

NORTH YORKSHIRE COUNTY COUNCIL**SCRUTINY OF HEALTH COMMITTEE****24 September 2010****Work Programme****Purpose of Report**

1. The purpose of this report is to provide an opportunity for Members to review the Scrutiny of Health Committee's (SoHC's) work programme taking into account current areas of involvement and decisions taken in respect of earlier agenda items.

Remit of the Committee

2. The role of the SoHC is to review any matter relating to the planning, provision and operation of health services in the County, including Ambulance Trusts and the policies of the Strategic Health Authority.
3. Broadly speaking the bulk of the Committee's work falls into the following categories:
 - a) being consulted on issues which the Committee has agreed with the NHS locally are "substantial".
 - b) contributing to the development of local healthcare policy.
 - c) responding to national consultations by the Department of Health.

Committee Meetings

4. Additional Committee meeting - 10.30am on 15 October 2010 – Venue: County Hall

Agenda Items

- ❖ In-Depth Scrutiny Project, Stroke Awareness and Recognition, report task group led by County Councillor Tony Hall
 - ❖ Developments at Harrogate District Foundation Trust, including plans under the Transforming Community Services initiative.
 - ❖ Principles of a Specification for Mental Health Services in North Yorkshire
5. Friday 19 November 2010. Venue: To be confirmed.

Agenda Items

- ❖ Update on ambulance service developments in the Great Ayton and Stokesley area
- ❖ Priorities to be included in Yorkshire Ambulance Services Quality Account for 2010/11

Current and Emerging Areas of Work

Malton and Whitby Hospitals

6. Local members are regularly being contacted by the public who are expressing concerns about the long term future of both Malton and Whitby hospitals. A notice of motion from Ryedale District Council on 2 September 2010 requesting this Committee to examine the NHS' plans for the long term future of Malton Hospital is set out in APPENDIX 1. A letter to Jayne Brown, Chief Executive, NHS North Yorkshire and York from the Whitby Hospital Action Group (WHAG) and Jayne's response is attached as APPENDIX 2a and 2b respectively. Your Chairman, County Councillor Jim Clark and Vice Chairman, County Councillor John Blackie met with WHAG on 26 August 2010. They will report verbally on that meeting.

Hospital screening policies

7. A patient in the Whitby area recently contacted Cllr Jane Kenyan expressing concern that her husband who is also her carer would not be allowed to accompany her whilst she was undergoing breast screening. Cllr Kenyan has requested that this Committee investigates screening policies across all trusts serving North Yorkshire, including the extent to which patients can be accompanied by their spouse, friend or carer whilst the screening is taking place.

White Paper - Equity and Excellence: Liberating the NHS

8. The White Paper was published on Monday, 14 July 2010. As well as proposing far reaching changes for the NHS and the provision of health care, the White Paper will also bring about changes, particularly for top tier local authorities, in relation to health improvement and the co-ordination of health and social care.
9. Summary of proposals:
 - Putting patients first through greater choice, involvement and control and a more central role of clinicians in deciding on health priorities.
 - Greater focus on improved health outcomes to replace process-led targets
 - Greater accountability, local autonomy and democratic legitimacy through the development of GP commissioning consortia, working in partnership at local level with local authorities
 - Maintain NHS spending in real terms, though there will be efficiencies in the region of 45 per cent of total NHS management costs to offset rising demographic demands. There will be "no bail-outs for organisations which overspend public budgets".
 - Creation of an independent NHS Commissioning Board to oversee commissioning and champion improvement and patient involvement in health services. The development of GP commissioning consortia and the creation of the NHS Commissioning Board will pave the way for the abolition of Strategic Health Authorities in 2012/13 and Primary Care Trusts in 2013.

- New roles and resources for local councils in public health, leadership on joint strategic needs assessments, and a new statutory health and wellbeing board to ensure coordination, integration and partnership working on social care, public health and health improvement.
 - Abolition of the health oversight and scrutiny role for councils.
 - Creation of a national HealthWatch for England to be the national voice of patients and the public.
 - New twin role of Monitor and the Care Quality Commission (CQC) with Monitor becoming the economic regulator for all health and social care providers and CQC becoming the quality inspectorate.
10. The new patient centred approach, commissioning led by GPs and the creation of the NHS Commissioning Board, health and wellbeing boards and HealthWatch will replace the functions of scrutiny of health committees.
11. A briefing from the Local Government Group is attached as APPENDIX 3. The indications are that the proposals will not change significantly in the Health Bill to be introduced to Parliament in the autumn.
12. A workshop for members of this Committee and the Care and Independence Overview and Scrutiny Committee was held on 10 September 2010.

