Item N°: 2

Health and Wellbeing Partnership Board
September 2010

NHS White Paper – implications

Executive Summary:

Purpose of Reports

To enable Board members to appreciate the implications of the recent NHS White paper for partnership working in Oxfordshire. If the proposals become law there will be a lot of changes to be made. **Board members are encouraged to respond to the associated consultations.**

History and context:

Why are we doing this?

To ensure all organisations in Oxfordshire which have an impact on people's health and well being understand the changes that are proposed and how they can play a part in further shaping them.

Where are we in the process?

The White Paper sets out the governments intentions. Further White Papers are anticipated – e.g. Public Health in December, Social Care Reform in 2011. It will take some time before these are turned into Bills and enacted as legislation. There are multiple avenues for consultation during this time.

Where else has it been?

The issues raised have been discussed far and wide – for example by the County Council's Management Team, the PCT Trust Board, Enhanced Clinical Executive and the Joint Health Overview & Scrutiny Committee, amongst others.

Where else is it going?

It is very early days and the topic will continue to be discussed widely. For example the Faculty of Public Health and the Strategic Health Authority are organising events. Ultimately the county council's Cabinet will need to take a view on any changes to its structure and GPs will need to agree how they wish to exercise their new commissioning responsibilities.

Actions requested:

The Board is asked to:

Ensure their organisations play an active part in determining the best arrangements locally to secure the good health of the local population.

What does this item require members to take back to their organisation:
Members are asked to: Think about how they would like to respond to the initial consultations from the coalition government.

HWB Partnership Board aims supported by this paper:	
☐	agree priority outcomes for health and well-being in Oxfordshire
☐	promote action across partner agencies in planning and commissioning services for health and social care improvement
☐	monitor delivery of action across partner agencies, assess effectiveness
☐	monitor health improvement and other outcomes across the county
☐	review priorities as part of the commissioning cycle
☑	support involvement of service users in developing a strong strategic role
☑	further the development of joint financial arrangements
☐	ensure the implementation of priorities set out in the Sustainable Community Strategy and delivery of Local Area Agreement targets

Author of presentation:	**Author of presentation:**
Jonathan McWilliam Director of Public Health	John Jackson Director of Social & Community Services

Last date paper modified: 03 September 2010

NHS White Paper – implications

Introduction

In July 2010 the coalition government published a White Paper 'Equity and excellence: Liberating the NHS'. The White Paper sets out many reforms which will have radical implications for local organisations in Oxfordshire. These implications are summarised within the following four papers:

The Department of Health has launched four consultations around this white paper:

- Transparency in Outcomes: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583
- Increasing Democratic Legitimacy in Health: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117586
- Commissioning for Patients: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117587
- Regulating Health Care Providers: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117782

Everyone is encouraged to have their say in these proposals by responding to the separate consultations, prior to the closing date of 11 October 2010. Comments on the White Paper itself need to be sent by 05 October 2010 to:

NHSWhitePaper@dh.gsi.gov.uk

or:

White Paper team
Room 601
Department of Health
79 Whitehall
London
SW1A 2NS

Equity and excellence: Liberating the NHS

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

July 2010

Cm 7881 £14 .75

Foreward

The NHS is a great national institution. The principles it was founded on are as important now as they were then: free at the point of use and available to everyone based on need, not ability to pay. But we believe that it can be so much better – for both patients and professionals.

That's why we've set out a bold vision for the future of the NHS - rooted in the coalition's core beliefs of freedom, fairness and responsibility.

We will make the NHS more accountable to patients. We will free staff from excessive bureaucracy and top-down control. We will increase real terms spending on the health service in every year of this Parliament.

Our ambition is to once again make the NHS the envy of the world. *Liberating the NHS* - a blend of Conservative and Liberal Democrat ideas - sets out our plans to do this.

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

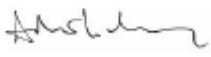
Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.

Prime Minister

Deputy Prime Minister



Secretary of State for Health

Our strategy for the NHS: an executive summary

1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

2. We will increase health spending in real terms in each year of this Parliament.

3. Our goal is an NHS which achieves results that are amongst the best in the world.

Putting patients and public first

4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

    a. Shared decision-making will become the norm: *no decision about me without me*.

    b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

    c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.

    d. The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

    e. The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.

    f. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.

    g. We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.

Improving healthcare outcomes

5. To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all:

    h. The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification.

    i. A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire cannot go undetected.

    j. Quality standards, developed by NICE, will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards.

    k. We will pay drug companies according to the value of new medicines, to promote innovation, ensure better access for patients to effective drugs and improve value for money. As an interim measure, we are creating a new Cancer Drug Fund, which will operate from April 2011; this fund will support patients to get the drugs their doctors recommend.

    l. Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice.

    m. Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality.

