Agenda Item No. 12

HEALTH WHITE PAPER REFORMS OF THE NHS AND ASSOCIATED CONSULTATION

To: **Cabinet**

Date: **18th September 2010**

From: **Executive Director: Community And Adult Services**

Electoral division(s): **ALL**

Forward Plan ref: **N/A** *Key Decision:* **No**

Purpose: To report the Government White Paper on reforms of the NHS and associated consultations.

Recommendation: Cabinet is recommended to consider the White Paper and associated consultations and comment on potential responses from the County Council.

Cabinet is further recommended to devolve responsibility for finalising the Council's response to the White Paper and accompanying consultation to the Cabinet Member for Adult Social Care, Health and Wellbeing in consultation with the Executive Director: Community And Adult Services

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1. BACKGROUND

1.1 On 12th July 2010 the Secretary of State for Health (Andrew Lansley) published the White Paper *Equity and Excellence: Liberating the NHS*. Subsequently a range of consultations have been issued by the Department of Health (DH), listed at section 4 below.

1.2 Most of the proposals in the White Paper need primary legislation to be introduced and a Public Health White Paper is expected later this year and another on social care reform is due in 2011. The majority of the reforms are expected (subject to legislation) to come into effect in April 2012 with significant development of the detail to be carried out beforehand.

1.3 A joint response from Cambridgeshire Together is being prepared and the joint Adult Wellbeing and Health Scrutiny Committee is developing a separate reply (more detail on the Scrutiny implications are at 4.6 below). It is understood that Health colleagues are considering a separate response in addition to the Cambridgeshire Together reply.

1.4 The overall intentions of the White Paper are strongly in line with the Coalition Government's approach to localism, including moves for local people to have a much greater say in the services they need and want. There are some inherent dangers in the proposals which, if the implementation is not planned carefully, could replace current bureaucratic arrangements rather than just remove them. The Paper represents a major restructuring, not just of health services but also of councils' responsibilities in relation to health improvement, and coordination of health and social care.

1.5 The proposals in the White Paper cover four broad themes:

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

1.6 Within these themes are a range of more specific proposals:

- Focus on patient choice, control and involvement, including shared decision making with clinicians, improved access to information and greater opportunities for patient feedback about services. Patients will be allowed to register with whichever General Practitioner (GP) practice they choose, regardless of where they live, and choose which hospital and consultant-led team they wish to treated them
- It is proposed that GP consortia will take over responsibility for commissioning health services in April 2013, after which Primary Care Trusts (PCTs) will be abolished.
- Greater focus on improved health outcomes to replace process-led targets. Doctors will be obliged to keep data on their own performance and publish detailed evidence of hospital mortality rates.
- Responsibility for commissioning most NHS services to be given groupings of GPs, through the creation of around 500 GP consortia across England. PCTs will be abolished.

- Establishment of a new independent NHS Commissioning Board which will oversee GP commissioning and champion improvement and patient involvement in health services. It will also be responsible for commissioning GP, dentistry, community pharmacy, primary opthalmic, maternity and specialised services. Strategic Health Authorities will be abolished.
- A requirement that all NHS trusts become or be a part of self-governing foundation trusts with the "aim to create the largest social enterprise sector in the world".
- Greater competition, with commissioning of services encouraged from a wider range of providers
- Reducing NHS management costs by more than 45% over the next four years.
- Cutting the numbers of NHS quangos and streamlining the Department of Health.
- Giving councils responsibility for supporting integration across health and social care and leading on Joint Strategic Needs Assessments.
- Transferring PCT responsibilities for local health improvement to local authorities, who will employ the local Directors of Public Health jointly with the Public Health Service, a new national body. The public health budget will be ringfenced, and authorities will be given national objectives for improving population health outcomes
- Establishing a new consumer champion, HealthWatch England, to strengthen the voice of patients and the public, under the aegis of the Care Quality Commission (CQC). It will provide leadership, advice and support to local Health Watch organisations, and advice to the NHS Commissioning Board, Monitor, and the Secretary of State for Health.
- Local Involvement Networks (LINks) will become the local HealthWatch, with the role of ensuring the views and feedback from patients and carers are an integral part of local commissioning of health and social care. They will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership functions. They will be able to propose Care Quality Commission investigations of poor services
- Local authorities will be able to commission their local Healthwatch or Healthwatch England to provide advocacy and support to individuals to access services or make a complaint.

2.0 Potential Overall Response

2.1 The Adults and Community Policy Development Group (PDG) have considered the White Paper and associated consultations to inform the Council's response. Initial views have been provided to the Primary Care Trust, they are co-ordinating a partnership response for the County. Given proposals concerning transfer of responsibilities and other significant impacts for the ways in which local authorities work it is also considered appropriate that the County Council responds directly to the Department of Health. The joint Health and Adult Social Care Scrutiny Committee are also developing a response.

2.2 Amongst other areas, the PDG are keen to comment on the potential for the reforms to make a significant difference to patients, the ways in which GP consortia will work and particularly how they will work in partnership.

