

Summary of the KCC NHS White Paper Consultation Response

Summary: The purpose of this paper is to summarise Kent Adult Social Services (KASS) response to the “Equality and Excellence: Liberating the NHS White Paper”, as part of Kent County Councils (KCC’s) cross-directorate working group.

FOR INFORMATION

Introduction

1. On the 12 July, Andrew Lansley, Secretary of State for Health published the White Paper “Equity and Excellence: Liberating the NHS” which sets out details of the transformation of the NHS. A KCC cross-directorate working group met on the 26 July to discuss how best to manage the different strands of work. The leads for drafting the responses to the ancillary consultation papers have been agreed with the expectation that these leads will work with the original cross-directorate group, staff and members across KCC to ensure a full, single, consistent reply. This work is being coordinated by Martyn Ayre (Senior Policy Manager, Corporate Policy), who will also be leading on the response to the main White Paper.

The ancillary papers and leads for Kent Adult Social Services (KASS) are:

Consultation	Lead
Commissioning for Patients Seeking views on how the new system of GP Consortia and the NHS Commissioning Board will work in practice	Pat Huntingford – Lead for KASS Sally Smith – Lead for KASS (previously Jennifer Maiden-Brookes)
Increasing Democratic Legitimacy Seeking views on strengthening local partnerships between NHS commissioners and Local Authorities (LA)	Nick Sherlock – Lead for KASS
The Arm’s Length Body Review Seeking views on changes to a range of our supporting organisations	Sue Williams – Lead for KASS
Freeing Providers and Economic Regulation Seeking views on how best to give real freedoms to hospitals and community services and on a new system of regulation	Nick Sherlock – Lead for KASS
The NHS Outcomes Framework Seeking views on a new framework to establish improving quality and healthcare outcomes as the primary purpose of all NHS funded care	Steph Abbott – Lead for KASS Sally Smith – Lead for KASS

Substance of Report

2. Commissioning for Patients

The Commissioning for Patients consultation document set out proposals for putting local consortia of GP practices in charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board. For the purposes of brevity the opportunities and limitations of such a proposal are summarised below.

Engagement, Quality and Consultation

GP practices are in effect small businesses focused on the provision of health care in defined geographical areas. To enable them to engage with national issues and to integrate into a system of countrywide commissioning of services a radical change of culture will be required. Sir David Nicholson's letter informing Trusts that all plans for service redesign must have the approval of local GP consortia (See Appendix 1a) reinforces this culture change. Sir Nicholson's letter suggests that mechanisms should be put in place to make sure that the Joint Strategic Needs Assessments (JSNA) continues to be used as the basis for underpinning commissioning strategies and decisions.

There is also concern that because of the potentially limited budgets the GP Consortia may inherent there could be hesitancy when commissioning high-cost specialised services, e.g. Learning Difficulty or Physical Disability, in order to conserve limited resources. In addition to how Consortia decisions are informed it is important that LAs and (when established) the NHS Commissioning Board seize the opportunity to support GP Consortia to adopt a model that will best fit the needs of the people of Kent. LAs can provide significant information on the back office functions of commissioning i.e. opportunities of collective commissioning arrangements for certain services and how this could work, and invaluable support in terms of monitoring the success of commissioning practices.

In terms of improving the quality of primary care, it is suggested that GP Consortia need to develop a scheme comparing and contrasting returns on a like-for-like basis in order to monitor quality controls and assess commissioning outcomes. Consortia could develop a standard mark for reference during the tendering process for services. This template could enable Consortia to determine an appropriate cost/quality split when commissioning services.

This design and monitoring of contracts will be an essential part of Consortia's commissioning responsibilities. Establishing a common framework would inform practice decisions around what they do and how they deliver services.

In terms of consultation with patients, the needs of the local community will have significant influence over the services commissioned, supporting the Government intention that there should be 'no decision about me without me'. The LA or Commissioning Board could coordinate partnership/public engagement to look at what is needed and what works.

Kent Health Watch has been successfully gathering feedback and passing it onto the appropriate service areas in health and social care since it was launched. This could be developed to incorporate the Health Watch function outlined in the White Paper. In addition, Patient Participation Groups (PPG) which act as an intermediary between patient and practice, can represent patients views to the practice and the practice views to the wider community. Both groups could provide an audit function which gauges customer satisfaction with Consortia.