Autonomy, accountability and democratic legitimacy

6. The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level:

    n. The forthcoming Health Bill will give the NHS greater freedoms and help prevent political micromanagement.

    o. The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia.

    p. To strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.

q. We will establish an independent and accountable NHS Commissioning Board. The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. We will limit the powers of Ministers over day-to-day NHS decisions.

r. We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.

s. Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.

t. We will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.

u. We will ring-fence the public health budget, allocated to reflect relative population health outcomes, with a new health premium to promote action to reduce health inequalities.

Cutting bureaucracy and improving efficiency

7. The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change:

v. The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes.

w. The Government will reduce NHS management costs by more than 45% over the next four years, freeing up further resources for front-line care.

x. We will radically delayer and simplify the number of NHS bodies, and radically reduce the Department of Health's own NHS functions. We will abolish quangos that do not need to exist and streamline the functions of those that do.

Conclusion: making it happen

8. We will maintain constancy of purpose. This White Paper is the long-term plan for the NHS in this Parliamentary term and beyond. We will give the NHS a coherent, stable, enduring framework for quality and service improvement. The debate on health should no longer be about structures and processes, but about priorities and progress in health improvement for all.

9. This is a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS. We are setting out plans for managing change, including the transitional roles of strategic health authorities and primary care trusts. Implementation will happen bottom-up.

Many of the commitments made in this White Paper require primary legislation and are subject to Parliamentary approval.

THE NHS WHITE PAPER
Report by Director for Social & Community Services

Introduction

1. In July, the Government published its proposals for the National Health Service in a Health White Paper "Equity and excellence: Liberating the NHS". This paper was supported by a number of other publications, the most important of which are "Liberating the NHS: Commissioning for patients", "Liberating the NHS: Local democratic legitimacy in health" and "Liberating the NHS: Transparency in outcomes – a framework for the NHS".

2. The deadline for comments is 5th October 2010. It is proposed that the response is agreed by the Leader of the County Council and the Cabinet Member for Adult Services in the light of the comments made at the three meetings that will be held in public to discuss this and other reports. The Joint Health Overview and Scrutiny Committee may decide to submit its own response separate to that of the County Council.

3. This report is not a summary of the four documents (which would not be feasible given the range of the material they contain). Nor does it focus on all the issues set out in the report. For example, issues like whether GP consortia should be responsible for commissioning £80 billion of NHS services is one which is the subject of considerable national debate. Instead, this report assumes that the broad principles set out in the White Paper will be implemented (since this reflects the wishes of the recently elected Coalition Government). The focus of this report is on the implications for the County Council and setting out potential issues with the way that the proposals will be implemented.

4. Those issues have been grouped into five themes:

   - The focus on patients
   - The focus on outcomes
   - The proposed commissioning arrangements
   - The role of the Local Authority
   - Joint working between health and social care

5. There are two further reports; one from the Director of Public Health on the implications for public health and one on the specific implications for the Joint Health Overview and Scrutiny Committee and democratic accountability generally. In addition, members have been sent a summary of the documents published by the Government.

Focus on patients

6. The White paper emphasises the importance of putting patients and the public first. "Shared decision making will be the norm: *no decision about me without me*" (page 3)

7. This approach should be welcomed. It echoes the approach that has developed within adult social care through Putting People First. The White

Paper also supports the principle of personal health budgets (paragraph 2.22) which are being piloted here in Oxfordshire by NHS Oxfordshire.

8. If the patient and the public are to be put first, then it is important that the way that the NHS is accountable to them is clear to all concerned. The White Paper sets out the following aspiration: "The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level" (page 4). Will this emphasis on clinical leadership always be for the benefit of the patient and the public?

9. Furthermore, Commissioning for Patients identifies that GP consortia will be accountable to the proposed NHS Commissioning Board (paragraph 1.14). How will conflicts (between the expectations of patients/the public and the NHS Commissioning Board) be managed? The role of the proposed local HealthWatch will be crucial. The current Local Involvement Network (LINk) will become the local HealthWatch. The proposed wider role of the local HealthWatch should be welcomed. However, does the Care Quality Commission (CQC) have the capacity and skills to oversee HealthWatch England?

10. The Government's proposals about the local HealthWatch does raise one financial issue. The funding of the LINk comes through the Area Based Grant which is no longer ring fenced. Is the Government intending to ring-fence the grant for the local HealthWatch? Clarification on this point would be helpful.

