**ITEM JHO5(c)**

# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE – 16 SEPTEMBER 2010

## EQUITY AND EXCELLENCE: LIBERATING THE NHS

## LOCAL DEMOCRATIC LEGITIMACY IN HEALTH

## DEMOCRATIC ACCOUNTABILITY (INCLUDING THE IMPLICATIONS FOR THE HOSC AND THE HEALTH AND WELLBEING PARTNERSHIP BOARD - CURRENT AND FUTURE)

## Introduction

1. Included within in the Department of Health's (DH) white paper and subsequent papers are a number of proposals for changes to the way that democratic accountability would be organised in the future. This paper will concentrate on what the government refers to as "Local Democratic Legitimacy in Health". It will briefly remind members of the present position; describe what change is proposed and provide some discussion/ comment on the proposals.

2. The DH has set a consultation deadline of 11th October 2011 and members may wish to agree a response to the consultation. Aspects to consider when preparing a response are included towards the end of the paper.

## The present position

### *Health overview and scrutiny*

3. Health Overview and Scrutiny Committees (HOSCs) were set up in 2003 with the aim of strengthening the way that public and patients views and concerns were to be represented in relation to health matters. This was in response to concerns that there was a "democratic deficit" within the NHS with decisions being taken by unelected boards and officials with little or no consultation with the public.

4. HOSCs were expected to take an overview of health services and planning within the area and to scrutinise priority areas to identify whether they met local needs effectively. HOSCs were given powers to:

5. Review and scrutinise any matter relating to the planning, provision and operation of local health services

6. Make reports and recommendations to local NHS bodies and local authorities on any matter reviewed or scrutinised

7. Require the attendance of officers of local NHS bodies to answer questions and provide explanations about the planning, provision and operation of health services

8.
9. Require NHS bodies to provide information about the planning, provision and operation of health services

10. Refer matters to the Secretary of State for Health:

    (a) where the committee is concerned that consultation on substantial variation or development of services has been inadequate
    (b) where the committee considers that the proposal is not in the interests of the local health service

11. In such cases the Secretary of State would call in the Independent Reconfiguration Panel (IRP) to investigate and report back before responding to the referral.

12. NHS bodies were required to:

    - Provide information requested by the overview and scrutiny committee
    - Attend before committees to answer questions
    - Respond to HOSC reports and recommendations within 28 days
    - Consult the HOSC on any proposals they may have under consideration for substantial developments or variations to services. (Locally the HOSC has the primary role in deciding whether or not a development or variation should be seen as "substantial").

13. They are also required to "consult and involve" patients and the public in any proposals for change.

***PPIFs and LINks***

14. Also in 2003 the Government abolished Community Health Councils (CHCs) and replaced them with Patients Forums (PPIFs). PPIFs were intended to help improve the quality of NHS services by bringing to trusts and PCTs the views and experiences of patients, their carers and families.

15. There was a PPIF in every NHS trust, NHS Foundation trust and PCT in England. Their primary roles were to:

    - Monitor and review NHS delivery
    - Seek the views of the public about those services
    - Make recommendations to the NHS accordingly

16. In Oxfordshire a close working relationship was developed between the HOSC and the PPIFs. The PPIFs had their own spot on the HOSC agenda

and PPIF members participated on a number of committees and working groups.

17. PPIFs were abolished on 31st March 2008 and replaced by Local Involvement Networks (LINks).

18. LINks are funded (via a non-ring fenced budget provided by the Government) and performance managed by the local authority. Their remit was extended beyond that of the PPIFs to include social care services. They are expected to give citizens a stronger voice in how their health and social care services are delivered. Their role is to find out what people want, monitor local services and to use their powers to hold them to account. LINks have the power to refer issues to the HOSC.

19. It is recognised generally that LINks have taken a long time to get going. Within Oxfordshire however there does continue to be something of the connection between the HOSC and the LINk that existed with the PPIFs in that the LINk has its own regular spot on the HOSC agenda.

## White paper proposals

20. The proposals in the white paper are part of the coalition government's emphasis on "localism". The proposals are also intended to strengthen the role of patients and the public in shaping health services. Legislative changes required to implement all the above proposals will be included in a Health Bill this autumn, subject to responses to the consultation. It is proposed that local authorities would establish shadow arrangements in 2011 in preparation for statutory changes in 2012.

## The issues covered by the consultation

21. The white paper and subsequent documents include proposals that would involve:
    - local authorities taking on local public health improvement functions
    - a lead role for local authorities in promoting integration
    - the reconstitution of existing Local Involvement Networks (LINks) into "Local HealthWatch" organisations, acting as "independent consumer champions" accountable to local authorities
    - The HOSC losing its statutory powers which would be transferred to the Health and Wellbeing Board

22. The consultation paper proposes greater responsibility for local authorities in the four areas outlined below. While not all may appear to be directly related to local democratic legitimacy in health, they all need to be considered to put the white paper proposals into context.

## Leading joint strategic needs assessments

23. Local authorities would be given responsibility for leading joint strategic needs assessments (JSNA) across health and local government and promoting joint

commissioning between GP consortia and local authorities. They would not have any direct healthcare commissioning role, but would be expected to “influence” local commissioning decisions about NHS services.