Safeguards, Accountability and Reducing Inequalities

To ensure transparency and fairness in commissioning services a clear Joint Strategic Needs Assessment (JSNA) must be undertaken to establish what services are required. It is understood that this will be the remit of the LA. The introduction of a governance and accountability framework to facilitate improved integration and effective partnership working under the direction of the JSNA would be an effective safeguard. The Democratic Legitimacy consultation response has more information on suggested safeguarding measures.

Reducing inequalities that are avoidable is also raised within the consultation response. It is suggested that LAs could conduct an assessment of Consortia's approaches to health equality and equitable access to services e.g. are they striving to achieve a more even share of good health beyond improving the average health status of the local population? In addition, an education programme could be rolled out by LA's to highlight the differences between health inequalities and health inequities to Consortia (i.e. poor health can itself be the consequence of an unjust distribution of society e.g. opportunities in education or employment). The programme could also stress that health inequalities are avoidable; that early interventions to reduce inequalities are cost effective; and that promoting equality is a core part of delivering high quality care for both health and social care.

3. Increasing Democratic Legitimacy

This consultation builds on the proposals in the White Paper to increase local democratic legitimacy in health. This will be achieved through local authorities: i) being given a stronger role in supporting patient choice and ensuring effective local voice ii) taking on local public health improvement functions, and iii) promoting more effective NHS, social care and public health commissioning arrangements.

Health Watch Groups & Health and Wellbeing Boards

Paragraph 15 of the 'Increasing Local Democracy Paper proposes that "*Local Involvement Networks (LINks) will become the local Health Watch.*". Health Watch will support and help people access and make choices about services, and support individuals who want to make a complaint. It is the view of KASS that a clear governance structure needs to be developed whereby there are clear links between the Health Watch group and the LA, who will be the local commissioners of Health Watch groups. There are concerns that as the LA will be providing services a fine balance must be achieved so that there is not a conflict of interests.

- The management of the contract needs to be outside the political arena, as there may be occasions where Health Watch may have to challenge the LA on fundamental policy and service delivery issues
- Health Watch needs to be a public forum to prevent it from being seen as another LA service. The paper proposes that only 1 member of the public is required, which in KASS view is a 'bit light'
- The Health Watch will need a strong constitution and will need to have LA feedback into the Care Quality Commission (CQC) and a strong voice on the Health & Wellbeing Boards, if it is to be effective

In addition to Health Watch the proposal is to introduce statutory Health and Wellbeing Boards. It is understood that Health and Wellbeing Boards will allow LA's to promote integration across health and adult social care, children's services and the wider local agenda. The view from KASS is mixed; a statutory framework outlining expectations would be welcomed. However there is a need for the arrangements to remain flexible to allow for pragmatic development at a local level.

Where there are disputes locally, KASS suggests the following resolution proposals.

- Clear governance arrangements for the Board, including a process by which disagreements are aired and settled. All members of the Board will have to agree to these arrangements before taking a place on the Board
- Incentives from LAs to support Boards which work well together and settle disputes internally

- As a very last resort a process of appeal to the Secretary of State

Incentivising Integrated Working

The DH asks for comment on how to 'free up' the integrated working practices, which in its view had previous limited take-up. KASS propose that to promote and support integrated working for full joint commissioning certain barriers need to be removed. These barriers include funding streams, ring fenced budgets, regulations/legislation and governance which restrict the freedom of partners to fully enter into joint commissioning arrangements.

Freedoms and flexibilities should go beyond joint commissioning and focus on making a reality of Personalisation. For example, Direct Payments are still only given for social care needs, it is KASS view that this should be extended to health care needs. This arbitrary split will hinder the development of integrated community services between health and social care.

4. The Arms Length Body Review

The Arms Length Body report proposes that some functions of Arms Length Bodies (ALB) will no longer be provided at a national level. A change is required to achieve greater alignment with the wider system and to deliver a more responsive service. The review also points to the fact that commercial opportunities have not been fully exploited. In 2009/10, the sector as a whole spent in the region of £1.6 billion on business operations, including baseline revenue of £800 million. ALBs employ around 18,000 staff and they form a significant component of the national health and social care landscape. In 2004 this sector was rationalised and reduced from 38 organisations to 18. For the purposes of brevity, this section focuses on those organisations which will remain, those where the function will be transferred, and those that will be abolished.