2.3 It is proposed that the Council raises questions about whether the White Paper gives sufficient emphasis to services for children and young people. The proposals for joint commissioning and changes in leadership arrangements for public health will have a significant impact on outcomes and services for children and young people. This emphasis could be achieved by suggesting that the references to strengthening integration of health and social care include other key partners such as schools, police and the voluntary sector.

2.4 The Council should welcome the opportunity to take a more explicit leadership role in public health and the opportunity to build on the existing commitment and capacity within the Council to promote public health, addressing all the determinants of health. There are some areas which are not obviously addressed in the papers, including emergency planning and also the roles of emergency services (specifically the ambulance service). Officers will assess whether other gaps exist as part of developing the complete response.

2.5 We further recognise that these proposals are a part of the overall transformation of public services and, locally, we are looking at the complete package. This includes considering the impact of Police reforms alongside Health and Education reforms and appreciating the very clear connections to localism as expressed through Big Society and Total Place.

2.6 This response would reflect the agreed Local Government Association approach and provide the opportunity for the Council and partners to focus on the most effective ways of making the new arrangements work for our communities. It is also proposed that the Council make it clear that we are keen to work with Government to develop the detailed arrangements and would be willing to participate in early roll out or pilots.

2.7 The areas that Members, and therefore officers, could seek to particularly influence are usefully set out by the Centre for Public Scrutiny, the list below has been adapted from their comments:

- the local transition to the new arrangements
- the relationships between strategic management of and direction setting for the area and the local design and delivery of services
- the need to ensure that outcome measures for commissioners and providers appropriate, and therefore locally relevant
- how well GP Commissioners evaluate whether the services they commission meet local needs and change services that don't meet needs
- the effectiveness of Health and Well-being Boards as co-ordinators of healthcare, social care and health improvement
- the relationship between the Children's Trust, Local Safeguarding Children Board and the Health and Well Being Board
- the NHS Commissioning Board, especially around regional and specialist services
- the development and support of an effective local Healthwatch
- the relationship between councils and the Care Quality Commission and between local Healthwatch and national Healthwatch
- the influence local people have in designing services, including children and young people.

3.0 Implications for Local Government

3.1 Summary of the Local authorities' new functions:

The White Paper states that:

"Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement. Local authorities will therefore be responsible for:

- *Promoting integration and partnership working between the NHS, social care, public health and other local services and strategies;*
- *Leading joint strategic needs assessments, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and,*
- *Building partnership for service changes and priorities. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.*

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees. As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans."

The above excludes the transfer to Local Authorities of Public Health functions.

This approach is seen as enabling strategic co-ordination locally.

3.2 There will be new statutory arrangements within local authorities, which will be established as “health and wellbeing boards” 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 would allow authorities to take a strategic approach and promote integration across health and adult social care, children’s services, including safeguarding, and the wider local authority agenda.

3.3 These arrangements are seen as giving local authorities influence over NHS commissioning and corresponding influence for NHS commissioners in relation to public health and social care. It is intended that there will be coherent and co-ordinated commissioning strategies across services, for example in relation to mental health and older people’s care.

4.0 Implications for Cambridgeshire

4.1 Directors of Public Health will be appointed within local Government, with responsibility for outcomes defined by the national Public Health Service. In Cambridgeshire we already have a shared Director of Public Health. The integration of public health with local authorities carries with it responsibilities

for the strategic planning for health improvement and services as well as back office structures.

4.2 The connections between strategic public services (councils, police, schools, fire and rescue) and health delivery need to be maintained in order to focus all services on the priorities and objectives that have been agreed. How this will work under the White Paper proposals is yet to become clear.

4.3 There will be a Public Health and Wellbeing Board to ensure co-ordination of local public health, NHS Commissioning, social care and children's services. The Cambridgeshire Together partnership approach could take this forward.

4.4 The public health budget will be ring fenced to the delivery of statutory responsibilities through the national Public Health Service. The degree of impact will relate to the Public Health Service objectives, local public services need to ensure that we can continue the significant partnership working that has been a key part of the Cambridgeshire approach to improving health and well-being. The County Council already has responsibility for a wide range of preventative work and responsibilities that improve health outcomes such as teenage pregnancy, personal social and health education in schools, prevention of drug and alcohol misuse and the work of CYPS Locality Teams. Therefore the move of the leadership responsibility for public health to the County Council should be seen as an opportunity to embed public health and public health values within the organisation, rather than create a discreet and stand alone function. Discussions will also be needed with District Councils about their public health function, such as environmental health, and how to achieve greatest synergy, building on the partnership approach established so far.

4.5 Across the region work has been started to look at the greater integration of health and local government services and the White Paper overtakes this work. However the research and findings that are available will be used to inform and support the transition.

4.6 The proposal that the new functions for local authorities should replace the statutory requirements for health scrutiny needs to be considered locally. There is likely to be a significant role for a joint overview and scrutiny arrangement to ensure the successful implementation of the Government proposals. In the longer term there will be a need to ensure that the Council, either jointly or unilaterally, has an effective structure for continuing to scrutinise local adult social care and health provision, and children's health and wellbeing.

4.7 Some issues include:

- What will be the impact of the move to GP consortia on partnership and joint working at County, district and more local levels? How will GP consortia work with local authorities and other public services to ensure that co-ordinated work e.g. on reducing hospital admissions, and improving health and well-being continues?
- How will the authority and GP consortia work together on commissioning services?

