Consultation response

The King's Fund's response to the Department of Health consultation *Liberating the NHS: Local Democratic Legitimacy in Health*

11 October 2010

The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

We welcome the opportunity to comment on these proposals. This is one of a series of responses by The King's Fund to the government's proposed reforms covering commissioning, regulation and the outcomes framework. These are available from our website, together with an overview of our response to the reform programme as a whole.

Overview

The relationship between the NHS and local authorities is crucially important, and we welcome the government's aims to strengthen the involvement of local government in health. Our understanding of the government's main proposals is that local authorities would take on responsibility for leading health improvement at a local level, and that new 'health and well-being boards' would be established in each local authority. These boards would have three main functions: assessing the health needs of their local population; co-ordinating and integrating the commissioning of health and social care services; and scrutinising plans for service redesign.

These proposals create a real opportunity to place a greater emphasis on health prevention and to further integrate planning for health improvement activities with that in other service areas, such as transport, housing and leisure, in order to tackle the wider determinants of ill-health. However, there also remains an essential role for public health within the wider NHS (in addition to the proposed Public Health Service) and we urge the government to establish this clearly in the forthcoming public health White Paper.

The extent to which the government expect health and well-being boards will play a local leadership role for health is unclear. In our view, the multiple functions of the proposed boards would not be well-served by a single body. For example, transferring the scrutiny role of Overview and Scrutiny Committees (OSCs) to these boards would risk conflicts of interest as a board may be scrutinising decisions its members have been involved in making.

We are not convinced that the boards would be effective in their task of co-ordinating and integrating commissioning of health and social care services. As GP consortia will control the majority of the NHS budget and be primarily accountable to the national NHS Commissioning Board, local boards could have limited power over them. Any moves to strengthen the influence of the health and well-being boards over NHS commissioning plans – for example, giving them powers to approve local commissioning plans – would have to be supported by appropriate expertise. This risks duplicating the support commissioners need to secure for themselves. It also creates dual lines of accountability for consortia and may subject them to conflicting

priorities. Finally, joint and integrated working is most effective when it is led locally. Centrally imposed restructuring could risk damaging progress already made in this area.

Overall, it is clear that the government has an ambition to strengthen the democratic legitimacy of decisions about health and health care by giving a stronger role to local authorities. The proposed reforms look set to produce a dual system in which GP commissioners would in theory be accountable to both the NHS Commissioning Board (which is itself accountable to the elected Secretary of State) and to local authorities. The real challenge of such a system is in ensuring that its parts mesh together seamlessly, that there are no major gaps in accountability, and that the two lines do not pull organisations in different directions. We question whether, in practice, local authorities are likely to have much influence over the decisions of GP commissioning consortia.

We set out below our responses to specific consultation questions. We have restricted our comments to those topics on which we have most expertise.

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?

[No response]

Q2 Should local HealthWatch take on the wider role outlined in paragraph17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

There have been many years of poor performance on NHS complaints. The new system introduced in 2009 is still bedding down. It is not clear whether moving responsibility for complaints advocacy from the Independent Complaints Advocacy Service to local HealthWatch networks will improve the situation for patients. We think there may be advantages to providing local support for complainants that is available from a single source and that can support complaints which may involve multiple organisations and/or the links between them. However, we are concerned about whether local HealthWatch will have the skills or the resources to provide suitable advocacy support, particularly given the potential for significant local variability in their form and function. As a minimum, we would request that there is some form of national oversight – perhaps by HealthWatch England – to monitor the effectiveness of the new arrangements.

We agree that local HealthWatch could play a useful function by signposting patients to information about providers and treatments, but we would like to emphasise that making decisions about treatment options or the most appropriate place for a patient to be referred must involve clinical input and should be taken jointly by patients and their clinicians.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

[No response]

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

The existing legal framework has created a wide range of flexibilities for local organisations to collaborate in the provision of health care and has been welcomed by those at the vanguard of integrated working (Ham 2009).

However, the framework is premised on a system in which commissioners of health (PCTs) and social care (local authorities) work to co-terminous boundaries. Under the government's proposed reforms, social care will continue to be commissioned by local authorities while health services will be commissioned by GP consortia, whose populations will vary in size according to local decisions and may span two or more local authority areas. Pooling budgets

for the care of sub-groups of the population in the new system will be considerably more complex in terms of agreeing resource allocations and establishing lines of accountability across these variable geographical boundaries. This could create a significant barrier to local organisations introducing more integrated ways of working.

There would need to be a new legal, regulatory and risk framework to support the development of local arrangements. Such a framework would need to be developed in tandem with the Law Commission's review of adult social care law and the work of the Commission on the Funding of Care and Support.

This autumn The King's Fund is hosting a series of seminars to examine how to speed up progress in bringing health and social care services closer together. A policy discussion paper setting out recommendations will be published later in the year and made available to the Department of Health.

