NHS

Liberating the NHS:

Local democratic legitimacy in health

A consultation on proposals

Communities and Local Government

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	14531
Title	Local Democratic Legitimacy in Health
Author	Department of Health & Communities and Local Government
Publication Date	22 Jul 2010
Target Audience	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs
Circulation List	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	The document sets out proposals to strengthen the role of local government in health by: i) local authorities taking on local public health improvement functions; ii) local authorities having a new role in promoting integration; and iii) Local HealthWatch organisations acting as independent consumer champions, accountable to local authorities.
Cross Ref	Equity and Excellence: Liberating the NHS (July 2010)
Superseded Docs	
Action Required	Interested parties should respond to the consultation
Timing	**Respond by 11 October 2010**
Contact Details	The White Paper Team - Consultation responses 6th Floor Richmond House 79 Whitehall London SW1A 2NS nhswhitepaper@dh.gsi.gov.uk www.dh.gov.uk/liberatingtheNHS
For Recipient's Use	

Foreword

A decade of centralising, controlling government has left our public services strangled with red tape, focused on processes not outcomes, and weakened by the need to account to bureaucrats instead of the public. Too many decisions have been made nationally, rather than locally, without enough public involvement. The NHS, like other public services, has suffered as a result. The creativity and innovation of health professionals has been stifled while the public are frustrated at the lack of opportunities to speak up and make a difference to their local health services.

Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know best what will work in their communities. Our plans to make this happen in health are set out in the recent white paper: *Equity and Excellence: Liberating the NHS*. It will restore real decision-making powers to patients and GPs.

The NHS is one of Britain's greatest achievements, and a service of which we can all be proud. It will continue to be a national service, held to account by Parliament. But for the first time in forty years, there will be real local democratic accountability and legitimacy in the NHS. Elected councillors and councils will have a new role in ensuring the NHS is responsible and answerable to local communities. By commissioning HealthWatch - the new way for patients and the public to shape health services - councils will be responsible for ensuring local voices are heard and patients are able to exercise genuine choice. Councils will also take the lead in improving local public health.

In this new role, councils will be assessing local needs, promoting more joined up services, and supporting joint commissioning. This builds on the excellent work that is already being done by some councils in joining up services to improve local health and social care and will help ensure a closer working relationship between health and other council responsibilities, such as housing and environmental health. This means that patients who need the help of both health and social care services can expect to get much more coherent, effective support in future.

This short paper seeks your views on these important changes to establish local democratic accountability in the NHS. We look forward to hearing from you.

Rt. Hon. Andrew Lansley CBE MP
Secretary of State for Health

Rt. Hon. Eric Pickles MP
Secretary of State for Communities and Local Government

Contents

1.	Introduction	1
2.	Strengthening public and patient involvement	4
3.	Improving integrated working	6
4.	Local authority leadership for health improvement	14
5.	Conclusion and summary of consultation questions	16

Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

3. This short document, *Local democratic legitimacy in health,* provides further information on proposals for increasing local democratic legitimacy in health, through a clear and enhanced role for local government. Through elected members, local authorities will bring greater local democratic legitimacy to health. They will bring the perspective of local place - of neighbourhoods and communities - into commissioning plans. Local authorities can take a broader, more effective view of health improvement. They are uniquely placed to promote integration of local services across the boundaries between the NHS, social care and public health.

4. This consultation has been produced jointly by the Department of Health and the Department for Communities and Local Government.

5. It is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

    - *Commissioning for patients*
    - *Regulating healthcare providers*
    - *The review of arm's-length bodies*
    - *Transparency in outcomes: a framework for the NHS*

    The Government will publish a response prior to the introduction of a Health Bill later this year.

6. National accountability for the health service is critical. It currently receives about £100 billion of taxpayers' funding, and it is right that it is held to account for the stewardship of these finances and outcomes through Parliament. The reforms the Government set out in *Liberating the NHS* will remove ongoing political interference from the health service, through the creation of an independent NHS

Commissioning Board, but national accountability will remain. In the future, there will be a more transparent relationship between national government and the NHS, with less scope for day-to-day political interference.