- How will agencies work together in ensuring user-focused service provision for adults and children, and what potential is there for new ways of working?
- What commissioning and functions will be best dealt with at locality levels and what at County wide levels, and how will these be organised?
- How will the transition to the new arrangements be managed locally?
- Will there be one large consortium for Cambridgeshire, or several smaller ones? How will this affect the commissioning, management/monitoring and provision of integrated health and social care services, such as older people's services, health visiting?
- How will decisions be made about appropriate levels of commissioning for services from those more specialist services (SCBU) that might warrant a regional approach to community based services such as health visiting which need to be commissioned at the most local level linking in to schools, children's centres and Locality Teams
- How will the proposals fully deal with actual or perceived problems of different levels of services being available and significant variations in need and deprivation across the County?
- It is essential that GP consortia have or can access the skills and capacity to commission services effectively, and have clear and effective arrangements to manage and monitor contracts with providers, particularly in relation to quality of services, patient safety, and financial management. Consortia need to be in a strong position to negotiate with foundation trusts and other major providers GP consortia could be encouraged to participate in strategic partnerships that already exist such as the Children's Trust and Area Partnership in order to obtain intelligence about local need and possible partnership based solutions to meeting that need
- How can GP consortia develop the essential back office functions, including those outlined above, in a way that achieves savings?
- How will GP consortia fulfill the requirement to involve patients and the public, at both local and strategic levels?
- The connections of the White Paper proposals to Total Place and the LGA driven Places Based Budgets is not clear
- How and to what level will the local Health Watch be resourced, in order that it can fulfill its role effectively?

5.0 Health Consultations

5.1 There are currently four key consultations which begin to articulate the detail of changes needed in enacting the White Paper:

Liberating the NHS: regulating healthcare providers. **Closing date:** 11 October 2010

This document further outlines proposals on foundation trusts and the establishment of Monitor as an independent economic regulator for health and adult social care. It seeks views on specific consultation questions.

Liberating the NHS: commissioning for patients. **Closing date**: 11 October 2010

DH has launched this consultation and engagement process on how we should implement proposals for putting local consortia of GP practices in

charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board

Increasing democratic legitimacy in health. **Closing date**: 11 October 2010

This consultation builds on the proposals in the White Paper to increase local democratic legitimacy in health. This will be achieved through local authorities: i) being given a stronger role in supporting patient choice and ensuring effective local voice ii) taking on local public health improvement functions, and iii) promoting more effective NHS, social care and public health commissioning arrangements.

Transparency in outcomes: a framework for the NHS **Closing date:** 11 October 2010

The Government's White Paper sets out how the Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework. This consultation considers how DH should develop the NHS Outcomes Framework.

5.2 The Department of Health has also conducted a review of its arm's-length bodies (ALBs) which sets out our proposals for ALBs in the health and social care sector. These proposals form part of the cross-Government strategy to increase accountability and transparency, and to reduce the number and cost of quangos.

5.3 Additional detail on the consultations is at the Appendices attached, including the key questions which each raise.

5.4 It is proposed that the responses to the consultations and commentary on the white Paper are managed by the cross Directorate group that has been established by the Executive Director: Community and Adult Services and reported through Strategic Management Team (SMT) and informal Cabinet.

6.0 SIGNIFICANT IMPLICATIONS

6.1 Resources and Performance

There are some implications.

6.2 Statutory Requirements and Partnership Working

There are potentially some significant implications.

6.3 Climate Change

There are no significant implications for any of the headings within this category.

6.4 Access and Inclusion

There are some implications.

6.5 Engagement and Consultation

There are some implications.

Source Documents	Location
Government White Paper on reforms of the NHS and associated consultations http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm	See weblink

Appendix A

Liberating the NHS: regulating healthcare providers

Closing date: 11 October 2010

1. Introduction

1.1 On 12th July 2010, the Secretary of State for Health published the White Paper "Equity and Excellence: Liberating the NHS".

1.2 This has been followed by a series of documents providing further information and inviting views on specific aspects of the proposals in the White Paper. These documents, and the White Paper itself are on the Dept of Health website www.dh.gov.uk/liberatingthenhs

1.3 The consultative document "Regulating Healthcare Providers" focuses on foundation trusts and on economic regulation in health and social care. Responses are invited by 11th October 2010.

2. Foundation Trusts

2.1 The Government's intention is to give foundation trusts greater freedom, and to regulate them in the same way as other providers, in order that all providers of NHS care can compete on a level playing field.

2.2 All NHS Trusts will either have to become, or be a part of, a foundation trust within three years; the Dept of Health will support them in this.

2.3 The legislative framework for foundation trusts will be retained. Their principal purpose will continue to be the provision of goods and services to the health service. As at present, any surplus or proceeds from the sale of assets will need to be reinvested in the organisation or used to pay debt.

