CABINET – 21 SEPTEMBER 2010

HEALTH WHITE PAPER

Report by Director for Social & Community Services

Introduction

1. In July, the Government published its proposals for the National Health Service in a Health White Paper "Equity and excellence: Liberating the NHS". This paper was supported by a number of other publications, the most important of which are "Liberating the NHS: Commissioning for patients", "Liberating the NHS: Local democratic legitimacy in health" and "Liberating the NHS: Transparency in outcomes – a framework for the NHS".

2. The deadline for comments is 5th October 2010. It is proposed that the response is agreed by the Leader of the County Council and the Cabinet Member for Adult Services in the light of the comments made at the three meetings that will be held in public to discuss this and other reports. The Joint Health Overview and Scrutiny Committee may decide to submit its own response separate to that of the County Council.

3. This report is not a summary of the four documents (which would not be feasible given the range of the material they contain). Nor does it focus on all the issues set out in the report. For example, issues like whether GP consortia should be responsible for commissioning £80 billion of NHS services is one which is the subject of considerable national debate. Instead, this report assumes that the broad principles set out in the White Paper will be implemented (since this reflects the wishes of the recently elected Coalition Government). The focus of this report is on the implications for the County Council and setting out potential issues with the way that the proposals will be implemented.

4. Those issues have been grouped into five themes:

   - The focus on patients
   - The focus on outcomes
   - The proposed commissioning arrangements
   - The role of the Local Authority
   - Joint working between health and social care

5. There are two further reports; one from the Director of Public Health on the implications for public health and one on the specific implications for the Joint Health Overview and Scrutiny Committee and democratic accountability generally. In addition, members have been sent a summary of the documents published by the Government.

Focus on patients

6. The White paper emphasises the importance of putting patients and the public first. "Shared decision making will be the norm: *no decision about me without me*" (page 3)

7. This approach should be welcomed. It echoes the approach that has developed within adult social care through Putting People First. The White Paper also supports the principle of personal health budgets (paragraph 2.22) which are being piloted here in Oxfordshire by NHS Oxfordshire.

8. If the patient and the public are to be put first, then it is important that the way that the NHS is accountable to them is clear to all concerned. The White Paper sets out the following aspiration: "The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level" (page 4). Will this emphasis on clinical leadership always be for the benefit of the patient and the public?

9. Furthermore, Commissioning for Patients identifies that GP consortia will be accountable to the proposed NHS Commissioning Board (paragraph 1.14). How will conflicts (between the expectations of patients/the public and the NHS Commissioning Board) be managed? The role of the proposed local HealthWatch will be crucial. The current Local Involvement Network (LINk) will become the local HealthWatch. The proposed wider role of the local HealthWatch should be welcomed. However, does the Care Quality Commission (CQC) have the capacity and skills to oversee HealthWatch England?

10. The Government's proposals about the local HealthWatch does raise one financial issue. The funding of the LINk comes through the Area Based Grant which is no longer ring fenced. Is the Government intending to ring-fence the grant for the local HealthWatch? Clarification on this point would be helpful.

Focus on outcomes

11. There is a very strong emphasis throughout all the documents that the NHS should be assessed on the basis of outcomes for patients and the public. "The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets" (page 4 of the White paper). Page 8 of the White Paper identifies some relatively poor outcomes of the NHS compared with other countries. This approach is seen as building on the work of Lord Darzi in his report "High Quality Care for All: NHS Next Stage Review Final Report".

12. This emphasis on outcomes should be particularly welcomed. However, these must not be defined narrowly. To take continence for example, the measure of success should not be the success of operations designed to address incontinence but the number of people who suffer from incontinence.

It is not appropriate to carry on with a situation where the standard health service response to incontinence in an older person is often to give them a pad.

13. If this emphasis on outcomes is to work then the outcomes must be carefully defined. The Government intends to issue the "first NHS Outcomes Framework" in the light of the Spending Review. Outcomes will be supported by quality standards developed by the National Institute of Health and Clinical Excellence (NICE). The first three (on stroke, dementia, and prevention of venous thromboembolism) were published in June. Within the next 5 years, NICE expects to produce 150 standards which will include quality standards for social care.

14. It will also be important that payment systems reward outcomes and not activity. The White Paper recognises this: "Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality." (page 4) The White Paper also emphasises the importance of the payment arrangements being transparent. Both of these points should be supported.

15. However, it is not clear that the mechanisms set out in the various documents to determine payments will deliver this. There will be central prescription of the payment systems (by the NHS Commissioning Board) and separately centrally prescribed prices by the economic regulator (Monitor). How is central prescription of payments systems and prices consistent with effective local commissioning? Furthemore, what incentive does it give to providers such as the acute trusts to work to reduce the number of patients treated outside of hospitals. Adult social care has nearly 20 years experience of commissioning services where there is no central prescription. The commitment to extend (centrally prescribed) payments by results to new areas of health service commissioning is unwelcome and likely to lead to poor outcomes and poorer value for money.

16. One proposal which may help to address this is that "We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources." (paragraph 2.17, Commissioning for Patients).

17. The other issue relating to outcomes is that there appears to be some presumption that improving health outcomes is primarily the responsibility of the NHS (GPs, commissioners and providers). Evidence suggests that other agencies have critically important roles to play e.g. the role of District Councils for leisure, housing, planning and environmental health; the role of the County Council for transport and trading standards. This needs to be recognized.

The proposed commissioning arrangements

18. Commissioning is sometimes confused with contracting. However, it is much wider than that. Commissioning for Patients defines it as: "understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality" (paragraph 1.7) This description is consistent with the approach developed by adult social care over the last 20 years.