7. One of the central features of the proposals in the White Paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs and other primary care professionals are already supporting patients in managing their health, promoting continuity and coordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside the full range of other health and care professionals.

8. 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. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public. It will not be appropriate for all commissioning decisions to be made at a local level and some specialist services, such as paediatrics, will need to be commissioned at a higher geographical unit, by the NHS Commissioning Board. *Commissioning for patients* - published alongside this document - gives further detail of how GP commissioning consortia and the NHS Commissioning Board will work.

9. Within this strong national system, the Government wants to strengthen local democracy. Giving people the opportunity to exercise their voices as individuals is an important part of this. The proposals build on the existing mechanisms, such as patients using information about a provider to exercise choice, or participating as an active member of a local foundation trust. 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.

10. Within this new system, local authorities will have an enhanced role in health. The Government intends that they will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA)[1] 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.

11. 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. This has the potential to meet people's needs more effectively and promote the best use of public resources. The local authority will lead the process of undertaking joint strategic needs assessments across health and local government services and promote joint commissioning between GP consortia and local authorities. GP consortia and the NHS Commissioning Board will be responsible for making health care commissioning decisions, informed by the JSNA. We would encourage local authorities to take the NHS Constitution into account when influencing local commissioning decisions about NHS services.

12. The Government will work with the Local Government Association to understand the potential benefits of place-based budgets through the Spending Review period. We will look at the potential application of these approaches to cross-cutting areas of health spending that require effective partnerships with local authorities and other frontline organisations, for example older people's services, and substance misuse.

13. The Government is committed to ensuring that there is a strong local voice for patients through democratic representation in healthcare. The Coalition Programme proposed directly elected individuals on the primary care trusts (PCT) board as a mechanism for doing this. However, because of the proposed transfer of commissioning functions to the NHS Commissioning Board and GP consortia, the Government has concluded that PCTs should be abolished. Instead, we propose an enhanced role for elected local councillors and local authorities, as a more effective way to boost local democratic engagement. In this document, the Government is bringing forward practical plans that give stronger effect to its intentions for local democratisation in health.

[1] A joint strategic needs assessment is an assessment of the health and wellbeing needs of the population in a local area and since 2007 it has been a statutory duty for primary care trusts and local authorities to undertake one. They aim to establish a shared, evidence based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities. In practice the JSNA falls to the Directors of Public Health, Directors of Adult Social Services and Directors of Children's Services to carry out, as set out in the JSNA guidance.

Strengthening public and patient involvement

14. *Liberating the NHS* set out plans to create a much more responsive NHS that is genuinely centred on the needs and wishes of patients, through increased choice, an information revolution, stronger voice, and commissioning by GP consortia. These changes will radically shift the power of the health service away from Whitehall and closer to the individual and the professionals that serve them.

15. Choice, control and better information are at the heart of these plans, but these need to be backed up by support for individuals and local voice. We want local people to have a greater say in decisions that affect their health and care and have a clear route to influence the services they receive. Since the *NHS Plan*, structures for leading local involvement have been subject to numerous changes. The Government intends to build on the current statutory arrangements, to develop a more powerful and stable local infrastructure in the form of local HealthWatch, which will act as local consumer champions across health and care. Local Involvement Networks (LINks) will become the local HealthWatch.

16. We propose that local HealthWatch be given additional functions and funding. Like LINks, they will continue to promote patient and public involvement, and seek views on local health and social care services which can be fed back into local commissioning. Also like LINks, they are likely to continue to take an interest in the NHS Constitution.

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?

