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Health White Paper:
Implications for participants in local involvement

By Mike Cooper for Tamarind Chambers, October 2010.

The Coalition Government published its Health White Paper, *Equity and excellence: liberating the NHS*, in July 2010, and a set of associated consultation papers.

Here we outline some of the key proposals in the Health White Paper from the perspective of participants in local involvement mechanisms, including Local Involvement Networks (LINks) and other local community, patients and carers groups, what changes they would bring and their potential implications, and some suggestions for how these issues could be addressed.

We have produced and submitted a full response to the White Paper, with particular focus on issues of public engagement and accountability – see http://tamarindchambers.wordpress.com.

1. Principles and aims of the Health White Paper

The Health White Paper says that the Government is committed to maintaining the NHS available to all, free at point of use, based on need; and that they will increase health spending.

The Government's aims are to:

- **Put patients and public first**, creating an NHS that is genuinely centred on patients and carers and giving citizens a greater say in how the NHS is run.
- Make **improvement in quality and healthcare outcomes the primary purpose of all NHS-funded care**; measuring outcomes not processes and discarding top-down targets.
- Bring **greater autonomy, accountability and democratic legitimacy** to the NHS; empowering professionals and providers, giving them more autonomy and making them more accountable to patients and the public.
- **Cut bureaucracy and improve efficiency**: so the NHS is less fragmented and works better across boundaries; and reduce management costs and release efficiency savings to reinvest in the NHS.

It is difficult to disagree with much of this, but the White Paper leaves serious questions as to whether the proposals it contains are an effective way of achieving these aims.

2. Outline of proposals in the Health White Paper

2.1 Putting patients and public first

Patients will be at the heart of the NHS: through shared decision-making and increased choice and control for patients and carers.

An information revolution will improve access to information and communication between patients and clinicians; expand and improve use of patient generated information and outcome measures, experience surveys and real time feedback; and give patients control of their health records.

The collective patient and public voice will be strengthened: there will be a new national body, HealthWatch England; Local Involvement Networks (LINks) will become local HealthWatch; and local authorities will have an enhanced role in promoting choice and NHS complaints advocacy. ***More on this below.***

2.2 Improving healthcare outcomes

Patient experience and outcomes will be improved by:
- Measuring outcomes not processes, payment for performance not activity.
- Using clinically credible and evidence-based measures, with quality standards for health and social care to be developed by NICE.
- Discarding top-down targets.
- A culture of openness and challenge that ensures patient safety is placed above all else.

A new **Public Health Service** will be established, through which the Secretary of State will set local authorities national objectives for improving health outcomes; local authorities will determine how this is achieved, including by commissioning services from providers of NHS care, from a ring-fenced budget.

2.3 Autonomy, accountability and democratic legitimacy

Professionals and providers will be empowered, given more autonomy and, in return, made more accountable for the results they achieve, by:
- 'Shifting decision-making as close as possible to individual patients'.
- Liberating professionals and providers from top-down government control, so they can shape their services around the needs and choices of patients.

Power and responsibility for commissioning services will be devolved to local consortia of GP practices (GP Consortia, GPC), which will:
- Commission the majority of NHS services, including for people not registered with a GP.
- Be able to choose to buy in commissioning activities.
- Have duty to involve patients and public.

All GPs will be members of a GPC.

Strategic Health Authorities and Primary Care Trusts (PCTs) will be abolished.

A new national NHS Commissioning Board – 'independent and accountable' – will:
- Set quality and guidelines for commissioning.
- Support development of GPC.
- Hold GPC to account for NHS resources and outcomes.
- Be accountable to the Secretary of State.

Services to be commissioned by NHS Commissioning Board, not GPC:
- Services of GPs themselves.
- Primary dental, ophthalmic and pharmacy services.
- Specialised / low volume services.

Local authorities will be given new functions to increase local democratic legitimacy of the NHS:
- Promote integration and joining up of local NHS, public health and social care.
- Responsibility for health improvement and public health (transferred from PCTs) – with a ring-fenced budget.

Local authorities will establish a new statutory 'health and wellbeing board', made up of councillors, commissioners of NHS, public health, social care, and other services, and a representative of healthwatch, which will:
- Join up commissioning of local NHS services and make joint working easier.
- Take strategic overview of health and social care.
- Give local authorities influence over the NHS, and NHS commissioners influence over public health and social care.

NHS providers will be given greater autonomy and 'freedom':
- The powers of Ministers over day-to-day NHS decisions will be limited.

- Government will promote social enterprise.
- All NHS Trusts will become Foundation Trusts (FTs), locally accountable to their members.
- Plus government will consult on abolishing cap on FT income from non-NHS sources; and allowing FTs flexibility to 'tailor governance to their local needs'.

The Care Quality Commission will have a strengthened role as an effective quality inspectorate across both health and social care; Monitor will become the economic regulator, promote competition, regulate prices and safeguard the continuity of services.

2.4 Cutting bureaucracy and Improving efficiency

The NHS will be required to cut bureaucracy and make efficiency savings, it will be 'delayered' and quangos will be abolished, and savings reinvested in improving quality and outcomes.