Focus on outcomes

11. There is a very strong emphasis throughout all the documents that the NHS should be assessed on the basis of outcomes for patients and the public. "The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets" (page 4 of the White paper). Page 8 of the White Paper identifies some relatively poor outcomes of the NHS compared with other countries. This approach is seen as building on the work of Lord Darzi in his report "High Quality Care for All: NHS Next Stage Review Final Report".

12. This emphasis on outcomes should be particularly welcomed. However, these must not be defined narrowly. To take continence for example, the measure of success should not be the success of operations designed to address incontinence but the number of people who suffer from incontinence. It is not appropriate to carry on with a situation where the standard health service response to incontinence in an older person is often to give them a pad.

13. If this emphasis on outcomes is to work then the outcomes must be carefully defined. The Government intends to issue the "first NHS Outcomes Framework" in the light of the Spending Review. Outcomes will be supported by quality standards developed by the National Institute of Health and Clinical Excellence (NICE). The first three (on stroke, dementia, and prevention of venous thromboembolism) were published in June. Within the next 5 years,

NICE expects to produce 150 standards which will include quality standards for social care.

14. It will also be important that payment systems reward outcomes and not activity. The White Paper recognises this: "Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality." (page 4) The White Paper also emphasises the importance of the payment arrangements being transparent. Both of these points should be supported.

15. However, it is not clear that the mechanisms set out in the various documents to determine payments will deliver this. There will be central prescription of the payment systems (by the NHS Commissioning Board) and separately centrally prescribed prices by the economic regulator (Monitor). How is central prescription of payments systems and prices consistent with effective local commissioning? Furthemore, what incentive does it give to providers such as the acute trusts to work to reduce the number of patients treated outside of hospitals. Adult social care has nearly 20 years experience of commissioning services where there is no central prescription. The commitment to extend (centrally prescribed) payments by results to new areas of health service commissioning is unwelcome and likely to lead to poor outcomes and poorer value for money.

16. One proposal which may help to address this is that "We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources." (paragraph 2.17, Commissioning for Patients).

17. The other issue relating to outcomes is that there appears to be some presumption that improving health outcomes is primarily the responsibility of the NHS (GPs, commissioners and providers). Evidence suggests that other agencies have critically important roles to play e.g. the role of District Councils for leisure, housing, planning and environmental health; the role of the County Council for transport and trading standards. This needs to be recognized.

The proposed commissioning arrangements

18. Commissioning is sometimes confused with contracting. However, it is much wider than that. Commissioning for Patients defines it as: "understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality" (paragraph 1.7) This description is consistent with the approach developed by adult social care over the last 20 years.

19. Commissioning for Patients goes on to set out how commissioning should work in the future: "Most commissioning decisions will now be made by consortia of

GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them." (paragraph 1.14)

20. From a practical point of view: "It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect the views of their patients' needs and their own referral intentions." (paragraph 1.15) GP Consortia will be able to buy in support and decide whether they want to collaborate across consortia through say a lead commissioner. Support may be bought in from "external organisations, including local authorities, private and voluntary sector bodies". (paragraph 2.13)

21. Much of the debate about the principle of GP led commissioning has focused not on the principle of whether this should happen but whether it will work in practice. It is clear from the comments above that the Government recognise that the way in which it will be implemented is critical to its success. Ultimately the focus of GPs and their practices will be on the health and wellbeing of their patients. They will want to have commissioning arrangements which enable them to continue to focus on that.

22. Local authorities have the potential to help with this. Local authorities already lead on commissioning some health services (such as health services for adults with learning disabilities here in Oxfordshire). They also work closely with PCTs on commissioning other health services. Examples in Oxfordshire include the work that has been done on stroke, falls and continence. Both approaches are endorsed in Commissioning for patients (see paragraphs 6.8 and 6.11). Local authorities also have the expertise and experience that has been developed over the last 20 years in commissioning adult social care services. It will be important that we explore with GPs here in Oxfordshire in conjunction with the PCT what role the County Council can play to support the work of the GP consortia.

The role of the local authority

23. Local authorities will have "greater responsibility in four areas:
- leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity." (paragraph 10, Local Democratic Legitimacy in Health).

24. To some extent, the first three of these roles exist at the moment (the fourth would be a new role for local authorities although the Director of Public Health has been a joint post for several years). The key issue will be the power and influence that the local authority will have to carry out these roles effectively.

The details about this are not yet available although there are some positive statements of principle in the reports which should be welcomed.

25. One critical element will be the role of the health and wellbeing board which will be created by statute. The Government makes clear that this will "take on the function of joining up the commissioning of local NHS services, social care and health improvement." (paragraph 4.17, White Paper). This should be welcomed.