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

There are already a wide range of freedoms and flexibilities which allow space for integrated working. The challenge is to translate these to the structures of the new system (*see* Q4) and to create a context in which they are likely to be exploited. The proposed restructuring could make such links less likely in the next few years; changes in leadership, organisational complexity and funding pressures have been identified by current PCT chief executives as major obstacles to more integrated working between health and social care organisations (NHS Confederation Primary Care Trust Network 2010). A preferable alternative to whole-scale restructuring would be to strengthen existing partnership arrangements and to share learning from successful areas, encouraging others to develop their own arrangements.

Encouraging and supporting integrated working requires:

- **Strong local leadership**
  Evidence suggests that efforts to co-ordinate and integrate services are best led locally so that they are appropriate to local contexts and build on existing relationships (Ham 2009; NHS Confederation Primary Care Trust Network 2010). The focus of such work needs to be on developing shared visions and strategies for care, establishing strong local leadership, and building a shared culture of trust (Ham 2009; Heenan and Birrell, 2006).

  It is essential that there is continued investment in organisational and leadership development activities and that attention is given at a local level to protecting existing inter-organisational relationships wherever possible as the government's reforms are implemented.

- **Regulatory processes that support rather than inhibit integration**
  The government should ensure that audit and regulatory systems do not prohibit or act as a disincentive to joint working. The common framework for regulation of both health and social care already established by the Care Quality Commission is an important foundation. The government should consider carefully how it might mitigate the negative consequences of a more robust competition regime for inter-organisational relationships at a local level and opportunities for collaboration and integration. It is essential that policy frameworks are developed to accommodate and support collaboration, as well as competition, between providers (Ham and Smith 2010).

  In order to stimulate more activity in those areas which do not yet have plans for integrated working, the government could consider a more prescriptive approach, requiring the NHS Commissioning Board to hold commissioners to account against outcomes associated with integrated care – for example, through developing quality indicators focused on care transitions. Such an approach should allow local organisations flexibility over particular structures and functions, while ensuring a focus on consistency of care quality.

The government should also consider how the current system of regulation can move beyond a focus on individual organisations towards a focus on care systems and pathways, so that performance assessment is more closely linked to patients' experiences of care (Ham and Smith 2010).

- **Improved IT systems**
  Experience from successful integrated health networks in America highlights the importance of shared information systems for enabling integrated working (Nuffield Trust 2009). It is not clear that the government's current 'voluntary' approach to the summary care record will permit the kind of information sharing required for fully integrated working. We look forward to seeing more detailed plans in the information strategy this autumn, and encourage an approach that facilitates greater communication across providers and sectors. For example, consistent use of NHS patient identifiers by social care as well as health care providers would enable existing data sets to be linked up.

- **Alternatives to the tariff**
  The current Payment by Results system for reimbursing providers is based around individual episodes of care. The government should explore alternative financing systems for the care of people with long-term conditions and complex needs, based around capitated payments which cover the whole of the care pathway (Ham and Smith 2010).

- **Better aligned funding arrangements for health and social care**
  Under the current system the assessment, planning and allocation of resources for health care and for social care are organised completely differently. Bringing these systems into closer alignment would make it easier for local commissioners to develop better integrated services for patients.

  We welcome the government's proposals to work with the LGA to explore the potential of place-based budgets. A recent conference organised by The King's Fund found that experience from the Total Place pilots suggests that place-based approaches to funding public services can produce more cost-efficient services that are better designed around the needs of service users. A summary of key insights from the conference is available on The King's Fund's website at: http://www.kingsfund.org.uk/publications/articles/placebased.html

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

[see response to Q7]

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?

In order to have some leverage in relation to GP commissioning consortia, health and well-being boards would need to be granted statutory powers. However, under such an arrangement there would be a tension between consortia's dual accountabilities to the NHS Commissioning Board and local health and well-being boards, which may have differing aims. We think this is a major problem with the proposed design of the boards and would encourage significant reflection on this.

If the government does proceed with its plans for health and well-being boards, it should ensure that the aims of the local authority are replicated in the quality framework against which GP consortia will be held to account by the NHS Commissioning Board. This framework ought in any case to include requirements for GP consortia on health improvement. Local authorities might also contribute specific requirements and feedback on, for example,

elements of integrated working among the consortia with whom they collaborate, which could contribute to the national Board's overall assessment of consortia.

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Our understanding is that there are three principal functions proposed for the boards:

- co-ordinating and integrating the commissioning of health and social care services
- assessing population health needs and leading, or at least overseeing, health improvement activities
- scrutinising plans for service redesign.

Supporting the co-ordination of commissioning services across health and social care is a commendable aspiration. But it is not clear to us whether the boards are intended to provide a strategic overview or to be an executive body in relation to commissioning. In either case, it is unclear what (if any) powers such bodies could hold in relation to GP consortia, particularly in the context of the consortia's duty of accountability to the national NHS Commissioning Board. There is a strong chance that the boards would be relatively powerless and insignificant in relation to the NHS. For example, it is not clear what influence decisions by the health and well-being boards on prioritisation of treatment areas as part of the Joint Strategic Needs Assessments would really have on resource allocation decisions by GP consortia, who will hold the vast majority of funds for health care.