## Supporting “local voice”

24. It is proposed that LINks, in becoming local "HealthWatch" organisations, would be "more like a citizen’s advice bureau" with additional responsibilities. These would include supporting individuals, e.g. in choosing a GP, and a local NHS complaints advocacy services which would replace the Independent Complaints Advocacy Service (ICAS) that would be abolished. The latter would be commissioned by local authorities "through local or national HealthWatch" (a new body to form part of the Care Quality Commission (CQC). Details around this are a little hazy.

25. Local authorities would "continue to fund HealthWatch and contract for their services" and have powers to intervene and re-tender contracts in cases of under-performance. The consultation paper makes no distinction between the current host organisations for LINks, currently commissioned by local authorities, and the LINks themselves. That could suggest that similar arrangements would be maintained as to those that exist now. There is nothing to say how LINks could be improved constitutionally or otherwise to help them to undertake this enhanced role. There would, the white paper says, be additional funding to pay for the wider responsibilities of HealthWatch.

## Promoting joined up commissioning of local NHS services, social care and health improvement

26. The consultation paper is clear that integrated working between health and social care should increase. It indicates that the Government favours the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing.

27. It is suggested that Health and Wellbeing Boards should be set up within the local authority and become statutory partnerships to co-ordinate joint working. They would also lead the JSNA, support joint commissioning and other joint activity and “undertake a scrutiny role in relation to major service redesign”.

28. The boards would “have a lead role” in determining the strategy and allocation of any local application of place-based budgets for health. Their members, the white paper suggests, would include the Leader or Directly Elected Mayor of the local authority, representatives of social care, NHS commissioners, patient champions, including a representative of HealthWatch and Directors of Public Health. The consultation document suggests that there is some "novelty” in bringing together elected members and officials in this way.

*Transfer of statutory health overview and scrutiny functions*

29. It is proposed that the current statutory functions of health overview and scrutiny committees, including the power of referral to the Secretary of State, would transfer to the Health and Wellbeing Board. The role of the IRP would remain as now.

30. It is also suggested that a separate formal health scrutiny function should continue within the local authority to scrutinise the work of the Health and Wellbeing Board but with none of the current statutory health scrutiny powers.

**Leading on local health improvement, prevention and public health**

31. The consultation paper proposes the transfer of responsibility and funding from the NHS to local authorities from 2012 for local health improvement activity, including the prevention of ill-health by addressing "lifestyle factors such as smoking, alcohol, diet and physical exercise". A national Public Health Service (PHS) would be created to "integrate and streamline" health improvement and protection and emergency planning, with an increased emphasis on research, analysis and evaluation.

32. It is proposed that local Directors of Public Health be jointly appointed by local authorities and the PHS and employed by local authorities with a ring-fenced health improvement budget allocated by the PHS. Local authorities would be able to commission providers of NHS care to provide health improvement services. It would seem likely, although it is not specifically stated anywhere, that the Health and Wellbeing Board would have a role in this commissioning process.

## Discussion and comment

33. The white paper proposes giving local authorities a greater role in tackling health issues with Health and Wellbeing Board assuming a central role. They would be the main vehicles for bringing together and co-ordinating all of the local bodies that have an impact on health and ensuring that the partnerships work.

34. This must lead to concerns about the proposal to transfer statutory health scrutiny powers to the proposed Health and Wellbeing Board. How independent could such a Board be when it could be central to many of the decisions that are to be scrutinised?

35. Furthermore, how realistic would it be to expect that a separate health scrutiny function could be carried out without those powers? It is generally recognised that the HOSC in Oxfordshire has been successful in working with NHS bodies and other interested bodies and individuals to develop good patient and public consultation in health. However, while much of that success has been brought about by building and maintaining good relationships, there is no doubt that the statutory powers have had a major effect.

36. For example, it could be argued that maternity and paediatric services at the Horton General Hospital would not have been retained without the HOSC having the power to refer the matter to the Secretary of State. Also, would

there now be a community hospital in Oxford and would the South Central Ambulance Service be taking the issue of rural services quite so seriously without the HOSC having its powers?

37. While answers to those questions cannot of course be given with any certainty, it seems quite clear that proposals in the White Paper and subsequent documents are, at the very least, likely to lead to confusion. Who for example would scrutinise the performance of partnerships? The Health and Wellbeing Board which would have the role of co-ordinating those very partnerships and so could not be described as independent or the HOSC which would have no statutory power to do anything about any plans or decisions relating to health matters?

38. Surely it would make sense to leave the statutory powers with the HOSCs to enable them to scrutinise effectively? Scrutiny should be seen to be independent of those planning services. Members may wish to respond to the consultation on this issue.

39. No doubt members will find interesting the proposal to transform LINks into HealthWatch. LINks have not been a great success anywhere, largely because of the very weak structures with which they were saddled. It is generally recognised that they have struggled to make any sort of impact on services. Just changing the name and giving them a seat on the Health and Wellbeing Board is not going to improve matters. If LINks are going to have any success they must be properly funded; have a proper structure and sufficient support staff.

## Conclusion

40. There are aspects of the proposals that give rise to concerns around “democratic legitimacy”. Members may wish to consider whether they have a view on:

    I. Whether HOSCs should retain all of their existing powers and continue to have the statutory health scrutiny role rather than that being transferred to the Health and Wellbeing Board
    II. How HealthWatch could be made to be more effective than LINks and provide a real voice for health and social care service users. For example that HealthWatch should be funded adequately and provided with an effective constitution and support to enable it to function effectively