26. Oxfordshire has had a Health and Well-Being Partnership Board for 3 years. This does not have executive powers (in contrast to the Government's proposals) so runs the risk of becoming a "talking shop". The existing Board has tried to counter that by focusing on its key priorities (ageing successfully, obesity and mental well-being). Discussions will need to take place with all stakeholders but particularly GPs (who are already represented on the Board) to turn the existing Board into an effective decision making forum. We shall also need to review its role vis-à-vis the Children's Trust – an issue raised in Local Democratic Legitimacy in Health.

27. To achieve the objective of becoming an effective decision making forum, it will be crucial that the Board is focused on that role. For this reason, I would agree with the view that it does not make sense to include the scrutiny functions currently carried out by the Joint Health Overview and Scrutiny Committee. This is not a trivial activity as those involved in the work of the Committee will testify and it can play a crucial role in challenging proposed changes within the NHS (such as the proposals for the Horton).

28. The Government has also given some indication of its thinking on the overall approach to adult social care. "We want a sustainable adult social care system that gives people support and freedom to live the life they choose, with dignity. We recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including carers. We will seek to break down barriers between health and social care funding to encourage preventative action" (paragraph 1.17, White Paper). Its vision for adult social care is promised later this year. The Government has now set up the Commission on the funding of long term care which will report next summer. A White Paper on adult social care is promised for the autumn of 2011 followed by legislation.

Joint working between health and social care

29. There are repeated references in the documents to the importance of joint working between health and social care. For example, ""With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder." (paragraph 11, Local Democratic Legitimacy in Health). And also from the same document: "The aim is to ensure coherent and coordinated local commissioning plans across the NHS, social care and public health, for example in relation to mental health, older people's or children's care, with intelligence and insight about people's wants and needs systematically shaping and commissioning decisions." (paragraph 32)

30. This emphasis on joint working must be welcomed not least because it is what the patient/service user/citizen wants. How this might work is not yet clear but the Government has given a commitment to consult widely on options to ensure health and social care works seamlessly together.

31. The Government has also recognised that existing arrangements to encourage joint working between health and social care have not worked well enough. It is important for Oxfordshire members to appreciate that the close working here is not typical of what happens elsewhere in England. It is also important to note that there is scope to improve joint working here notably in terms of work with people with long term conditions especially older people.

32. The Government is right to emphasise that stronger joint working will help unlock efficiencies. There is clear evidence of this here in Oxfordshire from our joint arrangements for learning disabilities where we have good outcomes at a low cost. However, to deliver this, the necessary infrastructure needs to be in place supported by appropriate attitudes from all partners.

33. For joint working between the commissioning of health and social care to work, then policy and financial decisions must come together into a single place. The White Paper declares that "NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia" (paragraph 4.19). Is this consistent with the commitment to joint working?

34. What would be effective would be for the Government to prescribe in the forthcoming legislation that joint commissioning and pooled budgets must apply in appropriate circumstances (learning disabilities, mental health, supporting people with long term conditions). This would mean that public resources are used in the most appropriate way based on the needs of the local population. Thus our responds to question 6 posed in Local democratic legitimacy in health should be that we do want joint working to be underpinned by statutory powers.

35. However, if there is to be a statutory power requiring joint working through the pooling of resources then GPs are rightly going to expect there to be some governance in place which constrains the ability of the local authority to arbitrarily reduce spending on adult social care (and expect the consequences to be picked up from health resources). This could be managed through the health and wellbeing board.

RECOMMENDATION:

Members are asked to give their comments on the ideas set out in this report.

John Jackson
Director for Social & Community Services
September 2010

Public Health in Oxfordshire: Implications of the Coalition Government's Plans.

Purpose of this paper

This paper has three purposes:

1. **To inform** a wide audience about the implications of the coalition government's plans for the Public Health of Oxfordshire.
2. **To analyse** the implications for Public Health in Oxfordshire
3. **To propose the way forward**.

Introduction

The Secretary of State for Health has set out his vision for Public Health in England in recent speeches and White Papers as part of the broader coalition government's plans. This vision aims to improve the public's health and strengthen Public Health services as a priority. To achieve this it is proposed to create a new National Public Health service (PHS), separate from the NHS, including an enhanced role in health improvement for Local Authorities at local level. The PHS will be 'functional' from April 2012 and will 'go live' as statutory bodies from April 2013.

A Public Health White Paper will be published in December 2010 to set out the detail of the new National Public Health Service (PHS). Nonetheless there is sufficient information already in the public domain to describe the broad thrust of the proposals and to prepare for the future.

There are real opportunities for improving health in Oxfordshire through these plans, but skilful navigation will be required to keep the gains made in recent years and build on these further.