19. Commissioning for Patients goes on to set out how commissioning should work in the future: "Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them." (paragraph 1.14)

20. From a practical point of view: "It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect the views of their patients' needs and their own referral intentions." (paragraph 1.15) GP Consortia will be able to buy in support and decide whether they want to collaborate across consortia through say a lead commissioner. Support may be bought in from "external organisations, including local authorities, private and voluntary sector bodies". (paragraph 2.13)

21. Much of the debate about the principle of GP led commissioning has focused not on the principle of whether this should happen but whether it will work in practice. It is clear from the comments above that the Government recognise that the way in which it will be implemented is critical to its success. Ultimately the focus of GPs and their practices will be on the health and wellbeing of their patients. They will want to have commissioning arrangements which enable them to continue to focus on that.

22. Local authorities have the potential to help with this. Local authorities already lead on commissioning some health services (such as health services for adults with learning disabilities here in Oxfordshire). They also work closely with PCTs on commissioning other health services. Examples in Oxfordshire include the work that has been done on stroke, falls and continence. Both approaches are endorsed in Commissioning for patients (see paragraphs 6.8 and 6.11). Local authorities also have the expertise and experience that has been developed over the last 20 years in commissioning adult social care services. It will be important that we explore with GPs here in Oxfordshire in

conjunction with the PCT what role the County Council can play to support the work of the GP consortia.

The role of the local authority

23. Local authorities will have "greater responsibility in four areas:
    - 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; and
    - leading on local health improvement and prevention activity." (paragraph 10, Local Democratic Legitimacy in Health).

24. To some extent, the first three of these roles exist at the moment (the fourth would be a new role for local authorities although the Director of Public Health has been a joint post for several years). The key issue will be the power and influence that the local authority will have to carry out these roles effectively. The details about this are not yet available although there are some positive statements of principle in the reports which should be welcomed.

25. One critical element will be the role of the health and wellbeing board which will be created by statute. The Government makes clear that this will "take on the function of joining up the commissioning of local NHS services, social care and health improvement." (paragraph 4.17, White Paper). This should be welcomed.

26. Oxfordshire has had a Health and Well-Being Partnership Board for 3 years. This does not have executive powers (in contrast to the Government's proposals) so runs the risk of becoming a "talking shop". The existing Board has tried to counter that by focusing on its key priorities (ageing successfully, obesity and mental well-being). Discussions will need to take place with all stakeholders but particularly GPs (who are already represented on the Board) to turn the existing Board into an effective decision making forum. We shall also need to review its role vis-à-vis the Children's Trust – an issue raised in Local Democratic Legitimacy in Health.

27. To achieve the objective of becoming an effective decision making forum, it will be crucial that the Board is focused on that role. For this reason, I would agree with the view that it does not make sense to include the scrutiny functions currently carried out by the Joint Health Overview and Scrutiny Committee. This is not a trivial activity as those involved in the work of the Committee will testify and it can play a crucial role in challenging proposed changes within the NHS (such as the proposals for the Horton).

28. The Government has also given some indication of its thinking on the overall approach to adult social care. "We want a sustainable adult social care system that gives people support and freedom to live the life they choose, with dignity. We recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including

carers. We will seek to break down barriers between health and social care funding to encourage preventative action" (paragraph 1.17, White Paper). Its vision for adult social care is promised later this year. The Government has now set up the Commission on the funding of long term care which will report next summer. A White Paper on adult social care is promised for the autumn of 2011 followed by legislation.

Joint working between health and social care

29. There are repeated references in the documents to the importance of joint working between health and social care. For example, ""With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder." (paragraph 11, Local Democratic Legitimacy in Health). And also from the same document: "The aim is to ensure coherent and coordinated local commissioning plans across the NHS, social care and public health, for example in relation to mental health, older people's or children's care, with intelligence and insight about people's wants and needs systematically shaping and commissioning decisions." (paragraph 32)

30. This emphasis on joint working must be welcomed not least because it is what the patient/service user/citizen wants. How this might work is not yet clear but the Government has given a commitment to consult widely on options to ensure health and social care works seamlessly together.

31. The Government has also recognised that existing arrangements to encourage joint working between health and social care have not worked well enough. It is important for Oxfordshire members to appreciate that the close working here is not typical of what happens elsewhere in England. It is also important to note that there is scope to improve joint working here notably in terms of work with people with long term conditions especially older people.

32. The Government is right to emphasise that stronger joint working will help unlock efficiencies. There is clear evidence of this here in Oxfordshire from our joint arrangements for learning disabilities where we have good outcomes at a low cost. However, to deliver this, the necessary infrastructure needs to be in place supported by appropriate attitudes from all partners.

33. For joint working between the commissioning of health and social care to work, then policy and financial decisions must come together into a single place. The White Paper declares that "NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia" (paragraph 4.19). Is this consistent with the commitment to joint working?

34. What would be effective would be for the Government to prescribe in the forthcoming legislation that joint commissioning and pooled budgets must apply in appropriate circumstances (learning disabilities, mental health, supporting people with long term conditions). This would mean that public resources are used in the most appropriate way based on the needs of the

local population. Thus our responds to question 6 posed in Local democratic legitimacy in health should be that we do want joint working to be underpinned by statutory powers.

35. However, if there is to be a statutory power requiring joint working through the pooling of resources then GPs are rightly going to expect there to be some governance in place which constrains the ability of the local authority to arbitrarily reduce spending on adult social care (and expect the consequences to be picked up from health resources). This could be managed through the health and wellbeing board.

RECOMMENDATION

36. **Cabinet Members are asked to give their comments on the ideas set out in this report.**

JOHN JACKSON
Director for Social & Community Services

Contact Officer; John Jackson Tel: (01865) 323574

September 2010