If the role of health and well-being boards in relation to consortia was to be strengthened – for example, by requiring all consortia commissioning plans to be signed off by local authorities – health and well-being boards would require specialist skills and capacity to enable them to consider these plans meaningfully. There is a risk that this would simply duplicate the support that consortia themselves will seek in developing commissioning plans. As discussed above (*see* Q7), there is also a risk that consortia would be subject to conflicting demands from the NHS Commissioning Board on the one hand and the local authority on the other. However, in practice we believe that the pull upwards to the NHS Commissioning Board, which will be distributing funds, will be far stronger than the influence of the local authority. This may undermine the government's commitment to localism.

Giving local authorities a stronger role in health improvement offers real opportunities to give prevention activities a greater priority locally and to join up planning with other council services to enable a more holistic approach to tackling the wider determinants of health. It will be important that there are mechanisms to enable public health to be connected and integrated with other council services not mentioned in relation to the health and well-being boards, such as leisure services, housing and transport.

However, it is also essential that the wider NHS (in addition to the Public Health Service) retains a significant responsibility for health improvement. Health professionals have opportunities to intervene to support behaviour change – on diet, exercise, smoking and drinking – at moments when patients are most likely to be open to change, such as after a health scare or while they are pregnant. In addition to such interventions, GPs should also be taking a broader view of the health of their populations, both as providers with practice lists and as commissioners with responsibility for their populations. The forthcoming public health White Paper needs to establish the continuing responsibility of the NHS for health improvement and to set out clearly how responsibility for public health functions will be distributed between providers, commissioning consortia, local authorities and the new Public Health Service.

We do not believe it is appropriate for health and well-being boards to take over the function of Overview and Scrutiny Committees. Given the proposed functions and membership of the boards, there is too great a potential for a conflict of interest as the board would be scrutinising activities by some of its own members. We also think that the scrutiny role could clash with the boards' efforts to support co-ordination and integration between commissioners. For these reasons we think the scrutiny function should remain separate. It

may, however, be timely to review the effectiveness of OSCs in performing their scrutiny function.

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?

[No response]

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?

[No response]

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?

In order to realise the full benefits of linking planning and provision of public health with those of other council services, such as housing, transport and leisure services, it is essential that the arrangements are sufficiently flexible to enable both joint decisions at a regional level and devolved working at a district level on specific issues as required.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Form should follow function, so appropriate membership depends on which of the three different functions for the boards is prioritised (*see* our response to Q8).

Whichever is chosen, we think the proposal for attendance by someone from the national NHS Commissioning Board is unrealistic. If the NHS Commissioning Board introduces a new measure or policy that is relevant to the work of health and well-being boards, the current proposals would require members of the Commissioning Board to attend more than 350 local meetings within a limited time. This seems impracticable.

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

[No response]

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)?

We do not believe that the scrutiny and referral function of health Overview and Scrutiny Committees (OSCs) should be subsumed within the proposed boards. If the boards are to be granted all the functions set out in the consultation document, there is too great a potential for conflicts of interest, as board members could be scrutinising decisions they themselves have been involved in making. We also think that a scrutiny role could undermine the boards' attempts to support service co-ordination and integration.

In practice, it may be some time before decisions on service redesign are taken at a local level. GP consortia will be dealing with long-established and powerful acute hospitals. It is likely that it is only through successful collaborations with other local consortia that they will be able to create sufficient leverage through their commissioning decisions to reshape local service provision. In the meantime, decisions by the new economic regulator in relation to mergers and acquisitions may have the greatest impact on the shape of local service provision. The government may want to consider what input (if any) OSCs will be permitted into Monitor's decisions in future.

The King's Fund is planning to publish a number of papers looking at the evidence base and case for change around reconfiguration, which we will make available to the Department of Health.

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

[No response]

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?

The first order issue is to whom in the council the boards will be accountable: the cabinet, or the body of elected councillors? This is not established in the paper and should depend on which of the multiple responsibilities currently allocated to the board is to form the main focus of its activities. In considering this, the government will want to consider whether the boards are to be accountable for their processes, or the outcomes of their activities.

We were not clear whether the 'formal health scrutiny function' referred to in paragraph 50 amounts to a proposal for a separate internal body whose task would be to scrutinise the work of the board and its decisions. We believe that such arrangements would be unnecessarily burdensome.

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?

The Public Health Service, local authorities and GP consortia must work together closely to ensure equity of access to health and social care services and to work towards equity of health outcomes across all population sub-groups. The document does not provide details of how local health and well-being boards would be encouraged, supported or compelled to address inequalities in health and care. We are concerned that following the dismantling of the national performance regime there will be not be a strong driver to ensure local areas act on this very challenging area. We hope that the government will use the forthcoming public health White Paper to set out its plans for reducing inequalities in health, including creating duties beyond the legal minimum requirements, to ensure that reducing inequalities in health care and outcomes is a priority for local organisations.

Q18 Do you have any other comments on this document?

[No response]

References

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