Recommendation

13. That Members review the Committee's work programme, taking into account issues highlighted in this report, the outcome of discussions on previous agenda items and any other healthcare developments taking place across the County.

HUGH WILLIAMSON
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15 September 2010

Background Documents: None

APPENDIX 1

Ryedale District Council – Motion on 2 September 2010: Malton Community Hospital

“It was moved by Councillor Clark and seconded by Councillor Raper.

In view of the uncertainty and continuing press coverage in reference to Malton Hospital, this council resolves to:

- i. Request the North Yorkshire County Council Overview and Scrutiny Committee for Health to examine the situation.
- ii. Request Ryedale District Council Chief Executive to arrange a meeting between the Chief Executive of York and North Yorkshire PCT and Ryedale District Council.
- iii. Confirm its support for the continuance of and continual improvement of Health Care Services at Malton Community Hospital.

An amendment was then moved by Councillor Keal and seconded by Councillor Mrs Shields.

- iv. Seek a commitment from York and North Yorkshire PCT to keep Ryedale Ward open at full occupancy to meet the needs of residents in the district.

The amendment was unanimously approved.

The amended motion was put to the vote and carried unanimously.”

Dear Jonathan Stokoe

Cc Scrutiny of Health Committee; North Yorkshire PCT: Robert Goodwill MP: David Cameron PM

In response to the last four months of unchallenged decisions about services and the future of Whitby Hospital, we the Whitby Hospital Action Group (WHAG) present the following facts to challenge the PCT to prevent the North Yorkshire and York PCT from making any further unchallenged, unilateral cuts and closures in Whitby Hospital.

1.

The NHS Constitution which is an all party Constitution came into force 19 January 2010. It is an active and underpinning legal document which scaffolds the implementation of services within the NHS. The role of the PCT Executive is to enforce the law as written by the legislative system and to follow how the judiciary system interprets the law.

In reading this document it is important to remember that the PCT enforce and implement the NHS Constitution. They are not exempt from the consequences of misenforcement or misinterpretation. The NHS Ombudsman is the 'watchdog' for PCT behaviour and a legal review can be requested if the actions of a PCT are found to be in contradiction to the NHS Constitution.

The rights of patients, the public and staff are clearly defined in the NHS Constitution. The 'binding pledges' within the rights are seen as developmental to the rights. It is these rights and pledges that WHAG are contesting as the basic rights of patients, the public and staff, are not being met or considered. WHAG find that the PCT have acted in contradiction to the Constitution by reducing the provision of services in Whitby and Malton.

2.

The WHAG members find the North Yorkshire and York PCT in default of the binding pledges within the Constitution which renders the recent closures and cuts at Whitby Hospital illegal under the NHS Constitution. These cuts and closures have put the local community at high to extreme risk in terms of the risk assessment procedures in the National Patient Safety Agency (NPSA).

In particular, WHAG find the following to be of concern :

A.

Under the NHS Constitution the first right and pledge to consider is 'the NHS commits to provide convenient, easy access to services within the waiting times set out in the NHS Constitution.'

WHAG are contesting that Whitby residents no longer have a convenient and easy access to NHS services as so many have been closed at the Hospital for example, the maternity ward, Abbey ward and minor injuries.

B.

Under section 2a of the NHS Constitution 'the NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered'.

WHAG are contesting that the North Yorkshire PCT have not been transparent about their decisions regarding Whitby Hospital cuts and closures.

This was obvious at the public meeting Thursday 24th March 2010 at Sneaton Castle. The decisions to 'cut and close' were discussed after the decisions had been implemented. The GPs of Whitby and the surrounding rural area, Surgeons who practice between Whitby and Malton and the nursing staff of Whitby Hospital made it quite clear that they had not been consulted in any planning and decision making processes. The PCT are in default of this pledge.

The assurances given by the PCT on Thursday 24 March 2010 and latterly June 18th 2010 were empty and false. At the meeting of Friday 18th June 2010 at Sneaton Castle, Jayne Brown of the PCT gave local and county councillors assurances that there would be no further closures and cuts at Whitby but by 5th August 2010 further cuts in services in minor injuries were made and staff were re-deployed to Malton resulting in further loss of services at Whitby Hospital during the busy tourist season.