2.4 The following changes are proposed:

- Removal of the cap on the private income of foundation trusts
- Foundation trusts to be able to change their constitution, with the agreement of their boards of governors and directors, without requiring the consent of Monitor
- Making it easier for foundation trusts to merge with or acquire another foundation or NHS Trust, or to de-merge.
- Removal of statutory restrictions on borrowing
- Greater flexibility over governance arrangements. For example, smaller trusts, or those providing community services, may not be required to have a majority of the public or patients on their board of governors; and they could have staff-only membership

3. Economic regulation

3.1 Monitor, currently the regulator for foundation trusts, will become the economic regulator for all of health and adult social care in England. Its principal duty will be to protect the interests of patients and the public, by promoting competition where appropriate, and through regulation when necessary.

3.2 It will license providers of NHS services in England, regulate prices, promote competition and support service continuity. This may include balancing conflicting objectives such as maintaining access to services in remote areas versus

improving efficiency or promoting competition.

3.3 The Secretary of State will have power to appoint the Chair of Monitor and approve the appointment of its Chief Executive. Monitor will continue to be a non-departmental public body, subject to Parliamentary scrutiny.

4. Licensing

4.1 The Care Quality Commission (CQC) will continue to register providers of health and adult social care. Monitor will license providers of NHS healthcare services, who will need to have gained CQC registration.

4.2 This includes general licence conditions e.g. that the organisation is properly constituted and has a business plan, reporting requirements and rules to protect patient interests. Monitor will also be able to set special conditions e.g. additional requirements on providers to promote choice by accepting some services such as diagnostic tests from other providers; requirements to protect continuity of service.

5. Price regulation and setting

5.1 Monitor, working with the NHS Commissioning Board, will set prices or price caps for services subject to national tariffs. It will have a duty to have regard to the need to make best use of limited NHS and social care resources.

5.2 In exceptional circumstances and on rare occasions, Monitor could modify tariffs for individual providers. e.g. if a provider had higher costs because it gave a service to a small, isolated rural population and there were no other providers able to enter the market and offer the service at tariff price.

6. Promoting competition

6.1 It is intended that patients will be able to choose between any willing provider for most services, and Monitor will have a duty to promote competition. This includes investigating markets where competition is not functioning properly, advising the government and NHS Commissioning Board on barriers to competition, and referring anti-competitive behaviour to the Competition Commission. It will be able to enforce competition law in relation to any provider of health or adult social care services, whether or not they hold a licence.

6.2 Commissioners will be required to promote choice, and not to restrict competition. Monitor will be able to investigate and remedy complaints about commissioners' procurement decisions or other anticompetitive conduct.

7. Continuity of service

7.1 Monitor will be able to set conditions in providers' licences to protect continuity of specified services. This could include a requirement to give notification of the planned termination of a service and continue to provide that service during the notice period, and arrangements to protect the assets needed to deliver it.

7.2 Monitor will have powers to make special arrangements to ensure key services continue if a provider becomes insolvent. This will probably be funded by a general levy on providers.

8. Consultation questions

Below are the key questions in the consultation document

- *Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?*
- *Should statutory controls on borrowing by foundation trusts be retained or removed in the future?*
- *Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?*
- *What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?*
- *What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?*
- *Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?*
- *Do you agree with the proposals set out in this document for Monitor's licensing role?*
- *Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?*
- *What more should be done to support a level playing field for providers?*
- *How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?*
- *Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?*
- *Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?*
- *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?*

Liberating the NHS: commissioning for patients

Closing date: 11 October 2010

1. Introduction

1.1 On 12th July 2010, the Secretary of State for Health published the White Paper "Equity and Excellence: Liberating the NHS".

1.2 This has been followed by a series of documents providing further information and inviting views on specific aspects of the proposals in the White Paper. These documents, and the White Paper itself are on the Dept of Health website www.dh.gov.uk/liberatingthenhs

1.3 The consultative document "Commissioning for patients" focuses on proposals for future commissioning of health services. Responses are invited by 11th October 2010.

2. GP consortia

2.1 Power and responsibility for commissioning most healthcare services will be devolved to consortia of GP practices; this will be set out in legislation. GP consortia will be responsible for commissioning elective hospital and rehabilitative care, urgent and emergency care (including out of hours services), most community health services, mental health and learning disability services. Consortia will be responsible for meeting prescribing costs. The rationale is that this approach will shift decision-making closer to the patient.

2.2 Consortia will be responsible for commissioning services for any patients registered with its constituent practices, and for ensuring comprehensive emergency services for any person in their area.

2.3 They will be responsible for determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities; determining what services are required to meet those needs; ensuring the appropriate clinical and quality specifications of these services; and contracting with providers, holding them to account for meeting their contractual duties, including quality standards and patient outcomes.

2.4 Consortia will not be responsible for commissioning primary medical services. This will be the responsibility of the national NHS Commissioning Board, who will hold contracts with individual GP practices in their role as providers of primary medical care. Consortia will however have a role in working with individual practices to drive up the quality of general practice and improve use of NHS resources. This could include promoting innovation, benchmarking and reviewing practice performance, and providing peer review and challenge to individual practices.

