**"Equity and excellence: liberating the NHS" – a response from Kent County Council.**

***Executive Summary***

- Kent County Council (KCC) strongly supports changes that will put patients and clinicians at the heart of decision-making in healthcare, emphasises the central importance of improving healthcare outcomes and reduces the burdens of performance-management and regulation.

- KCC applauds the Coalition Government's enhancement of the role of local democracy in holding the NHS to local account and is committed to working with local partners to ensure that scrutiny arrangements continue to be proportionate, transparent and effective.

- KCC looks forward to the future White Paper on Public Health and calls for the Health Bill to create a legal framework that promotes local flexibility and incentivises collaborative working amongst ALL stakeholders on the preventative agenda.

- KCC has long supported innovation and personalisation in social care and looks forward to working with GPs and others on the closer integration that will help spread the benefits into healthcare services.

- KCC welcomes the establishment of HealthWatch: KCC set up its own version of HealthWatch in 2008 and looks forward to working with LINk and others to develop new commissioning arrangements that strengthen and broaden public engagement and 'voice'.

- In recognising the leadership of the Department, KCC is clear that it too must show local leadership in developing new relationships with the embryonic consortia, at a pace that suits both parties – governance, in terms of the new Health & Well-being, GP consortia and Public Health functions need to be based on mutual trust and respect.

- The review of arm's length bodies proposes some fundamental realignment of functions which are broadly supported. KCC will wish to be assured that this does not lead to an unintended recentralisation of functions that would be better devolved to local agencies, eg the commissioning of drug and alcohol rehabilitation services, or transfers additional but unfunded functions to local government.

- Whilst welcoming the direction of travel in lightening the regulatory burden on healthcare, KCC cautions against the potential for an inadvertent increase in the complexity of regulation for social care. There is still a risk that the inspection and regulatory framework could prove fragmented, confusing and burdensome.

- KCC endorses many aspects of the proposals freeing up Foundation Trusts but would caution against legislative proposals that free FTs

from all accountability to local communities especially during a potentially fragile transition period.

- The issues of safeguarding and patient safety are overlooked. There is only a passing reference to the Children's Safeguarding Board and there is little indication on how vulnerable adults will be protected. We look forward to this omission being addressed during the transitional period

**Detailed commentary**

1. This is a response from Kent County Council to the over-arching White Paper *"Equity and excellence: liberating the NHS"*. This response has been prepared in order to meet the deadline of 5 October but we will be taking further soundings and will wish to supplement this response by means of:-
   (i) detailed responses to the four additional and subject-specific consultation papers, by the 11 October deadline, and
   (ii) a further supplement to this response following discussions at Cabinet (11 October) and full Council (14 October).

2. As requested in the White Paper, this commentary focuses on the issues of primary legislation and implementation although where we think it is important, we also comment on the findings of the report of the review of arm's length organisations which was published at the same time but is not part of the formal consultation even though the consequences of its changes will have significant impacts on matters covered in the consultations.

3. KCC wholeheartedly endorses the fundamental ambition of 'putting patients and public first' and welcomes the enhanced role for local government in making this happen. Achieving this will indeed necessitate real transformational change – operational and cultural, even more than organisational. Several aspects of the proposed changes will undoubtedly prove controversial amongst the many different stakeholders and our hope is that the ambition behind these far-reaching changes does not get watered down as the Bill progresses through Parliament.

4. Whilst it seems inevitable that the current health scrutiny function will need to change too, for the transition period itself, scrutiny of the proposed NHS changes as they impact locally will be of great importance in assuring local people and communities that 'their' NHS will be protected and improved. This is, in our view, of particular importance – providing key checks and balances, as it were – if, for example, one of the consequences of granting greater freedoms to Foundation Trusts over their governance arrangements were to be to

make them less accountable to and more remote from the people they serve.

5. Legislation can achieve much but successful implementation by 2013 will be largely dependent on confidence-building actions that foster trust between new and perhaps unfamiliar partners, such as GPs and local councillors. It is critical therefore that all transitional arrangements are carefully calibrated to address all partners' concerns. In this regard, it is absolutely critical that the Bill's provisions for the future Public Health Service are 'paving' and enabling and not prescriptive. There are several possible permutations for how the national-local and local-local configurations of the Public Health Service might work. It would not be wise, in the spirit of "form follows function", to lock us legislatively into a one-size-fits-all set of institutional arrangements ahead of a Public Health White Paper intended to shape the discussion on its precise purposes and functions. For similar reasons, the legislative proposals for GP consortia should not prematurely lock out possibilities that GPs may wish to pursue and it is probably unwise to delineate on the face of the Bill which services are to be commissioned by consortia and which by the NHS Commissioning Board.