The WHAG members find the North Yorkshire PCT failing to involve the local population and professionals in decision making processes and therefore cannot claim transparency in the decisions made about services that remain in Whitby. If there were consultative processes, the patients and public of Whitby were not invited. Were there others who were consulted? If so, by the Constitution, this information must be made public.

C.

Under Section 2a of the Constitution 'the NHS commits to make the transition as smooth as possible when you are transferred between services and to include you in relevant discussions.'

WHAG members find that this right and pledge is not being met by the service provision in Whitby by the North Yorkshire and York PCT.

The Malton experience of the 'Hospital at Home' scheme has been reported and slated by the GPs and patients (Ryedale Gazette and Herald F6.08.10). There is evidence in Whitby that patients do not experience a smooth transition from hospital to home as there are simply not enough District Nurses to implement this scheme.

The Malton experience has shown that GPs and District Nurses must make difficult decisions about patient care and often work alone to help patients and relatives cope - what are the implications of this? What support does an employee of the PCT have if

they work on the fringe of the guidelines and yet will be 'monitored and professionally evaluated' if they don't?

The North Yorkshire and York PCT has a freeze on recruitment but clearly needs more District Nurses to fulfil the constitutional pledge. How does the PCT intend to address this? If they recruit for District Nurses why can they not recruit for Emergency Nurse Practitioners at Whitby Hospital? It was made clear at Sneaton Castle March 24th that the PCT 'could not recruit' the required staff and cuts had to be made at the hospital.

How will the PCT justify recruiting in some shortage areas but not in others? Why could they not recruit? Where is the evidence that recruitment had been attempted and who is responsible for such poor performance in his/her job? This would be intolerable in other public sector institutions.

3.

The WHAG members are fully aware of the systemic bullying within the NHS and this has been a direct factor in the lowering of morale of the NHS staff in Whitby and Malton.

The low morale is further depressed by the unchallenged cuts in the ambulance service.

The PCT freeze on recruitment further damaged morale when 5 Whitby Hospital staff members were moved to Malton to prop up services in Malton but this further reduced services in Whitby. Patients and the public were only aware of this after the event.

Staff at Whitby and Malton Hospitals are concerned that they do not have the reassurances from the PCT managers that the rights of the Staff under the Public Interest Disclosure Act 1998 can be exercised without detriment to their employment. This is a regional example of the national problem of bullying in the NHS which cost the tax payer £325m in 2008 (The Observer, Sunday 27 January 2008.)

4.

The WHAG members challenge the North Yorkshire and York PCT that the reduction in services in Whitby Hospital heightens the risk assessment outcomes for the patients/ residents in Whitby placing the community in the serious risk category using the criteria of the NPSA. WHAG have assessed and used the NPSA risk assessment matrix and find that North Yorkshire and York PCT have placed the Whitby community at serious risk in 4 out of 12 categories within the last year.

Category	Consequence	Likelihood	Risk
Adverse publicity/reputation	3 – public and staff at low morale	5 – it has happened and reoccurred	15 which is serious
Human resources/ staffing	5 – cuts and loss of practitioners and staff and services	5 – it has already happened	25 – which is extreme risk
Service and business interruption	5- Maternity services lost/minor injuries	5 – it has already happened	25 – which is extreme risk

	interrupted		
Finance/budget	5-Deficit of £12m is > 1% of budget	5 – it has already happened	25 – which is extreme risk

It is important to read the table with the recent pandemic warnings of swine 'flu in mind. What provision of services were planned by the North Yorkshire and York PCT had the pandemic proved worse than it was?

It is important to read the table and demand from the PCT the required transparency and accountability in the unchallenged and unilateral decisions made by the PCT in terms of the risk assessment outcomes against the rights and pledges within the NHS Constitution.

Who made the decisions to 'cut and close' and when? Was there consultation with the local community, if so, when and with whom?

5.

If decisions regarding Whitby Hospital were taken by the Joint Strategic Needs Assessment and Local Area Agreements made, as the situation with services in Whitby are at a critical position, WHAG require transparent details of these processes and persons involved in these decisions to be made public.

6.