2.5 The NHS Commissioning Board will commission dentistry, community pharmacy, primary ophthalmic services, maternity and newborn care services, and highly specialised services which are best commissioned nationally or regionally (e.g. renal dialysis, heart transplants). The Board will involve consortia in these arrangements. It will work with criminal justice agencies and GP consortia to determine the most appropriate arrangements for prison health services

Every practice that holds a primary medical care contract, whether it is a GP or nurse led partnership, social enterprise, voluntary organisation or private sector

body. will have to be a member of a consortium. Practices will have flexibility to form consortia in the way that they think will secure the best health care and

2.6 health outcomes for their patients and locality.

The proposals do not specify an ideal size or population coverage for consortia, provided that they have sufficient geographical focus to agree and monitor contracts for locally based services and commission services jointly with local authorities, and are of sufficient size to carry out their responsibilities and manage

2.7 financial risk. Consortia should be able to evolve in terms of which practices they bring together, and to include new providers.

2.8 Consortia can either commission services directly themselves, or make arrangements with another commissioning organisation such as a lead consortium, for example in relation to low-volume services. They can arrange for some commissioning to be undertaken at a sub-consortium or practice level.

Consortia will have a management allowance to reflect the costs associated with

2.9 commissioning. They can buy in support such as needs analysis, procurement, and contract monitoring from external organisations, including local authorities, private or voluntary sector bodies. In the transition period, PCTs will provide much of this support to shadow consortia. In future, it is intended that a more competitive market for this type of support will develop. .

The NHS Commissioning Board will allocate practice-level budgets to the consortia, which will be responsible for managing these. They will have a duty to

2.10 ensure that expenditure will not exceed their allocated resources. These budgets will be kept separate from GP practice income

Consortia will be free to use resources to achieve the best and most cost effective outcomes for patients. A national economic regulator and the NHS

2.11 Commissioning Board will ensure transparency and fairness in spending decisions, and promote competition. In particular, it is intended that services should be commissioned that enable patients to choose from any willing provider that can meet the required quality standards. There will be arrangements to enable practices or groups of practices can bid to provide services in a way that avoids conflict of interest.

2.12 Consortia will have a duty to promote equalities and to work in partnership with local authorities.

2.13 The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of resources, and for fulfilling duties such as public and patient involvement and partnership. Each consortium will develop arrangements to hold its constituent practices to account.

The NHS Commissioning Board will develop a new outcomes framework that

2.14 measures health outcomes and quality of care (including patient-reported outcome measures and patient experience). This would include, for example, the health outcomes for people with long term physical or mental health conditions or learning disabilities, the quality of urgent care and acute hospital care, and progress in reducing health inequalities. A proportion of GP practice income will be linked to the outcomes achieved through the consortia and the effectiveness with which they manage NHS resources.

3. Partnership

3.1 Consortia will have a duty to inform, engage and involve patients and the public on an ongoing basis in identifying need, planning services and considering

proposals for service changes. If this is likely to result in changes to the configuration of services, they should report on the likely impact of those changes, and the impact of public involvement on their commissioning decisions.

3.2 Consortia should work closely with patients and their local communities. They should develop relationships with local HealthWatch (currently the Local Involvement Network), the national body HealthWatch England, practice based patient participation groups, voluntary organisations and community groups. Consortia should provide information on their performance.

3.3 Consortia will be able to contribute to joint action to promote health and wellbeing through participation in the proposed local authority health and wellbeing boards. This includes:

- contributing to assessing health and care needs, and ensuring their commissioning plans reflect these.
- Drawing on the advice and support of the board in relation to population health
- Achieving more Integrated delivery of adult health and social care, e.g. through pooled budgets or lead commissioning arrangements with the local authority
- Supporting improvements in children's health and wellbeing
- Contributing to safeguarding of children and vulnerable adults
- Co-operate with local authorities, the criminal justice system and other agencies in relation to tackling drug and alcohol misuse, offender health services and assessment of violent offenders.

3.4 Through consortia, individual practices could also be involved in these areas of partnership working.

3.5 Consortia should involve health and social care professionals from all sectors in designing care pathways or service provision that achieve more integration, higher quality, better patient experience and more efficient use of NHS resources

4. Role of the NHS Commissioning Board

4.1 To support consortia in their commissioning decisions, a statutory NHS Commissioning Board will be created which will:

- provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts

- promote and extend public and patient involvement and choice

- ensure the development of consortia and hold them to account for outcomes and financial performance

- commission certain services that are not commissioned by consortia, such as the national and regional specialised services

- allocate and account for NHS resources.

4.2 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for their performance. It will have powers to

intervene if a consortium is failing to fulfil its duties or is at risk of doing so.

Financial management

5.

5.1 Consortia, with the oversight and support of the NHS Commissioning Board, will be expected to break even on their commissioning budget, and to manage financial risks arising from changing healthcare needs, and from practices such as poor prescribing or over-referrals. How this will be done, and how over- or under- spends will be dealt with, e.g. whether and under what circumstances they can be carried forward into the following year, has yet to be worked out.

6. Preparation

6.1 PCTs will work with existing practices and practice-based commissioning groups to identify the likely shape of consortia, enabling them to take increasing responsibility for making commissioning decisions. PCTs should put their management resources at the disposal of shadow consortia, working with them to ensure skills and knowledge are retained. PCTs will work with shadow consortia to form relationships with patient and public groups and external partners.

