APPENDIX B

Local Democratic Legitimacy in Health – Consultation Paper

Introduction

The paper provides further information on proposals for increasing local democratic legitimacy in health, through a clear and enhanced role for local government and elected members. Local authorities are uniquely placed to promote integration of local services across boundaries between the NHS, social care and public health.

One of the central proposals of the White Paper is to devolve commissioning responsibilities and budgets to new GP consortia, which will be supported and held to account for the outcomes they achieve by the new NHS Commissioning Board.

Local authorities will be given an enhanced role in health, their responsibilities will include:

- Leading joint strategic needs assessments, to inform commissioning strategies
- Supporting local voices and patient choice
- Promoting joined up commissioning of local NHS services, social care and health improvement and;
- Leading on local health improvement and prevention activity

Local Authority Leadership for Health Improvement

When PCTs cease to exist, local authorities will take over responsibility and funding for health improvement activities. This is intended to unlock synergies with the wider role of local authorities in tackling the determinants of health.

Funding will include spend on prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical activity.

The creation of the new Public Health Service (PHS) will complement this role. However the PHS will also have powers in relation to public health emergencies.

Local Directors of public Health will be jointly appointed by local authorities and PHS. They will have ring-fenced budgets, allocated by the PHS. By being appointed by the local authority, the DPH will have direct influence over the wider determinants of health, advising elected members and senior management within the local authority.

The Sec. of State, with local authorities will agree local application of health improvement outcomes. It will be for local authorities to determine how best to secure outcomes. Local neighbourhoods will have the freedom and flexibility to set local priorities, working within a national framework.

Further consultation will take place later in the year on the abolition of PCTs and the establishment of the ring-fenced health improvement budget within local authorities.

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Improving Integrated Working

The government is clear that joint, integrated working is vital to developing a personalised health and care system.

The existing framework provided in legislation in the NHS Act 2006 sets out optional partnership arrangements for service-level collaboration between local authorities and health-related bodies. Arrangements include:

- PCTs or local authorities leading commissioning services for a client group on behalf of both organisations
- Integrated provision (e.g. care trusts)
- Pooled budgets

The paper suggests that take up of current flexibilities to enable joint commissioning and pooled budgets has been relatively limited. Joint commissioning around the needs of older people or children for example remains untapped – new commissioning arrangements will support this. GP consortia will have a duty to work with colleagues in the wider NHS and social care.

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?

Government believe there is scope for stronger institutional arrangements, within local authorities and led by Elected Members, to support partnership working.

One suggested option is to leave it up to NHS commissioners and local authorities as to whether and how they work together, and devise their own local arrangements. The preferred option however is to specify the establishment of a statutory role to support joint working on health and well-being. This would provide duties to cooperate and a framework of functions.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Health and Well-being Boards

One way in which to enhance roles and responsibilities is through a statutory Partnership Board – Health and Wellbeing Board – within the authority. Alternatively local areas may decide to design their own arrangements, within existing LSP structures.

Consideration could be given to the option of using this Board to replace the Alive Theme Board, although some thought is needed as what the relationship will be with the SLP as a whole.

If these Health and Wellbeing Boards were created, requirements would be minimal, with local authorities having freedom and flexibility for how it works.

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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?

The primary aim of the Boards would be to promote integration and partnership working. They would have 4 main functions:

- To assess their needs of the local population and lead JSNAs
- To promote integration and partnership across NHS, social care and public health
- To support joint commissioning and pooled budget arrangements
- To undertake a scrutiny role in relation to major service redesign

The Boards would have a lead role in determining the strategy and allocation of any local application of place-based budgets for health. There would also be a role in relation to other local partnerships, including those relating to vulnerable adults and children.

Q8 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, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Membership of the Boards would include: the Leader of the Council, social care, NHS commissioners, local government and patient champions, GP consortia, representative of the NHS Commissioning Board as well as a representative from the local HealthWatch. Local authorities may also invite representatives of the voluntary sector and other relevant public body officials. Providers may also be invited. This list is biased strongly towards officers and non-elected representatives and should have a greater proportion of elected members in order to provide democratic legitimacy.

