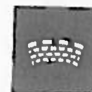

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LGG's
The New Health Landscape

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Olwen Dutton

Olwen is a partner specialising in local government. A former Chief Officer with a large County Council, she was also Chief Executive with a regional local government organisation. Olwen is a highly experienced local authority solicitor with many years of practical experience in local government law, during which she advised senior officers and members on complex strategic as well as legal matters.

Olwen currently advises on governance and risk, PFI, links between local government and health, restructuring, education and high profile environmental and planning matters as well as standards, data protection and human rights implementation. She has also undertaken sensitive and significant investigative work into senior officer and member conduct and dealt with high profile matters with intense media interest. Olwen is currently training and advising authorities throughout England and Wales on the practical implications of the Localism Act 2011 and the revised standards regime.

Main Issues for Local Authorities

- The new Health landscape
- Health and Well Being Boards
- Health Scrutiny
- Implications of Francis

The Background

- "The renaissance of local government's role in health"
- The significant impact on public health outcomes of local government services
- Integration of public health across all service areas
- The "empowerment not entitlement" agenda
- Treatment v prevention?
- Funding - £2.2bn public health budget

New Legislation

- National Health Service Act 2006
- Health and Social Care Act 2012
- The Local Authority (Public Health, Health and Well Being Boards and Health Scrutiny) Regulations 2013
- The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2013

The New Health Landscape

- History of local authorities and public health
- Marmot Review
- Acceptance that individual health is influenced by determinants such as income, education, environment and employment
- "The transfer of public health can be seen as a catalyst for the transformation of many local public services"
- Public health interventions are long term matters – impact for politicians ?

Marmot Review

Asked to prepare more effective evidence based strategies for reducing health regulations in England from 2010

- People living in the poorest neighbourhoods in England will, on average, die seven years earlier than people living in the richest neighbourhoods
- People living in poorer areas not only die sooner, but spend more of their lives with disability – an average total difference of 17 years
- The social gradient of health inequalities – put simply, the lower one's social and economic status, the poorer one's health is likely to be

Marmot Review cont...

- Health inequalities arise from a complex interaction of many factors housing, income, education, social isolation, disability – all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable. It is estimated that the annual cost of health inequalities is between £36bn to £40bn through lost taxes, welfare payments and costs to the NHS
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community

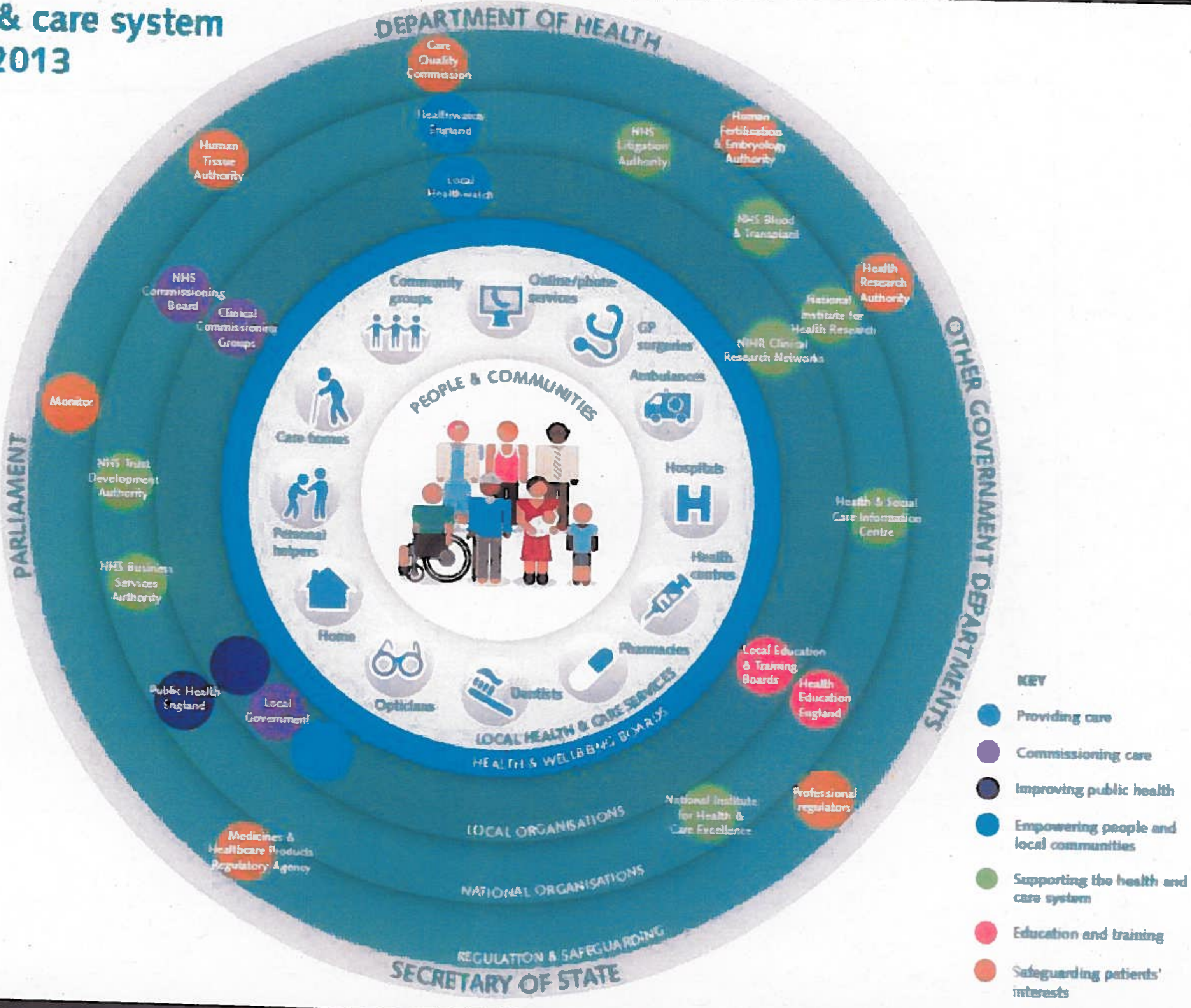
New Statutory Duties regarding Public Health

