and patient involvement and choice.
- Commissioning specialist services such as children's intensive care, spinal services, heart transplants, kidney failure services and specialist cancer services where economies of scale and patient safety issues require them to be commissioned within bigger geographical areas or at regional or national level.
- Commissioning maternity and newborn care services in order to promote choice across a range of settings and services.
- Commissioning health services for those in prison or custody subject to negotiation with both GP Consortia and criminal justice agencies to determine the most appropriate arrangements for prison health services.
- The NHS Commissioning Board will need powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure. The NHS Commissioning Board is proposing to work with the NHS to develop criteria or triggers for intervention.

Local Changes and Responsibility

1. GP commissioning Consortia

Consortia of GP practices will, in the future, commission the great majority of NHS services on behalf of patients, including planned hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services. Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

Within the new legislative framework, GP practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. They will be put on a statutory basis with powers and responsibilities set out through primary and secondary legislation. Consortia will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively.

The specific accountabilities, responsibilities and duties of consortia will be set out through primary and secondary legislation. This will include accountability and responsibility for:

- determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities;
- determining what services are required to meet these needs and ensuring the appropriate clinical and quality specification of these services;
- entering into and managing contracts with providers;
- monitoring and improving the quality of healthcare provided through these contracts;
- providing oversight, with the NHS Commissioning Board, of healthcare providers' training and education plans.

The legislation will also set out a consortium's duties in relationship to financial management, including ensuring that expenditure does not exceed its allocated resources and requirements in relation to reporting, audit and accounts. By the time legislation is passed, each consortium would need to have chosen its own Accountable Officer and Chief Financial Officer.

- Consortia will have duties in relation to equality and human rights and in relation to data protection and freedom of information.
- Consortia will have duties to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, services for carers, and to cooperate with local authorities and other agencies in relation to criminal justice.
- Consortia will have a duty to inform, engage and involve the public in identifying needs, planning services and considering any proposed changes in how those services are provided. Where this is likely to result in changes in the configuration of services, consortia will be expected to report on the likely impact of those changes and the impact of public involvement on their commissioning decisions.

2. Local Authority Roles and functions

Local Authorities will lead the statutory joint strategic needs assessment, which will inform the commissioning of health and care services and promote integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health. They will support joint commissioning and pooled budget arrangements, where parties agree this makes sense, and will undertake a scrutiny role in relation to major service redesign. One option for doing this is through the creation of statutory health and wellbeing boards within local authorities.

Structures for leading local public and patient involvement have been subject to numerous changes in the last ten years. The Government intends to build on the current statutory arrangements, to develop a more powerful and stable local 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.

Local government will also have an enhanced role in public health, with direct responsibility and ring fenced funding (allocated to local Directors of Public Health) for improving the health of local communities, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity.

Local Authorities will be responsible for:

- leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement;
- leading on local health improvement and prevention activity.

The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs. Services also need to be developed in ways that fit around the people who use them, and their families, and that they can understand and shape. People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions.

Local Authorities have the opportunity with these new arrangements to strengthen integrated working across the health and social care agenda, from the point of providing services, to people understanding how services need to be commissioned to best meet the health and well-being needs of local populations. They can also improve integrated working right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and reablement.

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. 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. In order to support this, new legislation is likely to include the establishment of a statutory role, for Local Authorities, to support joint working on health and well-being.

One way in which respective roles and responsibilities could be enhanced further, is through a statutory partnership board - a health and well-being board - within the local authority. This would provide a vehicle and focal point through which joint working and integrated commissioning could happen.

The Government proposes that **statutory health and well-being boards** would have four main functions:

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

There will be a statutory obligation for the local authority and commissioners to participate as members of the board and act in partnership on these functions. Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the health and well-being board would give the Local Authority influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care. It is anticipated that these new health and well-being boards would replace the roles of both Overview and Scrutiny and the LSP Health Theme group.

Membership of health & well-being boards & responsibilities of the Local Authority

It is anticipated that the board will bring together local elected representatives including the Leader of the Council and other key elected members with specific responsibilities for health, the Directors of Adult Social Care, Children's Services and Public Health, NHS commissioners, (both GP Consortia and the national NHS Commissioning Board where relevant) and patient champions including HealthWatch around one table. The elected members of the local authority will decide who chairs the board.

Health and well-being boards could agree joint NHS and social care commissioning of specific services, for example mental health services, including prevention, or agree the allocation and
strategy for place-based budgets on cross-cutting health issues. The precise role of place-based budgets should be a decision for the health and well-being board in light of local priorities.

Health and well-being boards will have a key new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services and address any concerns about significant changes to services planned by local Consortia.

Local authority leadership for local health improvement will be complemented by the creation of a National Public Health Service which will integrate and streamline health improvement and health protection bodies and functions, and will include an increased emphasis on research, analysis and evaluation. It will secure the delivery of public health services that need to be undertaken at a national level.

In order to manage public health emergencies, the Public Health Service will have powers in relation to the NHS, matched by corresponding duties for NHS resilience. The Local Authority will also play an important role in Public Health Service campaigns of national importance, which aim to protect public health or provide population screening; and it will have a role in national health improvement campaigns, tailoring programmes to meet the needs of its local population.

The local Director of Public Health will be jointly appointed by the Local Authority and the national Public Health Service. S/he will have a ring-fenced health improvement budget, allocated by the Public Health Service, and will be able to deploy ring fenced resources to deliver national and local priorities. The Director of Public Health will be direct accountability to both the local authority, and, through the Public Health Service, to the Secretary of State. Through being an employee of the local authority, the local Director of Public Health will have direct influence over the wider determinants of health, advising elected members and as part of the senior management team of the local authority.

The Secretary of State, through the Public Health Service, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes and this may include commissioning services, for example, from providers of NHS care. It is anticipated that in the coming Public Health White paper due out in December 2010 that it will include alignment of arrangements for health improvement with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

Local Involvement

The proposal for the development of HealthWatch is for it perform a wider role, so that they become more like a "citizen's advice bureau" for health and social care - the local consumer champion - providing a signposting function to the range of organisations

that exist. Government proposes that they are granted additional specific responsibilities, matched by additional funding, for:

- NHS complaints advocacy services. Currently, this is a national function for the NHS, It is proposed that this responsibility is devolved to local authorities to commission through local or national HealthWatch, so that they can support people who want to make a complaint.
- Supporting individuals to exercise choice, for example helping them choose a GP practice. Local HealthWatch will have a key role in offering support to those that need it.

The national HealthWatch England will form a statutory part of the Care Quality Commission (CQC), the quality regulator for health and social care.

3. What does this mean for the NHS in Plymouth?

Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards, means that PCTs will at some point in the future, no longer have a role. Government expects that **from** April 2013, PCTs, where GP Commissioning Consortia have developed sufficiently to take on a full commissioning role, will cease to exist. PCTs are expected to manage the transition of responsibilities to the new Consortia and share their current expertise and skill to help prepare for the new arrangements. Hospitals are all expected to become independent Foundation Trusts with unsuccessful hospitals (performance, patient safety or longstanding financial difficulties) resulting in the hospital being taken over or 'franchised' by another Foundation Trust.

4. Proposed Timetable for Implementation

In 2010/11: GP consortia to begin to come together in shadow form

In 2011/12: a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form.

In 2012: formal establishment of the new national Public Health Service and transfer of Public Health teams with ring fenced health improvement budget to Local Authorities (possibly in shadow form from 2011).

In 2012/13: formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body.

In 2013/14: GP consortia to be fully operational, with real budgets and holding contracts with providers. PCTs to be dissolved when GP Consortia are fully operational.