Gains in the Public's Health are made by individuals, carers, voluntary organisations, GPs, nurses, social workers, hospital doctors, transport planners, housing officers, environmental health departments, managers, scrutiny committee and leaders of organisations.
The role of Oxfordshire's Public Health department is to lead, prioritise and focus the effort of all these individuals and organisations. Disruption to the work of the Public Health Department should therefore be minimised during the coming months of transition.

This paper sets out the thrust of the new national plans and provides an analysis of the strengths, weaknesses, opportunities and threats for the Public Health of Oxfordshire in the situation.

The paper concludes with proposals for next steps to be taken to maximise the opportunities and minimise the threats.

Summarising the vision of the Secretary of State for Health

The Secretary of State takes a broad view of health. He is as concerned about the underlying causes of ill-health rooted in society as in health services themselves. This is to be welcomed.
His vision is of a well-informed and fully engaged public served by three main public sector organisations, called here the 'Three Pillars'. The Three Pillars are:

1. The NHS.
2. Local Authorities - in this case most mention is made of top-tier Local Authorities.
3. The new national Public Health Service (PHS).

The main features of each of these ***in terms of Public Health and health improvement*** are set out below.

Overall Coordination

The Secretary of State will chair a Cabinet Subcommittee with representatives of all government departments including the Department for Communities and Local Government. This will be responsible for coordinating a joined up approach to health. This includes traditional health services, Public Health, social care, education etc and will include wider aspects of health such as transport, housing and environmental issues.

The NHS:

- will retain its traditional values of universality and care which is free at the point of delivery
- will have a clear commissioning-provider split with more autonomy for NHS trusts
- will have its commissioning function coordinated nationally by a new commissioning board
- will be delivered at local level by GP commissioning consortia
- NB there is no requirement to have co-terminus boundaries with LAs

Local Authorities:

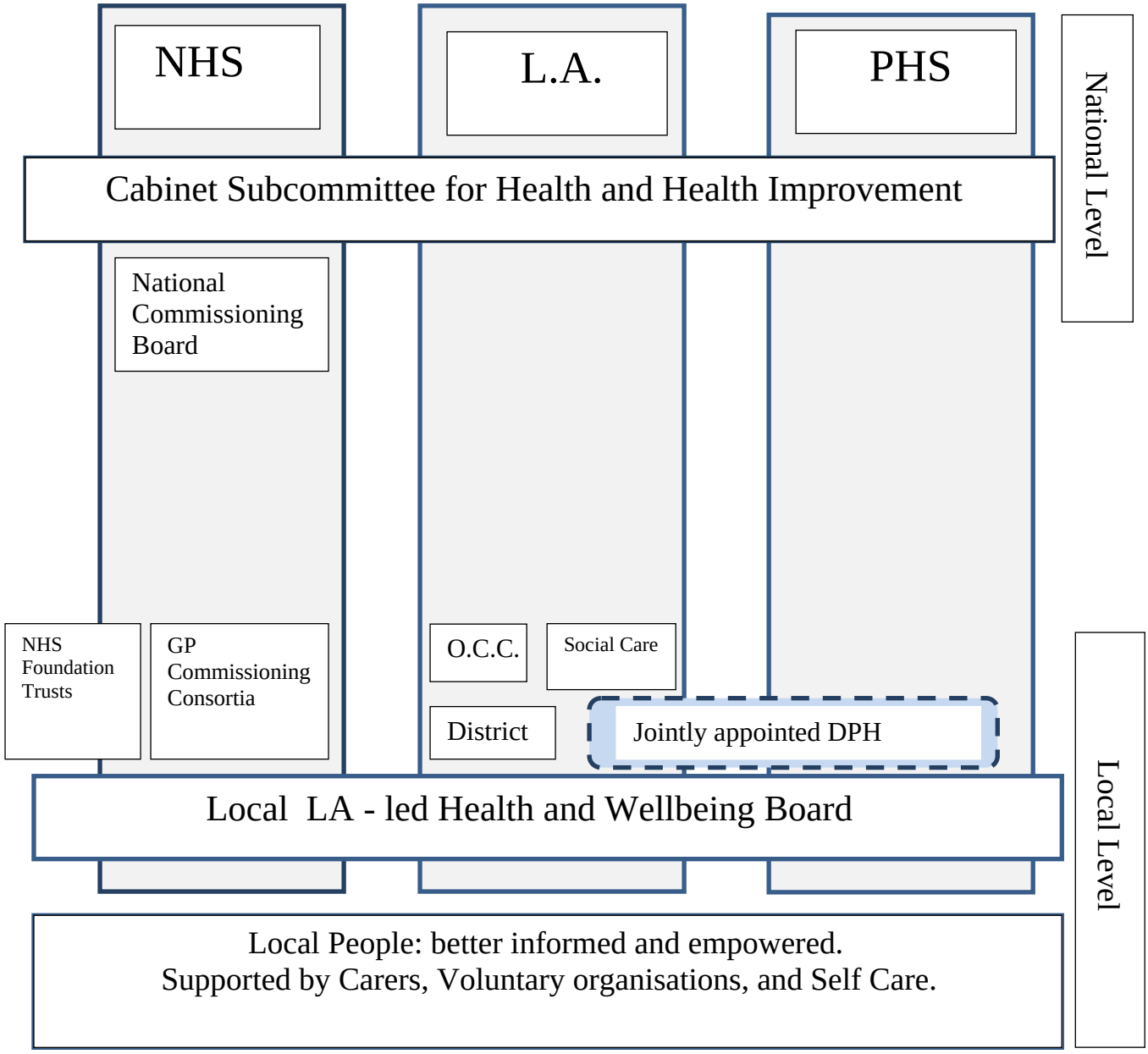
- will have increased responsibilities to coordinate overall health policy for an area, joining together in particular the work of local government, the NHS and the new National Public Health service. The favoured option for doing this is through a Health and Well-being Board at local level, led by Local Authorities. This is proposed to incorporate the current Health Scrutiny Function
- will have increased responsibilities for ' health improvement '
- will employ the local Director of Public Health, who will be jointly appointed by the National Public Health service
- will oversee a new ring-fenced budget which will be managed by the Director of Public Health
- will be accountable for achieving improved outcomes for the public's health
- NB white paper setting out the future of long term care, with implications for adult social care, is expected during 2011