17. We also propose that HealthWatch perform a wider role, so that they become more like a "citizen's advice bureau" for health and social care - the local consumer champion - providing a signposting function to the range of organisations that exist. We therefore propose that they are granted additional specific responsibilities, matched by additional funding, for:

- NHS complaints advocacy services. Currently, this is a national function for the NHS, exercised through a Department of Health contract for the Independent Complaints Advocacy Service. We propose that this responsibility is devolved to local authorities to commission through local or national HealthWatch, so that they can support people who want to make a complaint.

- Supporting individuals to exercise choice, for example helping them choose a GP practice. Giving patients and users the right to choice, and greater information, is essential, but it is not always sufficient to enable everyone to exercise it. Local HealthWatch will have a key role in offering support to those that need it.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

18. Local authorities have a vital role in commissioning HealthWatch arrangements that serve their local populations well. They will continue to fund HealthWatch, and contract for their services. Local authorities have an important responsibility, set out in statute, for discharging these duties, and holding local HealthWatch to account for delivering services that are effective and value for money. They will also ensure that the focus of local HealthWatch activities is representative of the local community. In the event of under-performance, a local authority should intervene; and ultimately re-tender the contract where that is in the best interests of its local population.

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

19. Local HealthWatch would still be able to report concerns about the quality of the provision of local NHS or social care services to HealthWatch England, in order to inform the need for potential regulatory action, independently of its host local authority. HealthWatch England will form a statutory part of the Care Quality Commission (CQC), the quality regulator for health and social care. This key role for local HealthWatch will be underpinned by continued rights to visit provider services.

Improving integrated working

20. People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs. Services also need to be developed in ways that fit around the people who use them, and their families, and that they can understand and shape. We have an opportunity to strengthen integrated working across the health and social care agenda, from the point of providing services, to people understanding how services need to be commissioned to best meet the health and wellbeing needs of local populations. We can also improve integrated working right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and re-ablement.

21. *Liberating the NHS* has been designed to strengthen integration in many ways, for example:

- by giving people using services more choice and control about what matters most to them. Critically this includes choice of treatment and care not just choice of provider. People will have more power in the system to decide what matters most to them;
- by extending the availability of personal budgets in the NHS and social care, with joint assessment and care planning;
- quality standards will be developed systematically across patient pathways, for example the recently published NICE dementia standard;
- through the CQC as an effective inspectorate of essential quality standards, that span health and social care;
- through payment systems being used to support joint working, for example the proposals around payment by results and hospital readmissions, which should create opportunities for the full engagement of the wider health and care economy before discharging people from hospital; and
- through freeing up providers to innovate and focus on the needs of people using services rather than the needs of a top-down central bureaucracy. For example, the Government is proposing to remove the

constraints that currently exist for foundation trusts to enable them to augment their NHS role, by, for example, expanding into social care.

22. The existing framework provided in legislation[2] sets out optional partnership arrangements for service-level collaboration between local authorities and health-related bodies. The arrangements include:

- lead commissioning (with PCTs or local authorities leading commissioning services for a client group on behalf of both organisations);
- integrated provision (for example care trusts); and
- pooled budgets.

23. Take up of the current flexibilities to enable joint commissioning and pooled budgets has been relatively limited. It has tended to focus on specific service areas, such as mental health and learning disabilities. The full potential of joint commissioning, for example to secure services that are joined up around the needs of older people or children and families, remains untapped. The new commissioning arrangements will support this. GP commissioning consortia will have a duty to work with colleagues in the wider NHS and in social care to deliver higher quality care, a better patient experience and more efficient use of NHS resources.

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

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

24. The Government believes that there is scope for stronger institutional arrangements, within local authorities, led by elected members, to support partnership working across health and social care, and public health. Local authorities' skills, experience and existing relationships present them with an opportunity to bring together the new players in the health system, as well as to provide greater local democratic legitimacy in health.

25. One option is to leave it up to NHS commissioners and local authorities as to whether they want to work together, and should they so wish, to devise their own local arrangements. An alternative approach, which the Government prefers, is to specify the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing.