- Secretary of State must take such steps as Sofs feel appropriate for the purposes of protecting the public in England from disease or other dangers to health (s.2A NHS Act 2006)
- Each local authority must take such steps as it considers appropriate for improving the health of the people in its area (s.2B NHS Act 2006)
- Gives councils the power to provide financial incentives and provide financial assistance to persons to adopt healthier lifestyles and to minimise risks to health
- Implications of having such a duty ?
- Councils are not part of NHS but sometimes provide NHS services.
- NHS Services have to be provided within NHS requirements

The New Health Landscape

- New Bodies – NHS England; PHE; HWE
- Old Bodies with new remit – CQC; Monitor; NICE
- CCGs
- HWBs
- Health Scrutiny
- Implications of Mid Staffordshire.

The health & care system from April 2013



Health Bodies (1)

PARTNER BODY OR AGENCY	ACCOUNTABILITY	KEY DUTIES AND RESPONSIBILITIES	RESOURCES CONTROLLED	INFLUENCE
NHS England	Secretary of State for Health	Statutory duty to manage all NHS commissioning	Approx £80bn of NHS spend, commissioned direct and via CCGs	Very significant, via oversight of CCG and GP commissioning
Public Health England	Exec agency of DH	Statutory duty to provide a public health service to the NHS England	Around £830m spent jointly by PHE and DH at present	Will be looking to ensure that Public Health outcomes framework measures delivered
Healthwatch England	Statutory committee of CQC, with own identity	Statutory duties of advice and escalation of local concerns	Budget will be part of CQC grant from DH	Support to Local Healthwatch and handles escalated issues
Care Quality Commission	Statutory NDPB of DH	Statutory regulator of health and social care	£163m budget for registration and inspection	Could intervene on any specific service
NICE	Statutory NDPB of DH	New roles in guidance on social care and PH, in addition to current responsibility		Source of advice and guidance

Health Bodies (2)

PARTNER BODY OR AGENCY	ACCOUNTABILITY	KEY DUTIES AND RESPONSIBILITIES	RESOURCES CONTROLLED	INFLUENCE
Monitor	Independent regulator directly accountable to Parliament	Statutory duty to regulate the health market and competition		Degree of intervention in health market yet to become clear
Health Education England	Executive NDPB of DH	Responsible for workforce education and training	£4.9bn for education and training	HWB relationships likely to be through LTEBs
Local HealthWatch	Independent and accountable to local people and Healthwatch England	Statutory duties of advice, info and advocacy	DH funding to Councils to commission LHW	Depends on strength/credibility of Local HealthWatch
Council Executive and full Council	To local electorate	Statutory body, responsible for wellbeing of area	Council budget	Very significant, via Leader/Mayor or executive councillor
Directors of Adult and Children's Services	To the local council	To meet care and other needs of adults and children	Sizeable local authority budget	Major role in developing JSNA and JHSW