The National Public Health Service:

- will have clear managerial ' line-of-sight ' from the Secretary of State and the Chief Medical Officer down to Local Authorities, the local Director of Public Health and thus to the public
- Will be accountable for a range of activities including: health promotion, disease prevention, health inequalities, immunisation, screening, assessing local needs, control of communicable diseases, emergency planning in the NHS and specialist support to the local commissioning of organisations
- Will bring together a number of existing bodies, including Public Health services which are currently within the NHS, regional Public Health Observatories and the Health Protection Agency

These relationships are summarised in the diagram below.

Diagram Summarising Coalition Government Proposals for the Main Health Organisations



The diagram shows the three main 'pillars' of the 'health system' in coalition thinking, namely the NHS, LAs and the PHS. The national level is shown at the top of the diagram and the local level at the bottom. The known components of each pillar are set out in boxes on the respective pillar.

The two horizontal boxes which cut across all pillars show the two main mechanisms proposed to join-up public sector action. These are the Cabinet Sub-Committee at national level and the mooted Health and Wellbeing Boards at local level.

Implications of these changes for Public Health in Oxfordshire

These are set out below as a SWOT analysis (Strengths, Weaknesses, Opportunities and threats) below.

SWOT Analysis of Coalition Proposals for Public Health in Oxfordshire.	
Strengths	**Weaknesses**
➢ Public Health is seen as a national priority. ➢ The secretary of state will provide leadership. ➢ There will be a national Public Health service (PHS). ➢ The anticipated white paper will set a clear direction. (December 2010) ➢ A ring-fenced budget for some PH activities. ➢ Clear alignment with local government and a stronger role for local democracy. ➢ Clear responsibility for health improvement in local government. ➢ Retention of the Health Scrutiny function. ➢ Proposals are based on a very broad view of health. ➢ Proposals imply an understanding of the social causes of ill-health. ➢ Preventing ill-health is a priority. ➢ Reducing inequalities is a priority. ➢ There is a clear role for a local Director of Public Health.	➢ Inevitable loss of momentum due to major restructuring. ➢ Staff uncertainty for a prolonged period. ➢ Potential loss of skilled staff. ➢ Oxfordshire has a larger than average Public Health Department - a nationally allocated budget is unlikely to cover current staff costs. ➢ The ring-fenced budget cannot cover costs of all PH programmes. These costs will remain in the NHS. This may cause confusion. ➢ The existing Public Health Department contains core NHS functions (e.g. medicines management and priority setting) which require complex disaggregation. ➢ Key facts are unclear while awaiting the PHS white paper e.g. 1. Division of responsibility between national, regional and local level. 2. Size and shape of a regional level. 3. The preferred future employer for local Public Health staff (only the DPH employer is certain, though there is no slot-in proposed for existing DsPH). 4. The division between commissioning and providing roles.
Opportunities	**Threats**
➢ There is an overarching opportunity to create a slimmer, leaner, more efficient and better focussed public sector across Oxfordshire. ➢ Potential gains for the health of the people of Oxfordshire due to a clear PH role. ➢ Opportunity to retain the gains made in Public Health in recent years through a well-managed transitional process. ➢ Opportunity to continue the successful alliance between PH and LAs while keeping strong links with the NHS. ➢ The creative engagement of GPs in stronger Public Health programmes. ➢ The coordinating role of LAs could create a single set of priorities for the public sector across Oxfordshire. ➢ Potential economies of scale by commissioning parts of some PH programmes at multi-county level. ➢ A clear direction could be set by clear outcome measures to be improved. This should unite organisations in Oxfordshire if the lessons of Local Area Agreements are learned.	➢ Planning blight. ➢ The general climate of public sector 'squeeze'. ➢ Potential 'cuts' in Public Health caused by inadequate national budgets. ➢ Insensitive handling of 'NHS management cost reductions' leading to inappropriate cuts to Public Health. ➢ Public Health must not be 'left behind' in the hiatus caused by a 'late' White paper in December 2010. ➢ It must not be assumed that PH is 'OK' because of the ring-fenced budget. Costs of PH programmes will still sit in core NHS budgets. These must be budgeted for. ➢ Possible lack of detailed understanding of PH work by some GP decision-makers. ➢ Considerable preparatory work will be needed by OCC, working with the NHS, as the 'receiving' organisation, but the OCC change agenda is already burgeoning. ➢ Tensions between public sector organisations due to a general squeeze on budgets – just when maximum cooperation is critical. ➢ Possible unwillingness of the new NHS to act on PH priorities. ➢ Possible unwillingness of LAs to embrace the new health improvement role fully. ➢ Outcome measures become another set of targets lacking local relevance. ➢ Lack of financial control of Foundation Trusts dwarfs the real priorities for health.