Views are being sought on the arrangements of bringing together elected members and officers in this way, and how local authorities can ensure this is effective.

Q12 Do you agree with our proposals for membership requirements set out above

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Overview and Scrutiny Function

The existing functions of the OSC include:

- calling NHS managers to give information and answer questions about services and decisions
- Requiring consultation by the NHS where major changes to health services are proposed
- Referring contested service changes to the Sec. of State for Health

If Health and Wellbeing Boards are created, it is believed they are better equipped to scrutinise these services locally, therefore the statutory functions of the OSC will be transferred to the Health and Wellbeing Board.

Having a seat on the Board will give HealthWatch a stronger formal role in commissioning discussions than currently exist in LINks. However, there is some concern around the closer link with HealthWatch and the Health and Wellbeing Board. If HealthWatch have a seat on the board there may be a conflict of interest with the Board's role of holding HealthWatch to account.

Members of the Health and Wellbeing Board, including elected members, would be able to identify shared goals and priorities and identify early on in the commissioning process how to address any potential disputes. Government will work with local authorities and the NHS to develop guidance on how best to resolve issues locally.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

If Health and Wellbeing Boards had significant concerns about service changes, an attempt should first be made to resolve this locally. The Board may choose to engage external expertise to help resolve any issues. For s minority of cases there will still need to be a system of dispute resolution beyond the local level. Where local action cannot be taken, the Board can refer to the NHS Commissioning Board. Where the issue may be about the Commissioning Board (such as maternity services) the Health and Wellbeing Board may choose to refer directly to the Sec. of State. If the Health and Wellbeing Board still has concerns and the NHS Commissioning Board is satisfied that the correct procedures have been followed, the Health and Wellbeing Board would have statutory power to refer cases to the Sec. of State.

As the majority of board members would be non-elected, this represents a potentially substantial dilution of the democratic accountability of the scrutiny function.

Under proposals, there will be no local scrutiny of national commissioning of services such as dentistry, maternity services etc. (which will be commissioned by the NHS Commissioning Board), although there's reference to these issues being discussed by the Health and Wellbeing board. This appears to be a potential gap in the local scrutiny function.

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)?

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Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

A formal scrutiny function will continue to be important within the local authority. Local authorities will have to ensure they have adequate processes in place to scrutinise the functioning of the Health and Wellbeing Board and health improvement policy.

There is still a health scrutiny role for elected members. However, they will only be able to scrutinise how effectively the council undertakes its role of co-coordinating commissioning by the relevant partners. We should therefore be concerned about loss of specific powers to enable elected councilors to scrutinise how local health services are actually provided by NHS Trusts and others.

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?

Local HealthWatch

The White Paper sets out plans to increase choice and control for patients, by creating a local infrastructure in the form of local HealthWatch. Local Involvement Networks (LINks) will become local HealthWatch branches and will act as local consumer champions across health and care.

Like LINks, local HealthWatch will continue to promote patient and public involvement; however they will be given additional funding and functions so that they become more like a 'citizens advice bureau', additional functions include:

- NHS complaints advocacy services
- Supporting patients to exercise choice, i.e. choosing their GP practice

Local authorities have a vital role in commissioning HealthWatch arrangements. They will continue to fund HealthWatch and contract for their services. They will also ensure that the focus of local HealthWatch activities is representative of the local community. In the event of under-performance local authorities should intervene, and re-tender where it is the best interests of the local population.

Clarity is needed on what additional funding will be provided in order to commission local HealthWatch to undertake added responsibilities of NHS complaints advocacy services and supporting the Choice agenda. There needs to be adequate ring-fenced funding to ensure that an appropriate level of service can be commissioned. Clarity is also needed on whether there would be any potential for commissioning for local HealthWatch from any organisation other than the existing LINk, which is implied in the proposals, where it is suggested that councils should intervene if local HealthWatch underperforms.

The continued rights for HealthWatch to visit provider services are important, but will only be effective if there is a clear referral path for action, should there be problems.

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If referral is to the Health and Wellbeing Board, there is potential for conflict of interest

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 outlined above, with 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?

Further 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?

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