NHS England

An autonomous non-departmental public body

- Statutory responsibility for commissioning primary care services
- Role is to ensure the NHS delivers better outcomes for patients within its available resources to provide leadership for the NHS to commission some services and to champion patient and carer involvement.
- NHS England will:
  - Assess, assure and hold CCGs to account for delivering their statutory responsibilities
  - Commission certain primary services (e.g. dental, pharmaceutical services, NHS sight tests)
  - Commission specialised services (e.g. specialised cancer, haemophilia)
  - Commission armed forces and offender health care
  - Commission certain health services on behalf of Public Health England
- NHS England will support HWBs through the production of the JHWS
- Will HWBs and CCGs will be able to extend upwards influence on NHS England ?
- Subject to local authority scrutiny
- Concordat between NHS England and LGA October 2012; Set up Joint Leadership Group and Leadership Executive Group

Public Health England

- Leads for public health nationally
- Executive agency of the Department of Health, providing a public health service to NHS England – but is operationally independent of DH
- Ethos is a culture of subsidiarity, focused on support for local accountability (DH)
- Possible role evaluating performance against the public health outcomes framework
- May pursue intervention if necessary through a self improvement framework as with adult social care or children's services
- Budget holder and variants across public health spend across councils?
- Role in encouraging best practice
- Supports the development of the workforce

Healthwatch England

- National body – role is to "enable the collective views of users of NHS and social care services to influence national policy, advice and guidance"
- Committee of CQC
- Three main functions:
  - To provide leadership, guidance and support to Local Healthwatch organisations
  - To escalate concerns about health and social care to the CQC;
  - To provide advice to the Secretary of State, NHS England, Monitor and English local authorities; all have a duty to respond to advice
- Also Local Healthwatch (takne over from LINks)
  - Commissioned by council
  - Legal entity and social enterprise (s.183 H&SC Act 2012)
  - Provides advocacy service
  - Reports concerns to HWE; can recommend CQC takes action

Old Bodies, New Relationship- Care Quality Commission

- All health and social care facilities are required to register with CQC – GPs will now be registered by CQC
- CQC is the parent body for Healthwatch England and is likely to strengthen impact of feedback from the public on future operating practices
- Likely to be a more distant relationship with councils in relation to CQC for healthcare than social care unless there is a failure of a health facility

Old Bodies, New Relationship - Monitor

- Becomes the sector regulator for healthcare which regulates all providers of NHS funded services in England
- Duty to "enable" integrated care
- Could incentivise and encourage integrated care through its approach to tariffs and licensing
- Should encourage greater cooperation and coordination within health care services and between health and social care services through its role in enabling the best possible care for patients to be delivered

Old Bodies, New Relationship - NICE

- New responsibilities to produce evidence-based guidance for social care – issuing a series of public health briefings for local government will be a standard resource for public health responsibilities
- Piloting quality standards on social care issues, e.g.:
  - Care of people with dementia
  - Health and wellbeing of looked after children
- Extension of the role of NICE will assist HWBs to provide a more integrated response across the health and care system

Clinical Commissioning Groups

- Replaces but does not replicate PCTs
- CCGs hold budgets and commission the majority of NHS services for their patients
- Commission emergency, urgent care and healthcare services to persons for whom they are responsible
- Once authorised, CCGs will be statutory bodies, so have a specific purpose with duties and powers conferred but limited to that purpose
- Usually conterminous with local authority boundaries (some exceptions)
- Has the power to enter into partnership agreements (e.g. for pooled budgets) with councils
- Statutory duty to reduce inequalities (health)
- Duty to ensure public involvement

Health and Wellbeing Boards

- "A dynamic environment where the local health and wider needs of the population can be considered in partnership"
- To deliver "strong, credible and shared leadership"
- Responsible for encouraging integrated working, developing JHWA and JHWS
- Success depends upon building capable relationships
- Established under s.194 H&SCA 2012
- Duty applied to County Councils and unitary Councils, London Boroughs, Council of the Isles of Scilly, Common Council of the City of London
- Membership of HWB statutory - s.194(2) H&SCA 2012

Functions of HWBB

- Two Core Functions- JHWS/JSNA
- Not reserved under the Functions and Responsibilities Order
- But- statute provides these are the functions of the HWBB; so not executive functions
- If HWBB have other functions delegated to them brings in executive/council considerations
- Where is the capacity to deliver the strategy ?
- Have duty to involve the public.