The WHAG members would ask for a detailed response from the North Yorkshire and York PCT to explain why patients must compromise on services and treatment to reduce the budget deficit of £12m.

The PCT is responsible for the administration of the budget and if there is a deficit then this maladministration is the responsibility of the PCT and not the patients and residents of the community to whom the PCT have a duty of care for which is clearly outlined in the NHS Constitution.

The recent news that the NHS miscalculated their PFI costs for building new hospitals does not negate the requirement of the PCT to meet their obligations under the constitution for the people of Whitby.

7.

The WHAG members have testimonials from patients and relatives where services provided have not met the required specifications under the NHS Constitution. These are available for scrutiny. These texts provide a pivot for balancing failed services against NPSA risk assessment criteria. In each case, who made the decisions that affected the patient care and provision of services and why?

8.

WHAG members call upon the North Yorkshire and York PCT to answer this letter in an open and honest manner. We do not accept a repeat of the contrived meeting as was the case on Friday 18th June 2010 at Sneaton Castle. This was seen as an insult to the residents and patients in Whitby.

There are issues that need to be discussed in a formal and mediated forum. It is necessary that the PCT, Councillors, Medical Practitioners and residents take an active role in planning the provision of services that are fair and transparent and sustainable for all concerned.

People of Whitby are needed to support the work that is to be done in conjunction with the PCT and Medical Practitioners in the area. Without this multi-agency approach the underpinning mission statement of the NHS Constitution that 'the NHS is for everyone' will become a local dictatorship run by a few who are answerable to none.

Signed WHAG

Alf Abbott Pat Ingham Pat Cusson John Neville Sarah Wyatt



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23 August 2010

Dear Whitby Hospital Action Group

Thank you for your letter of 17 August 2010.

Your letter was very comprehensive and I will try to respond as succinctly as possible, whilst covering the issues you raise.

1. The PCT takes the NHS constitution very seriously and is committed to working within it. We do not believe any of the actions taken by the PCT in respect to Whitby Hospital are in breach of the constitution. The constitution states:

“You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet these needs as necessary.

This is the responsibility of your local PCT (*Primary Care Trust*), which must assess the health requirements of the local population and provide the services **as it considers necessary to meet their needs.**”

We believe that assessment of health need in the Whitby area has been undertaken and a range of health services have been provided to attempt to satisfy such needs. This includes the continued provision of a range of services at Whitby Hospital.

2. May I clarify the service changes that are referred to as ‘cuts and closures’.

- The transfer of maternity services to Scarborough hospital was done following the Review of maternity services in Scarborough, Whitby, and Ryedale by the Independent Reconfiguration Panel (IRP) review, submitted to the Secretary of State in June 2008. This recommended closure of the Whitby and Malton



units as continued provision was not considered sustainable. This action was taken to implement the findings of the IRP report, and not as a cost saving measure.

- The Minor Injury Unit (MIU) continues to function between the hours of 8am and 11pm. The suspension of the overnight service from March 2010 was following repeated failed attempts to recruit to relatively specialist nursing posts, and a resulting staffing shortfall. The patient demand for the service overnight is on average less than one patient per night. We do not feel such low demand necessarily requires overnight provision and very few MIUs are open 24 hours daily. As we continue our consultation and engagement on the future strategy for services in Whitby we will review the optimum service provision for the MIU. However, at this stage we believe very few patients are disadvantaged by the current opening hours.
- Abbey ward remains open and continues to accept direct admissions from GPs and transfers from other hospitals. The unit is appropriately staffed for the current occupancy and case mix of patients.
- There has been a temporary suspension of certain services in the theatres at Whitby hospital: principally gastrointestinal endoscopy and surgery under general anaesthesia. The PCT and its partners, after securing appropriate assurance on patient safety and appropriateness, is working to restart those services in the near future, subject to complying with any relevant recommendations. We do not believe a temporary closure to gain assurance on patient safety and the future use of the unit represents a cut or a closure.

2A. The PCT has a duty to commission services that are easily accessible and within agreed waiting times. We believe that for the residents of Whitby services are provided that are both accessible and within agreed waiting times. Furthermore, we can only commission services that are safe and conform to what is considered the best standards of practice. Thus, in the case of maternity services a national report recommended a service change, and in the case of certain types of treatment for patients with heart attacks or strokes, it is now considered best practice to transfer patients to specialist centres. Such specialist services can not be realistically provided at hospitals such as Whitby. Thus, although some patients may experience longer travel to more distant specialist centres, we believe the clinical evidence will provide patients with improved health outcomes.