The NHS will be less fragmented and barriers will be broken down, do that it works better across boundaries and between services.

3 Implications for participants in local involvement

3.1LINks to become HealthWatch: The Health White Paper (HWP) says that Local Involvement Networks (LINks) will become local HealthWatch; the consultation paper says 'LINks are not being abolished'.

3.2 Powers of HealthWatch: It is implied that HealthWatch will retain the functions and powers of LINks, although this is not explicitly stated:

1. LINk powers to enter and view apply to places where publicly funded care is provided, so the switch to GP commissioning should make no difference; *GPs as commissioners, will need to place this responsibility on independent providers via their contracts*.

2. LINk powers to ask questions and make recommendations to 'services-providers' are backed by the duty to respond placed on Trusts, PCTs and local authorities; DH guidance says that 'services-providers' are commissioners, which would imply that GP Consortia would be covered. *There should be a formal duty on GPCs to respond and to ensure through their contracts that independent providers are required to respond.*

3. LINk powers to refer social care matters to local authority Overview and Scrutiny Committees (OSC) appear to be retained by HealthWatch; but the power to refer NHS matters to an OSC, and thereby 'escalate' an issue to an independent body with specific powers, will be lost under the White Paper proposal to remove the local authority's statutory health scrutiny powers; HealthWatch will be able to refer matters to the proposed health and wellbeing boards responsible for strategic and joint funding matters, but they will not provide independent scrutiny and challenge of NHS commissioning.

3.3 Name 'HealthWatch: The HWP says a lot about integration of health and social care, and that HealthWatch, like LINks, will encompass both. But there is concern that the name HealthWatch could appear to exclude social care, and does not sound 'joined up'; LINks are beginning to become established and known in their locality, with relationships with their partners, and money has been spent on branding; plus the name HealthWatch is already used. *Given the emphasis on continuity with LINks, many would rather the proposed local body retain the name LINk.*

3.4 Boundaries of HealthWatch: It is implied that local HealthWatch will have the same geographical area as the LINk – but GPCs will not have the same boundaries. GPCs will form locally, there will not be a set pattern of boundaries and patients will have choice of GP. GPCs will not follow PCT boundaries, need not be contiguous and may overlap and change over time.

This mismatch between GPC and local authority boundaries complicates relationships between the GPC and GPC relations with the 'strategic' decision-makers of the health and wellbeing board and with public health and social care; and makes the proposed structure less transparent to patients and the public and make it more difficult for them to get involved.

HealthWatch should retain coterminosity with local authority boundaries.

A local HealthWatch may have to engage with a number of GPCs, and GPCs are likely to have to engage with more than one HealthWatch. Both will have to work to establish effective relationships and mechanisms for joint working.

3.5 Funding of HealthWatch: HWP: Healthwatch will be funded by the local authority.
This is not essentially different from now where local authorities hold the budget and contract for the LINk Host.

The implication of the HWP is that local authorities will **contract** direct with HealthWatch, as opposed to funding a separate Host organisation, but DH spokesperson has suggested that local authorities could choose to contract with a host organisation or make other arrangements. If HealthWatch itself is to hold a budget and employ staff itself, rather than have a separate Host, it will need to have some different structures from a LINk, although that does not mean that much of the established governance of LINks need change.

3.6 Accountability of HealthWatch: HWP: Healthwatch will be accountable to local authority. The accountability of LINks to their local community is poorly defined and some participants have complained about lack of accountability and difficulty of tackling LINks / Hosts that are not performing.
HealthWatch should retain accountability to its local community. Additional accountability to the local authority would introduce improved more formal local accountability for activities and use of public resources by LINks/HealthWatch.

Concerns have been raised that the proposal compromises the independence of HealthWatch. However, local authorities maintain a scrutiny function that can effectively scrutinise and oppose the executive, and they fund many other organisations that maintain their independence.

3.7 Transition from LINks to HealthWatch: Current LINk/Host contracts come up for renewal in March 2011, whilst HealthWatch will not be in place until January 2012. But it is not yet clear how LINks will 'become' local HealthWatch, and how they will continue to carry out their activities and represent their communities in the transition.

LINks should become shadow HealthWatch, continuing to operate through the transition and taking on any additional roles, and will require funding until the new contracts for HealthWatch are in place.

3.8 HealthWatch England: The White Paper proposes the establishment of a national HealthWatch England.

The establishment of HealthWatch England will provide an additional, national voice for patients and the public; a new forum to bring together information from local HealthWatch, build the bigger picture, and pass views on; and offer support and advice to local HealthWatch.

Many involved with LINks bemoaned the lack of a national voice for LINks. However we are concerned that HealthWatch England should not become an obstacle or filter for the views of local HealthWatch to pass through, or try to meddle in or direct local HealthWatch.

The relationship between HealthWatch England and local HealthWatch should be 'bottom-up'; HealthWatch England should not 'filter' the views of, or attempt to 'direct' or exert control over, local HealthWatch.