Specific HWB Powers and Responsibilities

- Duty to provide opinion as to whether commissioning plan has taken proper account of JHWS
- Power to write to NHS England with that opinion on the commissioning plan
- Power to provide NHS England with opinion on whether published commissioning plan has taken proper account of JHWS

HWB membership

- Statutory membership:
  - Councillors (at least one) – nominated by an elected mayor/leader
  - Director of Adult Social Services
  - Director of Children's Services
  - Director of Public Health
  - A representative of each CCG
  - A representative of Local Healthwatch
  - Such other persons as the local authority thinks appropriate – must consult with HWB
- HWB may itself appoint additional persons
- NHS England to attend when eitherJSNA/JHWS, or its own role
- discussed
- Health and Wellbeing Boards are s.102 LGA 1972 committees of the local authority (s.194 H&SCA 2012)

Governance issues

- HWB are committees of local authority but exercise executive functions
- Will be able to appoint sub-committees
- Leader/Elected Mayor nominates councillors as he chooses but Council appoints- as S102 Committee
- Access to Information will apply – but not 2012 Regulations unless executive functions delegated
- Subject to review – by Scrutiny
- Call in won't apply unless executive functions delegated
- Members of HWB have voting rights (this includes the officers)
- Duties and restrictions under Localism Act 2011 relating to DPIs apply to all members of HWBs
- Code of Conduct will apply

Local Authority Health Scrutiny

- Government consulted in Summer 2012 about proposed changes to health scrutiny- pre publication of Mid Staffs report
- New regulations into force from April 2013, guidance also to be published
- Government sees the main aim of health scrutiny to "act as a democratic leader to improve the health of local people. It is about looking at the wider local health economy, not just services provided, commissioned or managed by the NHS"
- "A fundamental way by which democratically elected community leaders may voice the views of their constituents and hold local NHS bodies and providers of NHS and public health services to account"

Health scrutiny

- Previous 2002 Health Scrutiny Regulations revoked.
- Health scrutiny functions now conferred directly on councils
- May choose to discharge these functions in whole or part through an O and S committee
- Or via another authority's O and S where it considers that committee is better placed to undertake the functions and the other authority agrees.
- But not by an officer

Health scrutiny

- Power to review and scrutinise <u>any</u> matter relating to the planning, provision and operation of the health service in its area
- Duty to invite interested parties to comment
- Duty to take account of all relevant information available and that provided by Local Healthwatch in particular
- If matter referred must acknowledge referral within 20 working days and keep referrer informed

Health scrutiny

- Local authority has power to make reports and recommendation to a responsible person on matters it reviews or scrutinises
- Reports must include-
  - Explanation of matter reviewed;
  - Summary of evidence
  - List of participants involved
  - Explanation of recommendations
- If local authority requests a reply the responsible person ("R")has 28 days to respond

Health service reconfigurations

- Applies to "substantial development" or "substantial variation"
- Council must be consulted by "R"
- If council makes recommendations and R disagrees R must notify authority and r and authority have duty to take such steps as practicable to reach agreement
- Authority has power to report to Secretary of State where consultation inadequate or proposals not in the interests of the health service in its area. Regulations give details of what this must include.

Scrutiny- joint committees

- Two or more authorities may appoint a joint O and S committee
- If a joint committee appointed the local authority may not discharge the function
- If R consults more than one Local authority re reconfiguration the councils MUST appoint a joint O and S and only that may make comments on the proposal, require information or the attendance of a representative of R
- A Joint O and S committee may not discharge any functions other than relevant functions under the regs

Mid Staffs Public Inquiry

The Francis Report

Why is this important to Councils ?

- Close relationship and growing integration between council functions and NHS;
- Relevance to local authority care services
- Scrutiny role of local authorities;
- General themes about how public services work

Recommendations - themes

- Clear, enforced Standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong, patient-centred leadership
- Accurate useful information

Accurate Useful Information

$$z^{*} = \frac{\sum_{i=1}^{m} r_i^{-1} Z_i \left[(2CS_i + PE_i)/6\right] + \sum_{i=m+1}^{n} v_i Z_i}{\sqrt{\sum_{i=1}^{m} \sum_{j=1}^{m} r_i^{-1} r_j^{-1} \times \left[(2CS_i + PE_i)/6\right] \times \left[(2CS_j + PE_j)/6\right] \times C_{ij} + \sum_{i=m+1}^{n} v_i^{2}}}$$

Implications of Mid Staffs for Councils

- "All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work"

" What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system - on putting the patient first"

An isolated case?