6.2 The Government will work with professionals and the NHS to develop the clinical leadership, access to data, and financial systems that consortia will need to commission effectively.

7. Timescales

2010/11: GP consortia start to come together in shadow form, building on existing practice-based commissioning consortia, and start to take some responsibilities from PCTs, supported by indicative budgets.

2011/12: Shadow GP consortia in place, taking on increased responsibilities; shadow NHS Commissioning Board, starting to support the development of the consortia.

2012/13: Formal establishment of GP consortia, with indicative allocations and responsibility to prepare commissioning plans; NHS Commissioning Board established

2013/14: GP consortia fully operational, with real budgets and holding contracts with providers

8. Consultation questions

The consultation questions that relate particularly to the size and structure of consortia, public and patient involvement and partnership working are set out below.

Other questions in the consultation document cover the roles and relationships between consortia, individual practices and the NHS Commissioning Board in relation to commissioning services, ensuring quality and effectiveness, and improving the quality of primary care.

- *What features should be considered essential for the governance of GP consortia?*
- *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?*
- *What safeguards are likely to be most effective in ensuring transparency and fairness in investment decisions and in promoting choice and competition?*
- *What are the key elements that you would expect to see reflected in a commissioning outcomes framework?*
- *What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?*
- *How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?*
- *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?*
- *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 and, where appropriate, staff?*
- *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?*
- *Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?*
- *How can multi-professional involvement in commissioning most effectively be promoted and sustained?*

Increasing democratic legitimacy in health

Closing date: 11 October 2010

1. Introduction

1.1 On 12th July 2010, the Secretary of State for Health published the White Paper "Equity and Excellence: Liberating the NHS".

1.2 This has been followed by a series of documents providing further information and inviting views on specific aspects of the proposals in the White Paper. These documents, and the White Paper itself are on the Dept of Health website www.dh.gov.uk/liberatingthenhs

1.3 The consultative document "Local democratic legitimacy in health" focuses on the role envisaged for local government in the proposed new arrangements, and on strengthening patient and public involvement. It has been jointly published by the Secretary of State for Health and Secretary of State for Communities and Local Government.

2. The local authority role

2.1 It is envisaged that through elected members local authorities will bring greater local democratic legitimacy to health. They will bring the perspective of local place – neighbourhoods and communities, into commissioning plans. They can take a broader view of health improvement and are uniquely placed to promote integration of local services across the boundaries between the NHS, social care and public health.

2.2 Local authorities will have increased responsibilities for:

- Leading Joint Strategic Needs Assessments (these are assessments of the health and wellbeing needs of a population in a local area) to ensure co-ordinated and coherent commissioning strategies
- Supporting local voice and the exercise of patient choice
- Promoting joined up commissioning between GP consortia and local authorities of local NHS services, social care and health improvement
- Leading on local health improvement and prevention activity

2.3 This approach is seen as providing the opportunity to further integrate health with adult social care, childrens services including education, and wider services, such as disability services, housing, and tacking crime and disorder,

2.4 The Government will look at how place-based budgeting could be applied to cross cutting areas of health spending that require partnership with local authorities, such as older people's services.

3. Strengthening public and patient involvement

3.1 It is proposed that Local Involvement Networks (LINks) will become the local HealthWatch, acting as consumer champions across health and care. Like LINks, HealthWatch will continue to promote patient and public involvement, seek views on health and social care services, and feed these in to commissioning. This includes the extent to which NHS commissioners and providers are taking account of the NHS Constitution, which sets out what patients can expect. Local HealthWatch will be able to report concerns about the quality of local NHS or social care services to the national consumer body HealthWatch England, and will be able to visit provider services.

3.2 It is further proposed that HealthWatch perform a wider role, becoming more like a 'citizens advice bureau' for health and social care, providing signposting to the range of organisations that exist. They will be given specific responsibilities, and additional funding, for:

- NHS complaints advocacy, which supports people who make a complaint. . Local authorities would be responsible for commissioning this either through the local or national HealthWatch.
- Supporting individuals to exercise choice e.g. help them choose a GP practice

3.3 Local authorities will commission local HealthWatch arrangements, and contract for their services, holding them to account for delivering services that are effective and value for money, and ensuring that their activities are representative of the local community. Authorities should intervene, and ultimately retender the contract if this is in the best interests of the local population.

Consultation Questions:

3.4 ***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 of having 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?

4. Improving integrated working

4.1 The overall White Paper proposals are designed to strengthen integration, with a focus on building services round individuals not institutions, and a much greater use of joint commissioning. The Government is therefore proposing a statutory role for upper tier local authorities to support joint working on health and well being.

Health and wellbeing boards

4.2 It is proposed that there would be a statutory partnership board – a health and wellbeing board – within the local authority. It would be up to the local authority to determine how it would work in practice. The statutory boards would have the following functions:

- Assess the needs of the local population and lead the statutory joint strategic needs assessment
- Promote integration and partnership, including promoting joined up commissioning plans across the NHS, social care and public health
- Support joint commissioning and pooled budget arrangements where this is agreed between all parties.
- Undertake a scrutiny role in relation to major service redesign

4.3 There would be a statutory obligation on local authorities and NHS commissioners to participate as members of the board and act in partnership on these functions.