6. To achieve this, we would strongly encourage a much closer dialogue between officials in the Department of Health with officials in the Department of Communities & Local Government, as well as with those directly representing the interests of local people, including their locally and democratically-elected representatives. It is also clear that the publication of Professor Sir Ian Kennedy's review of children's health services and the subsequent *"Achieving equity and excellence for children"* consultation report demand a concerted cross-Department effort. Therefore, a Health Bill with sufficient "plug-in points" to accommodate other changes still in the pipe-line is required. It is very important therefore that the Bill also goes with the grain of the forthcoming Localism Bill.

7. In promptly dismantling much of the inherited top-down targets-focused regime, the Coalition Government has already made significant progress in reducing the bureaucracy that has stifled the opportunity for creativity and the local flexibility of the NHS to work with its local partners. We look forward to helping build a system that rewards local responsiveness to meet local circumstances through better service-integration (for example, with both children's and adult's social care) and shared use of assets and back-office. The Health Bill may not be the right place to tackle legislatively the panoply of inter-Departmental blockages and disconnects (identified most recently by the Total Place pilots) that have held back closer integration of a wide range of public services. Therefore, it is to be hoped that the Localism Bill will address them systemically.

8. We do not underestimate the challenge of devolving decision-making on, for instance, service reconfigurations to closer to where the impacts are felt and we are positive about the role local democracy can play as an honest broker, seeking and promoting solutions on what are genuinely difficult and finely-balanced issues. This is distinct from our current scrutiny function and the County Council's response to the consultation on democratic legitimacy will set out our thinking in greater detail – suffice it to say here that changes to scrutiny functions will need to be step-changes, not evolutionary.

9. Performance-management remains everyone's responsibility and it is fully appreciated that the enhancement of local, including democratic, accountability must be matched by the ability for performance to be measured by the outcomes we achieve for patients and also to assess how those local outcomes measure up against outcomes in other places. This will best done not by reference to league tables or postcode lotteries but by clear, publicly-accessible information that maximises people's opportunities to make intelligent, well-informed choices for themselves and their families about where is the best place to get the treatment they need. With the demise of the CPA, there is an opportunity to allow local partners more space to create theor own locally-tailored frameworks.

10. Given the strong emphasis on *patient choice* in the White Paper, it is surprising perhaps that greater store is not placed on the potential for applying the lessons from *personalisation.* We know from our ground-breaking work in adult social care in Kent on 'self-directed care' and self-assessment (and the large-scale investment in both telecare and telehealth going back over several years) that whilst customer-satisfaction and care outcomes are both improved, costs are not increased by mainstreaming personalisation. Indeed, our evidence is that the smart application of technology to sustain people in their own homes has a beneficial impact on demand for (and the costs incurred in providing) healthcare interventions – this is particularly the case for people with long-term conditions or a combination of different debilitating conditions.

11. Kent has had its own version of HealthWatch which was set up in 2008. The patient and public voice in the NHS in England has had a chequered history since the abolition of the Community Health Councils in 2003. Kent is keen to work with the public and local partners to make sure that HealthWatch is a success at becoming what has been referred to as the "CAB of healthcare".

12. In order to do this, it is essential that the Bill is unambiguous about the roles, functions and accountabilities of the future HealthWatch bodies to the patients and public they serve and about the roles of the local authorities who will commission their services. Some of the statements on this aspect of the changes have created the misleading impression that LINks will simply evolve into HealthWatch. The functions of GP

consortia, Health & Well-being Boards, health overview & scrutiny committees and HealthWatch all need to be considered in the round to make sure they are compatible and coherent at a local level.

13. Whilst LINks have done some sterling work since being set up in 2008, HealthWatch will be much more than a simple evolution of LINk. Also, local authorities may wish to consider commissioning services from a range of potential providers. Whilst building on the goodwill and expertise LINk has helped establish, local authorities will not wish to be statutorily locked into a simple continuation of current LINk arrangements, albeit under a new name if 'voice' is to be further strengthened. For instance, we would anticipate that the effective engagement of children and young people in commenting on and co-designing health and social care services will be better achieved by commissioning from amongst services already in place and effective but not part of the local LINk.