2B. The PCT has indicated that the current process of developing a long-term vision and strategy for services in Whitby is at a relatively early stage and will need to continue to involve patients, public, and all necessary stakeholders. The suspension of services in March (that is overnight MIU and some theatre procedures) was taken as a temporary measure, hence the lack of engagement and consultation. Since that point the PCT has been in regular discussions with local GPs and Scarborough Hospital on the future of services in Whitby. This included the discussion at the public OSC meeting which I attended in June.

My assurance at the June meeting was that Whitby Hospital would not be closing and the PCT saw the unit as a key part of healthcare delivery in the area. This statement remains true: the PCT is fully committed to a Whitby Hospital. However, we are not and have never made any commitment to maintain a certain level of beds or specific opening hours of specific services. The provision of such capacity will be based on the needs of the services and may change over time. Furthermore, as was explicitly indicated in the PCT strategy document presented at the June OSC, the

PCT believe the priority for healthcare services is to strengthen community services in or close to people's homes. As such in areas like Whitby there may be requirement to put more resources into community settings (for example through more district nurses) and less in hospital settings.

2C. Although some GPs in Malton have questioned the experience of the Ryedale Hospital at Home scheme, it is by no means the case that all Ryedale GPs opposed the initiative. The Ryedale Practice Based Commissioning (PbC) consortia (representing all Ryedale practices) has supported the type of strategy which has been proposed for Whitby. The current strategy document has been produced with large involvement from the GPs in Whitby.

The PCT does not have an absolute freeze on recruitment but has rather applied a control process over vacant posts. In the current economic climate we can only recruit to posts that are absolutely necessary: in the majority of cases community nursing posts are considered as essential and there remains recruitment in a number of community posts.

There has been a number of attempts to recruit into the MIU posts in the past. The failure does not reflect, as you imply, on the competence of individual managers but represents the difficulties on recruiting to specialist roles, in remote areas for a lone worker role.

3. Allegations of bullying are taken very seriously by the PCT and are always dealt with according to PCT policy which is based on national best practice. I have no evidence that there is any general issue of bullying specific to Whitby. If you have evidence that nurses and doctors in Whitby hospital have been engaging in bullying please let me know at the earliest opportunity. Staff can be assured that rights relating to the Public Interest Disclosure Act 1998 are not something the PCT can or would wish to avoid. However, there will often be a need for staff to support services at alternative units, and we would consider it better that mutual support between different units is used to maintain services (at Malton or elsewhere) than to allow such services to fail.

4. I do not support your risk assessment of the areas identified with the possible exception of the adverse publicity. We have acknowledged that in the past the PCT could have improved the way it communicated with local people and healthcare professionals in Whitby. Please be assured that we continue to work on improving our engagement with the local community and as I stated at the meeting in June we will always be open and honest in our approach even if, due to operational reasons, they are difficult messages to convey.

In the other areas, we do believe there are human resource challenges throughout the NHS, but these are not peculiar to Whitby, nor do we believe they provide a high risk to patient services. The maternity closure, as discussed above, was planned following national guidance and service provision has been maintained. There has been almost no service interruption of the MIU service.

The financial risk is a large challenge, but one that the PCT is engaged in tackling. The financial challenge dictates that we must assess all service as to their value for money, cost and clinical effectiveness.

The PCT has a plan for dealing with the challenges of Pandemic Influenza and other emergencies. This involves ensuring the most critical and essential services are maintained and supported by other services considered to be less critical.

5. The Joint Strategic Needs Assessment (JSNA) is part of the information used to assess health need in Whitby, and the JSNA is a publicly available document. The production of the JSNA is led by the PCT's Director of Public Health, in collaboration with local authority and other partners. The process is considered transparent and results are available.

6. The aim of the PCT is to deliver its required financial targets through maintaining or improving the services provided. The issue of PFI costs has no link that I am aware of to services in Whitby.

7. It is impossible for me to comment on individual patient examples unless I can consider the specific information. I realise this is not information you could share in a public letter, but would request that the PCT is able to scrutinise the evidence. I trust that if these breaches in service delivery were as significant as indicated, the relevant staff have reported them through the formal incident reporting system.