[2] Section 75 of the NHS Act 2006

26. The advantages of having a statutory arrangement are that it would provide duties on relevant NHS commissioners to take part, and provide a high-level framework of functions. In this way it would offer clarity of expectation about partnership working.

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

27. One way in which respective roles and responsibilities could be enhanced further, is through a statutory partnership board - a health and wellbeing board - within the local authority. This would provide a vehicle and focal point through which joint working could happen. Alternatively, local partners may prefer to design their own arrangements. We would like your views on how best to achieve partnership working and integrated commissioning.

28. If health and wellbeing boards were created, requirements for such a board would be minimal, with Local Authorities enjoying freedom and flexibility as to how it would work in practice.

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?

Functions of health and wellbeing boards

29. The primary aim of the health and wellbeing boards would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs.

30. The Government proposes that statutory health and wellbeing boards would have four main functions:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment;
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and

- to undertake a scrutiny role in relation to major service redesign (as set out in paragraph 42 - 50).

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

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 JSNAs?***

31. The health and wellbeing board would allow more effective engagement between local government and NHS commissioners. There would be a statutory obligation for the local authority and commissioners to participate as members of the board and act in partnership on these functions. Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the health and wellbeing board would give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.

32. 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. These arrangements would also enable local authorities to engage more effectively via GP consortia, who would be making health care commissioning decisions. A significant benefit of the health reforms will be the removal of political interference in the day-to-day running of the health service. The local authority and its partners will only be able to ensure that the needs of their population are adequately assessed if they work together to ensure that national politics are not replaced by unconstructive local politics.

33. The health and wellbeing board could also be a vehicle for taking forward joint commissioning and pooled budgets, where parties agree this makes most sense and it is in line with the financial controls set by the NHS Commissioning Board.

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?***

Operation of health and wellbeing boards

34. We anticipate that the statutory health and wellbeing boards would sit at the upper tier local authority level. However, the boards would want to put in place

arrangements to discharge their functions at the right level to ensure that the needs of diverse areas and neighbourhoods are at the core of their work, and that democratic representatives of areas below the upper tier can contribute. This would be particularly important in two-tier areas, where boards may want to delegate the lead for some functions to districts or neighbourhoods. Neighbouring boroughs may also choose to establish a single board covering their combined area, should that make most sense locally.

35. We anticipate that the health and wellbeing boards would have a lead role in determining the strategy and allocation of any local application of place-based budgets for health. The health and wellbeing boards would have an important role in relation to other local partnerships, including those relating to vulnerable adults and children's safeguarding. If the Local Children's Safeguarding Board became concerned that the local safeguarding arrangements were not working as they should, and in particular if there were concerns about the NHS partners, they could raise this with the health and wellbeing board, who would escalate it to the NHS Commissioning Board if they were unable to achieve local resolution.

36. To reduce bureaucracy, we anticipate that local authorities may want to use the proposed health and wellbeing boards to replace current health partnerships where they exist, and work with the local strategic partnership (at the upper tier) to promote links and connections between the wider needs and aspirations of local neighbourhoods and health and wellbeing.

37. If these proposals are taken forward, we will need to ensure that appropriate arrangements are made to support the full package of reforms in London with links between the borough boards and the Mayor. The Government would particularly welcome views on this point.

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?

Membership of health and wellbeing boards

38. If taken forward, the boards would bring together local elected representatives including the Leader or the Directly Elected Mayor, social care, NHS commissioners, local government and patient champions around one table. The Directors of Public Health, within the local authority, would also play a critical role. The elected members of the local authority would decide who chaired the board.

39. The board would include both the relevant GP consortia and representation from the NHS Commissioning Board (where relevant issues are being discussed). It may be relevant for the NHS Commissioning Board to attend when issues relating to the services that they commission are being discussed, for example family health services, specialised services and maternity services. We would specify both parties' duty to take part in the partnership in legislation.