14. It will be helpful to have early clarification of how the Health Bill will contain the necessary paving provisions for the establishment of the proposed National Public Health Service. It is essential the future NHS architecture is built with confidence and clarity about the statutory arrangements for ALL its component parts - and for that we need confidence that ALL the functions appropriate to the National Public Health Service are included, along with its relationship with the NHS Commissioning Board. Only in this way will it be possible to map coherently the totality of the complex commissioning relationships and financial flows between the NHS Commissioning Board, the GP consortia, local authorities and national Public Health Service (which will include the health improvement component being transferred into local government) with a view to securing greater efficiencies.

15. We are confident that the incorporation of the health improvement element of public health into local government will also help ensure public health expertise and intelligence better informs joint strategic needs assessments, upon which GP consortia and councils alike will draw for their commissioning strategies. Confidence will be further increased when we understand better the relationship envisaged between health improvement, the functions transferred from the National Treatment Agency and whether, where and how the drug and alcohol rehabilitation commissioning budgets are transferred to and fit within the ring-fenced Public Health Service budgets.

16. The strengthening of the status of the National Institute for Health and Clinical Excellence (NIHCE) as a non-departmental public body is welcomed. Even if at times its decisions have courted public and professional controversy, it has played an important role in establishing the connections between notions of *clinical effectiveness and cost-effectiveness.* With the anticipated sustained pressure on public finances this becomes more important. The extension of NIHCE's

remit to include social care is seen, in the light of our experience of the work on dementia pathways, as a very positive step.

17. We are not persuaded the case has been made for an *expansion* of Monitor's regulatory remit. There is a strong case, we believe, for tasking Monitor with a very focussed authorisation role during the transitional period to bring all remaining NHS bodies to the point of being – or becoming part of – a Foundation Trust. We think this would cover for the inevitably diminishing 'due diligence' role of SHAs as they are wound down and would also build on Monitor's existing body of expertise more effectively than by attempting to replicate it in a yet-to-be-established new unit in the Department of Health (as indicated in paragraph 4.23).

18. There seems to be no added value in creating Monitor as a national regulator for adult social care. The adult social care market is already mature and, except for the occasional light-touch intervention/inquiry by OFT, quite stable and it is unclear from the consultation document how Monitor could give effect to the role of economic regulator of social care without either duplicating the market-shaping activities that councils have carried on effectively since the community care changes of 1993 or by usurping councils' own discretionary powers on fees and charges.

19. We would strongly advise the Government to think again about the regulatory proposals for the role of Monitor, suggesting a phased approach which capitalises on their expertise in the authorisation and 'due diligence' processes on an intensive interim basis, with a VfM review beyond that to see whether their economic regulator functions could not be met by a combination of Care Quality Commission, National Audit Office and district audit, all of which will continue for the foreseeable future as relatively stable features in the inspection/regulation environment.

20. In paragraph 15, we referred to drug and alcohol rehabilitation services. In Kent, the commissioning budgets and functions for these services have been delegated by the PCTs to the Kent Drug & Alcohol Action Team, hosted by KCC, and have been widely recognised for the effectiveness of the outcomes that have been achieved in terms of quality, choice and responsiveness. We ask that the Bill contains no prescriptive provisions that would prejudice our building further on this. Undoubtedly, many councils will make similar 'special requests' – the over-riding point is that we must at all costs avoid new legislation that has the unintended consequence of stifling existing excellent practice.

21. It is timely to have an overhaul of the current flexibilities around S75 to enable a greater uptake of the range of joint arrangements. It is presumed that the legal provisions by which GP consortia will in future commission their own support functions will be new and separate.

KCC has a solid track record on commissioning a wide range of care services, including some on behalf of NHS partners (eg drug and alcohol rehabilitation, registered nursing care in care homes) and would wish to be in the position to continue and extend this, where appropriate and in agreement with GP consortia.

22. We request that the Bill deals with this explicitly. If it is to be a genuine level playing-field, we will need to know what the market entry requirements are and that the Bill classes local authorities as bodies that may bid for specified consortia-support business. This makes even greater sense in terms of helping to create an environment that facilitates, even incentivises, cost-reduction methods across the whole public sector, such as shared asset management and shared back-office services. We appreciate that PCTs can use the current FESC framework and would welcome an indication that this or an equivalent would be available on an equal basis for authorities who wish to go down this route.