How Can We Maximise the Opportunities and Minimise the Threats?

The overriding requirement is to secure the improvements made to the public's health over the last few years and to bring together speedily the relevant major stakeholders to agree a practical way forward for Oxfordshire's Public Health Department.

To do this it is recommended that we take the following practical steps:

PHASE 1

September 2010 to December 2010 (i.e. when the Public Health White Paper is published)

1. Clarify the current functions and work programmes of the Public Health Department including the direct and indirect budgets. This work is already well underway.
2. Ensure that public health is given due prominence in the transitional plans being formed by the PCT and the Strategic Health Authority (SHA).
3. Ensure that these plans contain clear proposals for the retention by the NHS of:
   - commissioning budgets required for public health programmes which will stay within the NHS
   - core NHS functions currently contained within the Department of Public Health which will be required by the NHS in the future (e.g. medicines management, priority setting and others)
4. Create, as part of these processes, a high-level task-and-finish group which will drive the Public Health transition. This should be balanced equally between the PCT as the ' donor organisation ' and OCC as the 'receiving organisation '. This will include representation from the PCT, LAs, the Public Health Department and GPs and should actively involve the Health Overview and Scrutiny Committee (HOSC).

PHASE 2

December 2010 to the formal inception of the PHS

Once the Public Health White Paper is released, the way forward will be clear. The actions required are:

1. A detailed transitional plan for Public Health functions and programs will be drawn up from December 2010 onwards. This must include critical human resource issues e.g. a timetable for restructuring and/or transfer of current staff.
2. The implementation of the transitional plan should be overseen by the high-level task-and-finish group specified above.

Conclusions

1. The Coalition Government's proposals for health incorporate significant opportunities for strengthening the Public Health of Oxfordshire.
2. The opportunities are balanced by very real threats as set out in this paper. These must be minimised by careful preparation involving the main stakeholders: the PCT, LAs, the Public Health Department and GPs.
3. These opportunities will not be realised without detailed preparatory work, considerable effort and the willing co-operation and engagement of public sector bodies across Oxfordshire.
4. A new high level group is proposed to lead this work.
5. This detailed work will dominate Public Health activity over the coming months.

Recommendation:

Public sector organisations in Oxfordshire should work closely together over the coming months to secure the continuation of a successful Public Health function for the future.

It is recommended that a high-level group, led by the major public sector stakeholders is set up to achieve this.

Jonathan McWilliam
Director of Public Health for Oxfordshire
29 August 2010

THE NHS WHITE PAPER
Report by Scrutiny Review Officer (Health)

1. The coalition Government has published its much anticipated white paper on the NHS. Called "Equity and excellence: Liberating the NHS", the paper sets out a vision for an NHS that, by 2013, will look very different from how it looks now. There are major implications for both the NHS and local authority.

2. Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are to be abolished and GPs will be responsible for commissioning the majority of services. The profile of Public Health will be increased and local authorities will employ the Director of Public Health and have responsibility for local health improvement. The LA will also have a major role in integrating health and social care.