- "The assumption … that any other hospital providing such poor care would have been uncovered by the systems in place… is a naive assumption and one which places reliance on a regulatory system which has been demonstrated to have failed in a significant way. **The assumption should be, we submit, the very opposite - that there are other failing hospitals and the system needs to be designed to ensure that those hospitals are also identified.**" – Tom Kark QC

Individual accountability

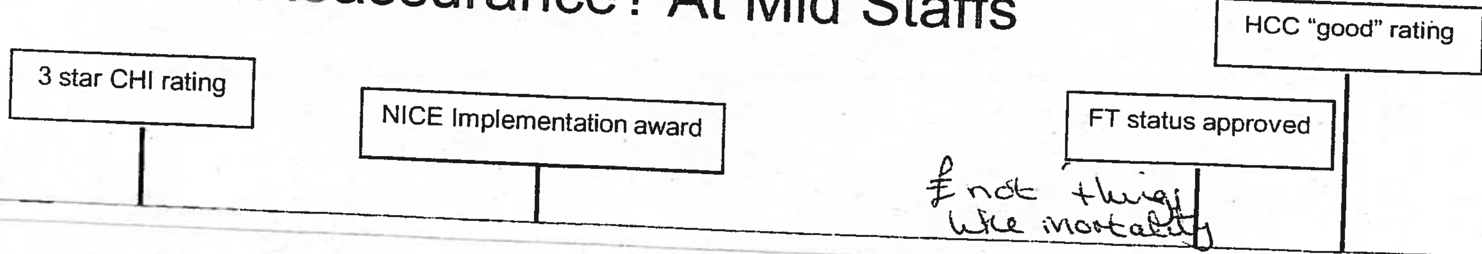
- I do not for a moment believe that those in responsible positions in the ... healthcare system went about their work knowing that by action or inaction they were contributing to or condoning the continuance of unsafe or poor care of patients.

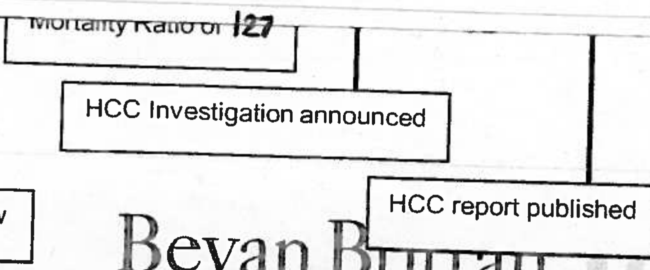
- What is likely to be less comfortable for many of those in such posts at the time is the possibility, and sometimes the likelihood, that whatever they believed at the time, they were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care.

Why things were not discovered sooner?

- Trust: lacked insight - generally defensive - lacked openness with patients/ public and external agencies
- External agencies: responsibilities not well defined – silos - "regulatory gaps" - failure to follow up warning signs - lack of effective communication
- Constant reorganisation in NHS- loss of corporate memory
- Systemic culture - inappropriate comfort from assurances given by the Trust or from action taken by other regulatory organisations
- Structure where identifying systems, processes and targets were main measures of performance
- Finances and targets not considering impact on the quality of care
- General lack of effective engagement with patients and the public, and failure to place clinicians at the heart of decision-making
- Patients concerns/complaints were not heeded

Reassurance? At Mid Staffs





Some other issues for Councils

- Culture
- Focus on achieving targets and financial savings at the expense of quality and safety and patent care
- Listening and observing
- Provision/procurement of services
- Effective scrutiny

Culture

Management response to incidents

- large numbers of adverse incident reports citing understaffing as a root cause at the turn of 2005/6
- – the paucity of information about adverse incidents reaching the Board, was important in allowing changes in workforce to be made without a real appreciation of their likely impact - John Newsham (Finance Director) –

Negative aspects of culture...

