APPENDIX D

Analysis of the NHS White Paper 'Equity and Excellence' and the consultation paper Local Democratic Legitimacy in Health

Key changes

1. **GP Consortia will commission directly from "any willing provider"**

Implications: All hospital trusts will need to become or be taken over by Foundation Trusts. MTWHT is not currently Foundation.

PCTs will be abolished by April 2013.

Private, community and voluntary sectors will be able to tender to provide services to GPs.

GPs will need to form consortia in order to secure providers. Some may choose to appoint managers/commissioners to do this. Consortia can be any size and could be based on existing Practice Based Commissioning Clusters. The consortia will need to work with LAs regarding adult social care etc. Consortia can form groups and may choose to appoint one group as the lead commissioner for one or more areas of work.

Opportunities: We have an opportunity here to strengthen our links with GPs and to be in a position to work closely with them regarding commissioning and public health in the future. We may be able to sell services to GPs or work with them via the new public health arrangements.

There may also be opportunities regarding shared premises and links to work relating to town centre regeneration.

2. Strengthened Patient Voice

Implications: LINks will become HealthWatch based within the Care Quality Commission. There will be local and national HealthWatch. This will act as consumer champions across health and care.

Health watch will also act as a 'CAB' for health and social care, providing signposting. They will also run NHS complaints advocacy services and support patients in making choice e.g. which GP.

Local HealthWatch will be able to report concerns to HealthWatch England to inform regulatory action independently of the LA.

LAs will have an increased role in promoting choice and complaints advocacy through the HealthWatch arrangements they commission. They will also need to hold HealthWatch to account for delivering effective and good value services. They will also ensure focus of HealthWatch is representative of the local community. They will intervene in under performance

Opportunities: It is not yet clear whether local HealthWatch will be, as LINk, county wide or become district level. There are opportunities to support HealthWatch in strengthening the local health economy and ensure it is meeting standards.
Both Councils could be in a position to support local residents in approaching a Kent wide HealthWatch or possibly in establishing local branches. They will need to ensure that the voices of patients in their Boroughs, particularly their more vulnerable residents, are not overlooked in favour of those in other areas of Kent.

3. LAs will be responsible for Health Improvement

Implications: From 2013, health improvement responsibilities will transfer to LAs following the abolition of PCTs. This is intended to 'unlock synergies with the wider role of LAs in tackling the determinants of ill health and health inequalities'[1].

The consultation paper sees funding for smoking, alcohol, diet and physical activity going to LAs. A full Public Health White Paper is expected later in the year.

LAs will also play an important role in the new Public Health Service (PHS) campaigns relating to screening programmes and delivering national campaigns at a local level.

Kent will need to appoint Joint Director of Public Health (KCC and new Public Health Service appointment). This director will hold a ring fenced budget allocated by the PHS. There will be direct accountability to both the LA and through the PHS to the Secretary of State. Local Directors of Public Health will have direct influence over the wider determinants of public health, advising elected members and as part of senior management at the LA.

Consequently, it is likely that districts will have a fundamental role to play due to their crucial role in the wider determinants such as housing, environmental health, legislation enforcement and health improvement. The implications of this are that the Councils' role in public health will increase rather than decrease and so every effort should be made to ensure consistency throughout this transitional period and into the new era from 2013.

[1] Local Democratic Legitimacy in Health consultation paper

Opportunities: Although the White Paper states that the PH budget for LAs will be ring fenced, this needs some clarification. There are significant opportunities to improve health via the wider determinants such as housing, education, transport and schools by returning the responsibility to LAs at both tiers.

Both Councils are in a strong position to maximise the benefit from these changes to Public Health owing to the well established Healthier partnership arrangements with NHS West Kent. The arrangements currently in place mean that we are able to enhance our existing role rather than accommodate a new responsibility. They are fortunate in being familiar with the public health strengths and weaknesses within the boroughs. This is not the case in other areas of Kent where the transition is likely to be more challenging.

However, both Councils need to ensure they secure the best possible investment for their residents and do not unduly suffer against areas of higher inequality and need within Kent. They will need to effectively direct resources to those areas which stand to benefit the most, thereby tackling our health inequalities.

4. National Public Health Service (PHS) to be established

Implications: This service will 'integrate and streamline health improvement and protection bodies and functions' and will carry an increased emphasis on research, analysis and evaluations. It will also co-ordinate national public health services.

The PHS will have powers in relation to NHS in order to manage public health emergencies as well as NHS resilience.

The Secretary of Sate through the PHS will agree with LAs the local application of national health improvement outcomes. LAs will then decide how best to secure those outcomes and this may include commissioning services. Local neighbourhoods will have the freedom to set local priorities within a national framework.

Opportunities: There is an opportunity for both Councils to take a leading role in the development and delivery of the PHS in Kent due to links with local universities, GPs and the local hospitals of excellence. There may be opportunities for training in relation to public health, including for GPs and commissioners, thereby strengthening the local health economies. The Boroughs could be positioned as centres of excellence for early intervention public health work within the new public health service and with regards to LA new health improvement responsibilities. There is also an opportunity to build on work to date with regards to SROI, mental health and Wellpoint. Again, the Councils need to ensure they are at the forefront by building on their existing strengths and not be overlooked in favour of other areas.

5. Local Health and Wellbeing Boards (LHWB)

Implications: The Government believes that there is scope for stronger arrangements within LAs led by elected representatives, to support partnership working across health and social care and public health.

The Government prefers the establishment of a statutory role within upper tier LAs to support joint working on health and wellbeing – a Local Health and Wellbeing Board. However, they are consulting on this and welcome suggestions on how best to achieve partnership working and integrated commissioning. If these boards were developed requirements would be minimal with significant level of freedom for the LAs.

These would have four main functions:

- Assess the needs to the local population and lead JSNAs
- Promote integration and partnership across areas through joined up commissioning plans
- Support joint commissioning and pooled budgets
- Undertake a scrutiny role in relation to major service redesign

There would be statutory duty for LAs and commissioners to form part of this board. This board would give LAs influence over NHS commissioning.

The consultation paper states that although these boards would be at upper tier level, they would need to discharge their functions at the right level to ensure needs of diverse areas are at the core of their work and that elected members below tier one can contribute. Boards may choose to delegate the lead for some functions to districts or neighbourhoods. Neighbouring boroughs can also combine boards.

Boards would include Leaders or Mayors, Social Care, NHS Commissioners, local government, GP consortia and NHS commissioning

board representation, HealthWatch and patient champions. The DPH would also play a critical role.

HOSC would be abolished and the statutory powers transferred to Local Health and Wellbeing Boards.

Opportunities: Both Councils will have the opportunity to set up their own Health and Wellbeing Board, building on the existing LSP arrangements, if agreed by KCC or to contribute to the county board. Both officers and Members will need to be involved in the board at either level.

Representation will again be crucial in ensuring the boroughs are not overlooked against those areas with more noticeable health inequalities.