3. The statutory responsibilities of the Health Overview and Scrutiny Committee will, it appears, be subsumed into a statutory Health and Well Being Board although some form of Health Scrutiny Committee would be retained but without statutory powers.

4. The main headlines with particular relevance to the county council are:
   - PCTs and SHAs will be abolished
   - Most commissioning will become the responsibility of local GP consortia and every GP practice will be required to be a member of a consortium as a corollary of holding a registered list of patients
   - A new Public Health Service will be created that will bring together existing health improvement and protection bodies
   - PCT responsibilities for local health improvement will be transferred to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service
   - The "*critical interdependence"* between the NHS and the adult social care system in securing better outcomes for people, including carers is recognised and more will be done to break down barriers between health and social care funding to encourage preventative action
   - Later this year the government will set out a vision for adult social care, to enable people to have greater control over their care and support and enjoy maximum independence and responsibility for their own lives
   - The Department of Health will establish a commission on the funding of long-term care and support, to report within a year and produce recommendations for reforming the system of funding social care.
   - A *"new independent consumer champion"* called HealthWatch England will be created and will sit within the Care Quality Commission (CQC)
   - Local Involvement Networks (LINks) will become the local HealthWatch
   - Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint
   - The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes
   - Building on the existing power of the local authority to promote local wellbeing new statutory *"Health and Wellbeing Boards"* will be established within local

authorities. They will be responsible for joining up the commissioning of local NHS services, social care and health improvement

- Local authorities will therefore be responsible for:
  - Promoting integration and partnership working between the NHS, social care, public health and other local services and strategies
  - Leading joint strategic needs assessments, and promoting collaboration on local commissioning plans, including joint commissioning arrangements where each party so wishes
  - Building partnerships for service changes and priorities (although the NHS Commissioning Board and the Secretary of State will retain accountability for NHS commissioning decisions)
- The above responsibilities would replace the current statutory functions of the Health Overview and Scrutiny Committee (HOSC)

5. Many of the changes in the White Paper require primary legislation. The Queen's Speech included a major Health Bill in the legislative programme for this first Parliamentary session. The Government will introduce this in the autumn. The principal legislative reforms relevant to OCC will include:
   - Enabling the creation of a Public Health Service, with a lead role on public health evidence and analysis
   - Transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health
   - Placing the Health and Social Care Information Centre, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
   - Enshrining improvement in healthcare outcomes as the central purpose of the NHS
   - Making the National Institute for Health and Clinical Excellence a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care
   - Giving local authorities new functions to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health
   - Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs
   - Establishing HealthWatch as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch

6. The indicative timetable for the most relevant changes is:
   - Health Bill introduced into Parliament during autumn 2010
   - Public Health white paper by late 2010
   - White paper on social care reform 2011
   - Arrangements to support shadow health and wellbeing partnerships begin to be put into place in April 2011
   - A comprehensive system of GP consortia will be put in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs
   - In April 2012:
     - The NHS Commissioning Board will be fully established

  - New local authority health and wellbeing boards will be in place
  - The Public Health Service will be in place, with ring-fenced budgets and local health improvement led by Directors of Public Health in local authorities
  - HealthWatch will be established
- The NHS Commissioning Board will make allocations for 2013/14 directly to GP consortia in late 2012
- GP consortia will take on responsibility for commissioning in 2012/13
- SHAs to be abolished in 2012/13
- GP consortia will take full financial responsibility from April 2013 and PCTs will be abolished after that date
- NHS management costs reduced by over 45% by 2014

7. The Government states that they, *"are clear about the coherent strategy, and will engage people in understanding this and its implications".* They will consult on, *"how best to implement these changes"*, not, it should be noted, on whether or not PCTs should be abolished and GPs given the responsibility for commissioning.

8. In particular, the Department of Health is seeking comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill. **Comments should be sent by 5th October**.

9. As always there is uncertainty around some of the specifics however it is clear that there is going to be major change ahead for both the NHS and local government in the area of health.

Possible questions raised by the White Paper

- **Q** What must be done to ensure that health services across Oxfordshire continue to provide equity of access, equity of outcome and improvement in the quality and safety of services for patients and carers?
- **Q** How best (and how quickly) should the transition to the new arrangements take place?
- **Q** What would be the most effective way of providing support to GPs in their commissioning role?
- **Q** How could Health and Wellbeing Boards be configured to ensure that they are effective as co-ordinators of healthcare, social care and health improvement?
- **Q** Should Health and Wellbeing Boards be given the statutory powers that lie at present with the HOSC or should the HOSC retain those powers?
- **Q** What would need to happen to support the development of an effective local HealthWatch?
- **Q** How should local people be involved in developing options for change to service provision?

Roger Edwards
Scrutiny Review Officer (Health)
1 September 2010