8. I do not believe the meeting on 18 June was contrived. The PCT was asked to make clear statements regarding services in Whitby and its commitment to Whitby Hospital. This was done honestly, and none of the actions taken since the meeting have been at odds with the plans discussed at the meeting. I am sorry if you feel insulted, but I can honestly state there is no secret plan to close Whitby Hospital. But we must accept that services in community hospitals must be appropriate and safe.

The position of the PCT of Whitby Hospital may be summarised as:

- The PCT supports the needs for community hospital services in Whitby;
- Community hospital services will primarily be those that provide minor injury, rehabilitation, diagnostic and minor injury services;
- Services in community hospitals will continue to evolve and whilst the PCT is committed to Whitby it recognises the specific form and scale of service may change.

Please feel free to contact me if you require further information.

Yours sincerely

Jayne Brown OBE
Chief Executive

Local Government Group Briefing - Health White Paper: "Equity and excellence: Liberating the NHS"

13th July 2010

Introduction

The Government published its White Paper on the NHS yesterday afternoon (12 July 2010). This briefing summarises the key proposals and highlights the implications for local government.

LG Group Key Messages

- The White 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.
- The LG Group **welcomes the focus of the White Paper on removing unnecessary bureaucracy and devolving power to the local level.**
- The LG Group also **welcomes the transfer of public health responsibilities to local authorities.**
- The proposals represent only one part of the government's agenda for change in health and social care. The White Paper also announces that there will be five further publications over the next few months which will seek detailed views on particular aspects of its proposals.
- **The Government plans to publish a further White Paper on Public Health in the autumn and will bring forward proposals for the future funding of social care in April 2011.**
- Clearly, there are many aspects of the proposals that are not yet fully developed and we look forward to discussing with the sector and with central government how local government can contribute to joining up health improvement, health services and social care locally to achieve better outcomes and greater efficiency.

briefing

Summary of proposals

- Putting patients first through greater choice, involvement and control and a more important role for clinicians in deciding on health priorities.
- Greater focus on improved health outcomes to replace process-led targets.
- Greater accountability, local autonomy and democratic legitimacy through the development of GP commissioning consortia, working in partnership at local level with local authorities.
- Maintain NHS spending in real terms, though there will be efficiencies in the region of 45 per cent of total NHS management costs to offset rising demographic demands. There will be "no bail-outs for organisations which overspend public budgets".
- Creation of an independent NHS Commissioning Board to oversee commissioning and to champion improvement and patient involvement in health services. The development of GP commissioning consortia and the creation of the NHS Commissioning Board will pave the way for

the abolition of Strategic Health Authorities (SHAs) in 2012/13 and Primary Care Trusts (PCTs) 2013.

- New roles and resources for local councils in public health, and a new statutory Health and Wellbeing Board to ensure coordination, integration and partnership working on social care, public health and health improvement.
- Abolition of the health oversight and scrutiny role for councils.
- Creation of a national Health Watch for England to be the national voice of patients and the public. Local involvement networks will become local Health Watch branches. Local authorities will retain their statutory duty to support patient and public involvement activity.
- New joint roles for both Monitor and the Care Quality Commission (CQC), with Monitor becoming the economic regulator for all health and social care providers and CQC becoming the quality inspectorate.

The Local Government Group is considering the White Paper through five key challenges:

1. **Do the proposals build on existing experience?** Deciding what is spent locally on health services needs to build on the innovative practice that already exists. In many areas, councils, PCTs and health practitioner-based commissioning consortia (including GPs, nurses, specialists and pharmacists) are already working together to improve services, efficiency and outcomes. We can use these areas as test-beds for new arrangements before they are rolled out nationally.
2. **Do they support an area-based budgeting approach?** The LG Group has developed an open and comprehensive offer to Government to help them achieve efficiency savings by adopting a place-based approach to deciding how public money is spent. Health resources will need to be included in this approach, in order to join up health and social care, and to invest in preventative and early interventions in order to reduce the need for health and social care.
3. **Do they promote a person-centred approach?** The proposals should support a person-centred approach to services, based on the needs and expectations of the individual rather than organisational considerations or convenience.
4. **Do they ensure accountability to local communities?** The proposals must include clear and transparent accountability arrangements to local communities, which build on existing accountability rather than creating new structures.
5. **Do they ensure that public resources are directed to the areas of greatest need?** In particular, they should address inequalities in health. We know that inequalities in health are, largely, avoidable and cost taxpayers many millions of pounds each year in spending on health and social care and loss of tax revenue through long-term ill-health.