40. In addition to the strategic role, at a practical level, health and wellbeing boards could agree joint NHS and social care commissioning of specific services, for example mental health services, including prevention, or agree the allocation and strategy for place-based budgets on cross-cutting health issues. The precise role of place-based budgets should be a decision for the health and wellbeing board in light of local priorities. For the board to function well, it will undoubtedly require input from the relevant local authority directors, on social care, public health and children's services. We also propose a local representative from HealthWatch will have a seat on the board, so that it has influence and responsibility in the local decision-making process. We recognise the novelty of arrangements bringing together elected members and officials in this way and would welcome views as to how local authorities can make this work most effectively.

41. To ensure that the board is able to engage effectively with local people and neighbourhoods, local authorities may also choose to invite local representatives of the voluntary sector and other relevant public service officials to participate in the board. They may also want to invite providers into discussions, taking care to adhere to the principles of fairness, engaging providers in an equal and transparent manner.

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

Overview and scrutiny function

42. In the current system, overview and scrutiny committees (OSCs) have the power to scrutinise major health service changes and the ongoing planning, development and operation of services. They are set up in local authorities and set their own priorities for scrutiny, reflecting the interests and concerns of the communities they serve. They are able to hold the NHS to account by:

- calling NHS managers to give information, answer questions and provide explanation about services and decisions and making recommendations locally;

- requiring consultation by the NHS where major changes to health services are proposed; and

- referring contested service changes to the Secretary of State for Health.

43. If a health and wellbeing board was created within a local authority, it would have a key new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services. It would be better equipped to scrutinise these services locally. To avoid duplication, we propose that the statutory functions of the OSC would transfer to the health and wellbeing board.

44. This transfer would strengthen the overview that local authorities have on health decisions and bring in the voice of the local HealthWatch. Having a seat on the health and wellbeing board gives HealthWatch a stronger formal role in commissioning discussions than currently exists for LINks. This would provide additional opportunity for patients and the public to hold decision makers to account and offer scrutiny and patient voice.

45. Members of the health and wellbeing board, including elected councillors, would have the opportunity to identify shared goals and priorities and to identify early on in their respective commissioning processes how best to address these. This emphasis on proactive local partnership would minimise the potential for disputes. We will work with local authorities and the NHS to develop guidance on how best to resolve these issues locally, so that they are only referred on in the most exceptional circumstances.

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

46. Within the scope of NHS services, as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, consistent with the public sector equality duties and supported by the national framework of quality standards, tariffs and national model contracts established by the NHS Commissioning Board. GP consortia will also have a duty to engage and involve the public in planning services and considering any proposed changes in how those services are provided. In addition, the health and wellbeing board would have an important role in enabling the NHS Commissioning Board to assure itself that GP consortia are fulfilling their duties in ways that are responsive to patients and the public.

47. If health and wellbeing boards had significant concerns about substantial service changes, an attempt should first be made to resolve this locally, for example with local commissioners, through the health and wellbeing board itself. The boards

would be expected to take account of the need to deliver services more efficiently, and of the wider quality, innovation, productivity and prevention (QIPP) agenda. The board may choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel.

48. For a minority of cases, there will still need to be a system of dispute resolution beyond the local level. This should happen only in exceptional cases as local resolution should be the preferred course of action. Where the dispute is unable to be resolved, the health and wellbeing board would have a power to refer the commissioning decision to the NHS Commissioning Board. If the issue relates to a decision made by the NHS Commissioning Board (e.g. in relation to maternity services) the health and wellbeing board may choose to refer it directly to the Secretary of State.

49. If the NHS Commissioning Board is satisfied that the correct procedure has been followed and that the decisions are based on clinical evidence, but the health and wellbeing board still has significant concerns about the issue, the health and wellbeing board would have a statutory power to refer cases to the Secretary of State. The Secretary of State would then consider the NHS Commissioning Board's report alongside the reasons for referral, seeking advice from the Independent Reconfiguration Panel. In the context of the new regulatory framework, the Secretary of State for Health's involvement will be subject to independent decisions made by regulators - the economic regulator, and the Care Quality Commission - for example on the basis of patient safety.