Remaining Organisations

In the review there are six ALBs that have a clear future, albeit operating in a regulated way. These are Monitor, the Care Quality Commission (CQC), the National Institute for Health and Clinical Excellence (NICE), the Medicines & Healthcare product Regulatory Agency (MHRA), the Health and Social Care Information Centre (HSCIC) and NHS Blood and Transplant. There is an expanded role for NICE, putting it on a firmer statutory footing, securing its independence and extending its remit into social care

Function Transferred

The General Social Care Council, will have its function transferred to an existing professional regulator - the Health Professions Council. Until further information is available it is difficult to say if this is a positive move. In addition, the Council for Healthcare Regulatory Excellence, will be moved out of the sector to operate on a full-cost recovery basis. The Council was set up to co-ordinate standards and good practice amongst the bodies responsible for regulating the healthcare professions in the UK, in the wake of the Kennedy Report into paediatric cardiac surgical services at the Bristol Royal Infirmary. The regulatory bodies covered by CHRE are:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- Health Professions Council
- Nursing and Midwifery Council
- Pharmaceutical Society of Northern Ireland
- Royal Pharmaceutical Society

Two of the ALBs, NHS Litigation Authority and NHS Business Services Authority, will be subject to a commercial review by industry experts to identify potential opportunities for greater efficiency through outsourcing, divestment and contestability and/or employee ownership. The Human Fertilisation and Embryology Authority and the Human Tissue Authority functions will be transferred to other organisations. Further work is required to examine in greater detail the practicalities involved and it is proposed that they remain as independent arm's-length bodies in the short term, with the aim that their functions will be transferred by the end of the current Parliament.

The view in KASS is that these bodies have considerable knowledge and it will be important that the scientific and ethical expertise built up is protected, and that the regulatory work both nationally and internationally remains robust. These are licensing and inspecting organisations that store and use human tissue for purposes such as research, patient treatment, post-mortem examination, teaching and public exhibitions. They also give approval for organ and bone marrow donations from living people. It is important that public confidence in the services and regulation they provide is retained.

Abolished

The Health Protection Agency (HPA) and the National Treatment Agency will be abolished as statutory organisations and their functions will be transferred to the Secretary of State as part of the new Public Health Service. The functions of the Health Protection Agency are "to protect the community (or any part of the community) against infectious diseases and other dangers to health" (HPA Act 2004). In England, the HPA provides the local health protection services which in the rest of the UK is delivered by the three other lead health protection bodies; the National Public Health Service Wales; Health Protection Scotland HPS; the Department of Health, Social Services and Public Safety, Northern Ireland. The Agency works closely with all these organisations.

The HPA has also been successful in bidding for contracts to design and deliver exercise and training programmes for the World Health Organization (WHO), Food and Agricultural Organisation (UNFAO), the European Commission(EC), the European Centre for Disease Prevention and Control (ECDC) and the United States Agency for International Development (USAID). The agency also undertakes bespoke resilience and preparedness projects for both public and private sector organisations and has experience of working with and for devolved administrations, parts of the NHS, non governmental organisations and other agencies and organisations.

The Alcohol Education Research Council, the Appointments Commission, the National Patient Safety Agency and the Institute for Innovation and Improvement will be abolished. Some of the functions of the National Patient Safety Agency will be transferred to a new research regulator following a review.

The review appears to have streamlined and reduced duplication but it is as yet unclear as to how this will work in principle given that many of the changes will take place between 2012 and 2014. There will be a dismantling of many of the agencies responsible for regulating and safeguarding the public and it is hoped that whatever form the new ALBs take they build upon the strengths and intelligence of the former body. If this happens there is great scope for ensuring that these bodies are fit for purpose and can deliver their functions more effectively, reducing management costs and remove duplication and unnecessary burdens on the front-line. They can also use resources effectively ensuring that the UK remains at the forefront of much of the work previously undertaken.