Further Information

For further information on this briefing, please contact Ben Kind, LG Group Public Affairs and Campaigns Manager, at ben.kind@lga.gov.uk or 0207 664 3216

New roles and resources for local councils

- PCT public health improvement functions will be transferred to local councils after the abolition of PCTs in 2013.
- Local Directors of Public Health will be jointly appointed by local authorities and the national Public Health Service. Further clarity is required around the arrangements for the employment of public health teams and the accountability of the Local Director of Public Health
- A ring-fenced public health budget will be allocated to local authorities to support their public health and health improvement functions.
- Councils will be required to establish “health and wellbeing boards” to join up the commissioning of local NHS services, social care and health improvement. This will allow local authorities to take a strategic approach on promoting integration across health and adult social care, children’s services (including safeguarding) and the wider local authority agenda.
- An extension and simplification of powers to enable joint working between the NHS and local authorities.
- Health Overview and Scrutiny Committees (HOSCs) will be replaced by the above functions.

LG Group view – *Local government has a central role to play in promoting public health and health improvement and we welcome the Government’s recognition that councils are the most appropriate local bodies to co-ordinate and lead on health improvement. We also support the proposal to establish “health and wellbeing boards” in the knowledge that many councils and local partnerships already have very similar structures to improve co-ordination and collaboration on health improvement and addressing health inequalities.*

We are pleased the Government recognises that councils will require additional resources to undertake the public health role. However, the imposition of a ring-fence is completely at odds with the place-based approach advocated by the Local Government Group. Mainstream services such as housing, early years support, transport, leisure and recreation and social care make a far more significant contribution to public health and health improvement than the marginal resource in the ring-fence.

Government must trust local councils to direct resources as they see fit and remove the ring-fence.

With regard to the proposal to remove health oversight and scrutiny powers from councils, the LG Group believes that HOSCs have made a real difference in championing the public interest and challenging health commissioners and providers to deliver better health services. The scrutiny of health services must be transparent and have a strong element of democratically accountable oversight, independent of the health service, in order to ensure that it is responsive to the local public’s needs.

Joint licensing role for Monitor and the Care Quality Commission

Providers will be subject to a twin licensing role. Monitor will become the economic regulator for all health and social care providers with responsibility for: promoting competition; regulating prices for NHS services; and supporting the continuity of services if services have become unviable or in protecting assets or facilities that are essential in maintaining the continuity of services.

The Care Quality Commission will focus on quality assurance for all health and social care, both public and private. Providers will have a joint licence overseen by both Monitor and the CQC.

Monitor will also have a role in ensuring competition and diversity of providers to ensure that neither commissioning nor providers use anti-competitive practices and will act as an arbiter to investigate complaints of anti-competitive practice.

The Government will be publishing more detailed proposals on economic regulation prior to the publication of the Health Bill.

Further proposals within the White Paper

Greater patient choice, information and control

People will be given greater choice of provider, including the right to choose to register with any GP, and greater involvement in decisions about their care. The NHS Commissioning Board will be a champion for patient and carer involvement.

There will be better information for patients and carers, a wider range of on-line services and new ways for patients and clinicians to communicate. All providers and commissioners will have a legal duty to provide accurate and timely data, and the Department of Health (DH) will publish an information strategy to seek views on how best to implement the changes.

Patients will have control over their health records and will be able to share them with other organisations, such as patient support groups and patient advocates.

There will be a further consultation on extending choice later in 2010. The White Paper reiterates the Government's commitment to extending choice through a roll-out of personal budgets for health. The NHS Commissioning Board will have a key role in extending choice and control, and Monitor will ensure that patients have a choice.

LG Group view – *The LG Group is committed to extending choice to people and sees this as the way forward in offering care and support that is tailored to individual needs. We support the intention of the White Paper and look forward to working with the Government to extend choice while seeking to achieve efficiencies.*

Greater focus on improved health outcomes

The NHS will focus on outcomes, rather than meet top-down targets. The first step towards this will be the new NHS Outcomes Framework which will include a set of national outcome goals, against which the NHS Commissioning Board will be accountable.