4.4 The statutory boards would sit at the upper tier local authority level, but could delegate the lead for some functions to districts or neighbourhoods. Neighbouring authorities could also establish a single board for their combined area. The boards could replace

existing local health partnership arrangements

4.5 The boards would have a lead role in determining the strategy and allocation of locally applied place-based budgets for health. They would have an important role in relation to other local partnerships, e.g. dealing with concerns about local safeguarding arrangements for vulnerable adults or children.

4.6 The boards would include:

- local elected representatives, including the Leader of the Council. The elected members would decide who chaired the board
- local authority directors for social care, childrens services and public health
- NHS commissioners – the relevant GP consortia and representation from the NHS Commissioning Board where relevant
- A local representative from HealthWatch.

4.7 Local authorities could also invite local representatives of the voluntary sector and other public service officials to participate in the board. Providers could be invited into discussions, as long as principles of fairness were adhered to.

Consultation questions

4.8 ***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?

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

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?

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas?

Q12 Do you agree with our proposals for membership requirements?

5. Overview and Scrutiny function

5.1 It is proposed that the statutory functions of the Health Overview and Scrutiny Committee (OSC) to scrutinise proposed major health service changes and the planning, development and operation of health services be transferred to the health and wellbeing board. The board, with its role of promoting joint working and integrated

commissioning, and its strategic oversight of health and care services is seen as being better equipped to scrutinise these services locally.

5.2 The Government view is that this would strengthen the overview that local authorities have on health decisions, and would strengthen the patient voice through the participation of the local HealthWatch in the board.

5.3 GP consortia will be free to decide commissioning priorities. If a health and wellbeing board had significant concerns about substantial service changes, it would be expected to seek to resolve this locally. If this was not possible, the board could refer the issue to the national NHS Commissioning Board, or as a last resort the Secretary of State for Health.

5.4 A formal health scrutiny function will continue to be important within the local authority, and the authority should have a process for scrutinising the functioning of the health and well-being board and health improvement policy decisions.

5.5 ***Consultation questions***
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?

6. Local authority leadership for health improvement

6.1 Local authorities will be given leadership for health improvement, linking with their wider role of tackling determinants of ill-health and health inequalities. When PCTs cease to exist, responsibility and funding for local health improvement activities e.g. smoking cessation, promoting exercise, will transfer to local authorities.

6.2 National level public health functions will be undertaken by a new national Public Health Service (PHS), which will cover health improvement and protection functions, with an emphasis on research and evaluation. The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. These will link in to local authority outcomes, particularly the approach to social care outcomes. It will be for local authorities to decide how best to achieve the national outcomes, e.g. by commissioning services. Local neighbourhoods will be able to set local priorities, within a national framework.

6.3 The PHS will have a lead role in preparing for and managing public health emergencies and ensuring NHS resilience.

6.4 Local Directors of Public Health will be jointly appointed by local authorities and the PHS. They will have a ring fenced health improvement budget, allocated by the PHS, to be used to deliver national and local priorities. They will be employed by local authorities, and as part of the authority's senior management team, giving advice to members, be able to influence the wider determinants of health.

More details will be included in a Public Health White Paper due later this year.

6.5

7. Timescales

7.1 Subject to legislation, it is intended that health improvement functions will transfer to local authorities from 2012. Statutory partnership functions would be formally established from 2012, but local authorities may be supported to establish shadow arrangements in 2011 between the PCT, emerging GP consortia, and LINks.

8. *Further consultation questions*

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?

Q18 Do you have any other comments on this document?

Transparency in outcomes: a framework for the NHS

Closing date: 11 October 2010

1. Introduction

1.1 On 12th July 2010, the Secretary of State for Health published the White Paper "Equity and Excellence: Liberating the NHS".

1.2 This has been followed by a series of documents providing further information and inviting views on specific aspects of the proposals in the White Paper. These documents, and the White Paper itself are on the Dept of Health website www.dh.gov.uk/liberatingthenhs

1.3 The consultative document "Transparency in outcomes - a framework for the NHS" sets out how the Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework.

The consultation asks for views on:

- the principles that should underpin the NHS Outcomes Framework
- a proposed structure and approach that could be used to develop the framework
- the potential outcome indicators (existing and future) that could be presented in the framework, including the proposed rationales for selection
- how the proposed NHS Outcomes Framework can support equality across all groups and can help reduce health inequalities
- how the framework can support the necessary partnership working between public health and social care services needed to deliver the best possible outcomes for patients.

2.0 Overview

2.1 The consultation starts the development of a set of outcome indicators that will provide an indication of overall performance of Health Services. There will be three outcomes frameworks established covering NHS, social care and public health for an integrated cross service approach.

The focus is being moved away from points of process, although there is some recognition that process measures will still be used within organisations.

2.2 The NHS Next Stage Review (led by Lord Darzi) developed the NHS definition of quality as:

- the **effectiveness** of the treatment and care provided to patients
- the **safety** of the treatment and care provided to patients
- the broader **experience** patients and their carers have of the treatment and care they receive.