5. Freeing Providers and Economic Regulations

The ancillary paper on providers and economic regulations asks for responses on number of areas around private income, Foundation Trusts, the role of Monitor and the fee for its licensing services. In order to summarise KASS response as clearly as possible it is necessary to break this section down into 2 areas, Foundation Trusts and Monitor.

Foundation Trusts

Currently there is a cap on the private income of Foundation Trusts, the proposal is to remove this cap. The proposal that statutory controls on borrowing by Foundation Trusts is also removed suggests that there would need to be some tough financial regulating to make sure that the borrowing was prudent.

There is also some concern around changing legislation to make it easier for Foundation Trusts to merge with, or acquire other Foundation or NHS Trusts. It is KASS view that any such merges should only go ahead if local public groups such as Health Watch, and local Consortiums have agreed the merger

Monitor

The proposal from the White Paper is that Monitor and CQC will work in tandem as joint-licensing agencies. Regulation of the NHS will be overseen by Monitor, specifically price regulation, promoting competition and ensuring access and continuity of services. CQC will continue in its role as the quality regulator of health and social care. The proposal is that Monitor will charge to fund its regulatory activities.

The role of price monitoring could be regulated through a combination of the following mechanisms.

- NICE will set standards upon which price will be based
- Commissioning Boards with CQC support can monitor appropriate prices nationally and if necessary intervene
- Consortiums with the support of Health and Wellbeing Board will ensure a locally acceptable price can be set

6. Transparency in Outcomes

The purpose of the Transparency in Outcomes consultation is to seek the help of those working in the NHS, patients and the public in developing this NHS Outcomes Framework

The consultation document explains and asks for views on:

- the principles that should underpin the NHS Outcomes Framework;
- a proposed structure and approach that could be used to develop the framework;
- the potential outcome indicators (existing and future) that could be presented in the framework, including the proposed rationales for selection;
- how the proposed NHS Outcomes Framework can support equality across all groups and can help reduce health inequalities; and
- how the framework can support the necessary partnership working between public health and social care services needed to deliver the best possible outcomes for patients.

Principles and Indicators

The Transparency in Outcomes Framework focuses on the principles of the NHS, which, when considering that LAs will be responsible for health and social care outcomes too, means that without further information it is difficult to know whether there are any contradictions or disparities between the suggested performance indicators. For example, in the consultation questions LAs are asked to suggest possible indicators for monitoring infant mortality rates. Recent research suggests that the main causes of infant mortality in the UK are a combination of unhealthy lifestyles, poor antenatal care and a rise in the number of older mothers. Possible indicators would therefore be infant mortality where parents are smokers or infant mortality where the mother is a drug user. These are very clearly indicators which are traditionally 'public health'. Without further information on the social care and public health frameworks it is difficult to comment on the proposed NHS indicators. There is a need for the DH to produce more guidance on the possible contents of the health and social care frameworks. All the frameworks need to be flexible and the performance indicators contextualised. With the closure of the PCT's and Strategic Health Authorities (SHA's) it is not clear who will have the capacity to capture the data required to monitor outcomes.

The consultation paper fails to cover efficiency, either in terms of NHS performance or and most crucially, the effectiveness of this new framework. If the new NHS model is to be patient centred then it is important that its effectiveness in terms of improving efficiency within the service is monitored. This transparency would be valuable in terms of patients and practitioners ownership of the system and proactively addressing areas of the system that are not working.

Improvement Areas

The new framework suggests that 'improvement areas' for LA's, Consortia, the Commissioning Board and partners will be determined at a national level based upon the indicator outcomes. Determining improvement areas for localities at a national level may lead to the loss of intricacies, knowledge and experience evidenced at a local level.

Implementation Proposals

The final drafts of the 5 ancillary consultation responses will be submitted to the DH before the 11 October 2010. This will be overseen by Martyn Ayre (Senior Policy Officer, Corporate) and will include individual corporate lead responses. The main White Paper response will be submitted by the 5 October. If the Health Bill is given Royal Assent the majority of reforms will come into effect in April 2012:

- NHS Commissioning Board fully established
- New LA Health and Wellbeing Boards in place
- Limits on the ability of the Secretary of State to micromanage and intervene
- Public Health Service in place, with ring fenced budget and local health improvement led by Directors of Public Health in local authorities
- NICE put on firmer statutory footing
- Health Watch established
- Monitor established as economic regulator

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