Concerns have been expressed over HealthWatch England being part of CQC, even an 'arms-length' part, rather than an independent body. LINks were told (rightly) that their role is not 'inspection', so it may not fit comfortably with the CQC which is the national quality inspectorate.

3.9 Referral to CQC: HWP proposes that local HealthWatch can refer to HealthWatch England independently of local authority; and that National HealthWatch England can refer to CQC. Currently a LINk can refer to CQC, independently of local authority.

Local HealthWatch should retain the power to refer matters directly to the CQC, with the proposed referral to HealthWatch England being additional, and not a 'filter'. Otherwise it would represent a centralisation of control and loss of local HealthWatch power.

3.10 Local health and wellbeing boards: HWP proposes that local HealthWatch will have a formal position on the board.
It is welcome that formal recognition is being given to the role of HealthWatch, but the exact nature of the role needs to be considered – being a member of the board brings with it a collective responsibility for decisions of the board, whereas *HealthWatch may prefer to maintain its independence and ability to challenge the board, by being given a guaranteed place at the table and access to the agenda and papers, without being a 'member'* (many LINks already have a 'place at the table' of OSCs, partnership boards and Trust boards on this basis).

3.11 Other patient and public involvement (ppi) groups: ppi groups attached to specific services/providers will continue and be encouraged to join their local HealthWatch; *this is no change from the current situation with LINks.*

3.12 Duty to involve: HWP says that the duty to involve patients and the public and to engage the public in their areas in commissioning will apply to GPC. Currently, for commissioned services, the duty to involve remains with the commissioning PCT.

A duty should be placed on NHS and social care commissioners, including GPCs, to ensure through their contracts that independent providers enable effective patient and public involvement.

There should be a clear duty on local, regional and national NHS and social care bodies to involve local HealthWatch, and not just talk to HealthWatch England.

3.13 NHS commissioning: Some services commissioned by PCTs, and therefore currently under the scope of LINks, will not transfer to GPC, but to the NHS Commissioning Board:
- Services of GPs themselves;
- Primary dental, ophthalmic and pharmacy services;
- Specialised services, jointly commissioned, but currently PCTs still accountable.

This would reduce local accountability and the role of local HealthWatch.

If primary NHS services (GPs, dental, opthalmic and pharmacy) cannot be commissioned by GPCs, an effective way to introduce local accountability and enable a role for the local HealthWatch would be to give an element of responsibility and accountability for these services to the proposed health and wellbeing boards.
Specialised services should be commissioned by bottom-up cooperation between locally accountable commissioners, not central imposition, and therefore under the scope of local HealthWatch.

3.14 Advocacy and support services: HWP proposes that local authorities will have responsibility for commissioning services to support individuals in exercising choice, in particular

for people who lack the means or capacity to make choices, and to provide NHS complaints advocacy (replacing ICAS); and can do this through local HealthWatch.

This would provide improved local accountability for these services.

This proposal would represent an additional role for LINk / local HealthWatch. If local HealthWatch takes on the provision of these services they will get specific funding for them.

There is a potential conflict between the role of representing the whole community and the proposed role of pursuing the interest of individuals, and the proposed new role could distract from the primary role of HealthWatch in involving patients and the public in an inclusive way.

Other groups in the community are already providing related services and may be better able to provide the proposed services under contract to the local authority.

The organisations providing these services should be required to provide commissioners, local authority scrutiny committees and local HealthWatch with summary anonimised data about the needs and experiences of those they support and complaints received.

3.15 NHS patient information services: The consultation paper says Patient Advice and Liaison Service (PALS) will continue within NHS organisations, whilst HealthWatch will 'build on the role of LINks in picking up community concerns and feedback', but the extent of the role of HealthWatch 'is still being considered'.

All providers of publicly funded health care should be required to provide an information and advice service to users, and to provide commissioners, local authority scrutiny bodies and local HealthWatch with summary anonimised data.

3.16 GP Consortia governance: HWP says that GPCs will be 'statutory public bodies', but that government will not be prescriptive about their internal governance. However certain conditions are required to enable the effective involvement of patients and the public and local HealthWatch.

GPC governance should ensure they are transparent, accessible and accountable to their local community, with a system of checks and balances and challenge that include non-professionals, and effective engagement with patients and the public, so they take account of the perspective of the whole community, not just respond to individual complaints.

GPCs should be subject to the Freedom of Information Act.

3.17 Scrutiny of NHS decisions and services. Effective external scrutiny, with its independence and its ability to look across services and take the perspective of patients and the public, can focus on what is important to its community and challenge decision-makers and providers and hold them to account.

Local authority overview and scrutiny of the NHS has been shown to bring value in terms of increasing local accountability, engaging stakeholders and the public and achieving real improvements to services. And it can provide an effective avenue for patients and the public as individuals and groups, to make their voice heard and to affect decisions and services, and can be a useful ally for LINks/HealthWatch.

The power of local authorities to scrutinise NHS commissioning decisions and service provision on behalf of their local community should be retained, so that the decisions of the health and wellbeing board and the GP Consortia are subject to independent external scrutiny, joined up with the scrutiny of public health and social care, with the engagement of local patients and the public and their representatives including HealthWatch.