2.3 The consultation proposes measuring these three areas in terms of:

- **the structures of care** – based on robust evidence, how should treatment and care be structured in order to maximise the chance of a good outcome for the patient?
- **the processes of care** – based on robust evidence, what are the things that

should be done to maximise the chance of a good outcome for the patient?
- **the outcomes of care** – what actually happens to the health of the patient - the outcome - as a result of the treatment and care they receive?

2.4 An NHS Outcomes Framework will therefore be introduced, made up of a set of national outcome goals aiming to provide an indication of the overall performance of the NHS. These outcomes will provide a means by which patients, the public and Parliament can hold the Secretary of State for Health to account for the overall performance of the NHS. They are intended to act as a catalyst for driving up quality across NHS services.

The following **principles** will guide the development of the NHS Outcomes Framework:

- Accountability and transparency
- Balanced
- Focused on what matters to patients and healthcare professionals
- Promoting excellence and equality
- Focused on outcomes that the NHS can influence but working in partnership with other public services where required
- Internationally comparable
- Evolving over time

2.5 Many of the outcomes in the Framework will require the NHS to work in partnership with adult social care services, childrens' services and other local services. The approach to outcomes in these joint areas will be based on the same principles as above, to ensure that outcomes are aligned across the NHS and local partners. The NHS Outcomes Framework should be designed so that it encourages more integrated care.

3.0 The Framework

3.1 The NHS Outcomes Framework is intended to:

- help patients, the public and Parliament understand how well the NHS overall is doing in terms of improving the health outcomes of the patients it treats and cares for
- allow the Secretary of State for Health to hold a new NHS Commissioning Board to account for the outcomes it is securing for patients. This new Board will be independent of the Government and responsible for allocating a budget of approximately £80bn to groups of GPs who will then purchase healthcare services to meet the needs of their local populations
- help drive improvements in what actually happens to patients' health as a result of the treatment and care they receive – patients' health outcomes.

3.2 The proposed framework is structured around five high level outcome domains covering everything the NHS is there to do. These are:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

4.0 The following sections set out the specific questions being raised in the consultation:

Scope, purpose and principles of an NHS Outcomes Framework

Principles

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?
2. Are there any other principles which should be considered?
3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?
4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Five domains

5. Do you agree with the five domains that are proposed above as making up the NHS Outcomes Framework?
6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

NOTE

For each domain, the Outcomes Framework will identify:

- an overarching outcome indicator or set of indicators
- a small set of specific improvement areas in which the NHS Commissioning Board will be tasked with securing improved outcomes

For each of the specific improvement areas, a corresponding outcome indicator will be identified in order to hold the NHS Commissioning Board to account for progress. The delivery of the outcomes in the NHS Outcomes Framework will also be supported by a suite of NICE Quality Standards.

Over the next 5 years, NICE will produce a library of approximately 150 Quality Standards covering the majority of NHS activity to support the Outcomes Framework. The detail of the proposals is contained in the consultation document and the relevant pages numbers are included below.

Structure

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

What would an NHS Outcomes Framework look like?

Domain 1 - Preventing people from dying prematurely

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?
9. Do you think the method proposed (page 20) is an appropriate way to select improvement areas in this domain?
10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed (page 21)?
11. If not, what would be a suitable outcome indicator to address this issue?
12. Are either of the suggestions at (page 21) appropriate areas of focus for mortality in children? Should anything else be considered?

Domain 2 - Enhancing the quality of life for people with long-term conditions

13. Are either of the suggestions at (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?
14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for

the future?

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

Domain 3 - Helping people to recover from episodes of ill health or following injury

16. Are the suggestions at (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?
17. What overarching outcome indicators could be developed for this domain in the longer term?
18. Is the proposal at (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?
19. What might suitable outcome indicators be in these areas?

Domain 4 - Ensuring people have a positive experience of care

20. Do you agree with the proposed interim option for an overarching outcome indicator set out at (page 32)?
21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at (page 32-33)?
22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out (pages 33-34)?
23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?
24. Do you agree with the proposed future approach for this domain, set out at (pages 36-37)?

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

25. Do you agree with the proposed overarching outcome indicator set out at (page 38)?
26. Do you agree with the proposed improvement areas proposed at (page 39-40) and the reasons for choosing those areas?

General Consultation Questions

27. 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 outcomes for all patients and, where appropriate, NHS staff?
28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?
29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?
30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?
31. Is there any other issue you feel has been missed on which you would like to express a view?

Identifying Potential Outcome Indicators

Potential indicators

32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?
33. Are other practical and valid outcome indicators available which would better support the five domains?
34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

Principles for selecting indicators

35. Are the principles set out on pages 48 and 49 (and set out below(on which to select outcome indicators appropriate? Should any other principles be considered?

Design principles for outcome indicators (paragraph 3.3)
This consultation has focused on indicators that:

- measure health outcomes rather than NHS processes
- are broad indicators - capturing as much NHS business and as many patients and conditions as possible
- can be significantly influenced by healthcare (where possible any public health and social care contribution is excluded from the indicators)
- focus on areas where there is evidence that performance can be improved
- can be disaggregated by age, sex, geography, other equalities strands and other variables such as condition
- are meaningful to the public
- are statistically sound
- can be measured from April 2011 (for the initial set).