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)?

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

50. Public scrutiny is an essential part of ensuring that Government and public services remain effective and accountable. It helps to achieve a genuine accountability for the use of public resources. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

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?

Local authority leadership for health improvement

51. In future, local authorities will have a stronger influence on the health outcomes of their local area. When PCTs cease to exist we intend to transfer responsibility and funding for local health improvement activity to local authorities. Embedding leadership for local health improvement activity within local authorities builds upon the existing success of the many joint Director of Public Health appointments between local authorities and PCTs. It is intended to unlock synergies with the wider role of local authorities in tackling the determinants of ill health and health inequalities.

52. Funding for health improvement includes that spent on the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise. So, for example, we envisage that smoking cessation services would be funded from the resources transferred to the local authority, but treatment for individuals with impaired lung function through smoking would be funded from resources allocated to GP consortia by the NHS Commissioning Board.

53. Local authority leadership for local health improvement will be complemented by the creation of a National Public Health Service (PHS). The PHS will integrate and streamline health improvement and protection bodies and functions, and will include an increased emphasis on research, analysis and evaluation. It will secure the delivery of public health services that need to be undertaken at a national level.

54. In order to manage public health emergencies, the PHS will have powers in relation to the NHS, matched by corresponding duties for NHS resilience. The NHS Commissioning Board will have a role in supporting the Secretary of State for Health and the PHS to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS.

55. The local authority will also play an important role in PHS campaigns of national importance, which aim to protect public health or provide population screening; and it will have a role in national health improvement campaigns, tailoring programmes to meet the needs of its local population.

56. Local Directors of Public Health will be jointly appointed by local authorities and the PHS. They will have a ring-fenced health improvement budget, allocated by the PHS; and they will be able to deploy these resources to deliver national and local priorities. There will be direct accountability to both the local authority, and, through the PHS, to the Secretary of State. Through being employees of the local authority, local Directors of Public Health will have direct influence over the

wider determinants of health, advising elected members and as part of the senior management team of the local authority.

57. The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes and this may include commissioning services, for example, from providers of NHS care. Local neighbourhoods will have freedom and flexibility to set local priorities, working within a national framework.

58. In the Government's work to develop a public health White Paper, we will engage stakeholders on arrangements for the abolition of PCTs and the establishment of the public health ring-fenced health improvement budget. Arrangements for health improvement will also be aligned with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

Conclusion and summary of consultation questions

59. This document has set out the Government's plans for increasing local democratic legitimacy in health, by giving local authorities a stronger role in supporting patient choice and ensuring effective local voice; promoting more effective NHS, social care and public health commissioning arrangements, through the proposed new health and wellbeing boards; and local leadership for health improvement. We will need to ensure, through this consultation exercise and broader policy work, that the health system is financially sustainable through the transition to the new structures that we lay out here, as well as in the longer term.

60. Implementation will be consistent with the new burdens doctrine. Subject to legislation, health improvement functions will transfer to local authorities from 2012. We propose that statutory partnership functions would also be established formally from 2012. However, if the idea receives positive support, the Departments of Health and Communities and Local Government will support local authorities to establish shadow arrangements with the PCT, emerging GP consortia and LINks in 2011. The Government proposes to make the changes through its forthcoming Health Bill, planned for introduction this autumn, subject to the responses received to this consultation.

61. The Government would welcome views on the following questions:

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?***

Q2 ***Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?***

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

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

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

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

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?***

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

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?***

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?***

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?***

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

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

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)?***

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

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?***

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?***

Q18 ***Do you have any other comments on this document?***

62. Responses to the questions in this consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS by 11 October 2010.

Annex 1: The consultation process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents: what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation

website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House

Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk
Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available at www.dh.gov.uk by the end of this year.