The outcomes will focus on clinical effectiveness, patient safety and patient experience of their care. The DH will be publishing a separate consultation document on the development of national outcome goals.

The outcome framework will be supported by quality standards developed by the National Institute for Health and Clinical Excellence (NICE). Within the next five years, NICE will develop 150 standards for all the main

pathways of care, covering both health and social care services.

LG Group View – *We welcome the focus on outcomes rather than targets and look forward to discussing with the Government how local areas, led by councils, can develop their own outcomes measures, based on the needs and expectations of local people.*

General practitioner-based commissioning consortia

Decisions on treatment and care will pass directly to groups of health practitioners who will be responsible for around £80 billion of NHS resources per annum. It is anticipated that there will be around 500-600 general practitioner commissioning consortia across England and all GPs will be required to join a consortium.

Each consortium will have to be of sufficient size to manage financial risk and to commission services jointly with local authorities. The NHS Commissioning Board will be responsible for holding consortia to account for their use of NHS resources. They will have the freedom to decide whether to undertake commissioning activities themselves or outsource commissioning activity to other organisations, including local authorities.

These consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty of patient and public involvement.

A consultation document giving more details on commissioning will be published shortly - the responses to which will inform the forthcoming Health Bill.

LG Group view – *Councils and PCTs are already working constructively with commissioning consortia in many areas to develop local services that directly address local needs. However, commissioning led by health practitioners is still in the early stages of development and not all practitioners have direct experience of this. We would recommend that the Government works with a few selected areas to “test-bed” this model of commissioning before it is rolled out nationally.*

Cutting bureaucracy and improving efficiency

There is an expectation that management costs will be cut by more than 45 per cent by abolishing PCTs and SHAs, a major reduction in the overall size of the Department of Health, and a major cull of health-related quangos which will be announced shortly.

PCTs will have an important but time-limited role in supporting health practitioners to develop their commissioning capacity and to ensure a smooth transition to the new model. It is planned that following the Health Bill in 2012/13, general practitioner-based consortia will take full financial responsibility from April 2013 when PCTs will be abolished.

LG Group view – *Councils know that cuts are necessary to reduce the budget deficit, however further reductions in public spending must go hand-in-hand with a radical reform of the way public money is spent. It is important that this includes an end to the ring-fencing of budgets in order to allow for efficiency savings through place-based budgeting.*

NHS Commissioning Board

An independent NHS Commissioning Board will allocate NHS resources to general practitioner-based consortia and support them in their commissioning decisions. It will also:

- provide national leadership on commissioning for quality improvement
- promote patient involvement and choice
- support the development of GP commissioning consortia
- commission national and regional specialist services and community services such as GP, dentistry, pharmacy and maternity services
- allocate and account for NHS resources.

The Board will be fully operational in April 2012, when Strategic Health Authorities will be abolished. A national Public Health Service will be created to promote public health, with responsibility for local delivery of public health transferred from PCTs to local authorities.

LG Group view – *The NHS Commissioning Board appears to represent a centralisation of decision making in the health service. It is essential for this Board to represent local decision making at the national level, whilst allowing local commissioners the flexibility to adapt services to local public needs.*

Patient and public voice

Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). Local involvement networks will be rebranded as Local Health Watch and will ensure that the voices of patients and carers are at the heart of the commissioning process. Local Health Watch will be funded by and accountable to local authorities and they will have a legal duty to ensure that Health Watch is operating effectively. Councils will have responsibility for commissioning Local Health Watch or Health Watch England to provide support and advocacy services.

At national level, Health Watch England will provide leadership to local branches and will provide advice to national bodies, including the NHS Commissioning Board, Monitor and the Secretary of State. It will also have the power to propose CQC investigations of poor services, based on local intelligence.

LG Group view – *We welcome the emphasis on greater public engagement at all levels of decision-making within the health service. However, we are concerned that Local Health Watch will carry the weight of responsibility in the public's eyes. The current system has had patchy success in putting patients and service users at the heart of commissioning plans and we will need to learn from best practice to improve effectiveness. Local decision making on public health must play a strong role in the delivery of any national public health service.*

The statutory responsibility to support public and patient involvement in health spending must go hand-in-hand with a radical reform of the way budgets are spent towards a system of place-based budgeting. It is also important that this includes an end to the ring-fencing of budgets in order to allow for the flexible provision of public services that are responsive to local needs.