- Lack of openness to criticism
- Lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions about the judgement and actions of others
- Acceptance of poor standards
- A failure to put the patient first in everything that is done

Openness transparency and candour

- Aim-Common culture with 3 characteristics-
- Openness- enabling concerns to be raised & disclosed without fear & questions answered;
- Transparency- true information about performance and outcomes shared with staff, patients, public
- Candour- patients harmed are informed and appropriate remedy offered whether or not complaint made

Targets at the expense of patient safety

"Although a focus on quality has developed significantly in the last 10 years, the DH has failed to place it firmly at the core of its policy by assessing the impact of key policies, such as financial rebalance, the FT agenda and structural reform on quality. The DH should ensure that there is senior clinical involvement in all decisions which may impact on patient safety and well-being.

Some of the evidence the Inquiry has heard shows that DH officials are at times too remote from the reality of the service they oversee. ... Nothing is more likely to focus the mind on the impact of decisions on patients than to listen to patients' experiences"

All the policies in the world....

"It is the intention of the Trust to ensure that **all adverse incidents and near misses are reported** in order to ensure that all known hazards to the health, safety and well being of staff, patients and others are eliminated wherever possible, and as a minimum reduced to the lowest level reasonably practicable.

It needs to be emphasised that the Trust adopts an **'open and fair'** policy in the investigation of adverse incidents. The overriding principle of such a policy is that when things have gone wrong, the Trust places more **emphasis on taking corrective action to improve practice** rather than to apportion blame and take punitive action. This is based on the assumption that Trust staff act in good faith. This does not however mean that disciplinary action will not be taken where appropriate and necessary following on from an investigation...

- **Accurate and timely reporting of all adverse incidents is an essential part of the risk reduction process**."

Adverse Incident policy (May 2007)

mid Staffs

Focus on Finance

- "It was clear that the Trust was operating in an environment in which its leadership was expected to focus on financial issues and there is little doubt that this is what it did. Sadly, it paid insufficient attention to the risks in relation to the quality of service delivery this entailed."

Complaints

- "Patients were not heard"
- "Failure to respond to warning signs...likely due to lack of importance attached to these sources of information"
- "Complaints, their source, handling and outcome provided an insight into the effectiveness of an organisations' ability to uphold both the fundamental standards an the culture of caring"

Complaints- recommendations

- O &S committees and Local Healthwatch should have access to detailed information about complaints
- Commissioners should require access to complaints information; commissioners required by NHS England to undertake support and oversight of GPs and given resources to do so.
- Learning from complaints must be effectively identified, disseminated and implemented and made known to complainant and public

Patient involvement- old models

- PPIF – failed to achieve anything but mutual acrimony between members and between members and the host. A preoccupation with constitutional and procedural matters … (para 1.21)
- LINks – an even greater failure – the potential for consistency represented by CPPIH removed (para 1.22)

Patient involvement- new model

- Local HealthWatch – "DH does not intend to prescribe an operational model, leaving this to local discretion. It does not prejudice local involvement in the development and maintenance of the local healthcare system for there to be consistency throughout the country in the basic structure of the organisation designed to promote and provide the channel for local involvement" – para 1.24
- "any body seeking to collect and deploy local opinion should avail itself of, but not be led by, what groups offer" – para 1.28
- Local authorities required to pass over funds received to Local Healthwatch organization ; if it becomes incapable of performing its function LA/HWE to intervene.

Gov't Response: Patient involvement

- HealthWatch England will deliver a full offer of training and guidance over the next financial year to ensure and support the development of a vibrant and effective local HealthWatch network. This training will support:

  - leadership of local HealthWatch and volunteers
  - the use of powers to 'enter and view' health and care services to observe activities carried out

– paras 2.57 and 2.59

Provision/procurement of services

- Commissioners ..must ensure services they contract from providers are well provided and provided safely
- Need proper scrutiny that providers are delivering the standard of service required under their contracts
- Commissioners should have powers of intervention when services are being provided which do not accord with contracts.
- "urgent need to … refocus commissioning into an exercise designed to procure fundamental and enhanced standards of service for patients as well as to identify the nature of the service to be provided".
- Public should be involved in commissioning and their views taken into account

Scrutiny (1)

- The local authority scrutiny of health functions failed to identify or to address the issues at Mid Staffordshire.
- O & Committee "a pleasant little talking shop" (Para 79);
- Lack of openness from the hospital to O&S Committee – "Even as the Healthcare Commission were writing in September 2008 to say: you are a dangerous place, get your A&E sorted out. Meanwhile, the management team is giving a slide show to the OSC saying: it is absolutely fine. The OSC went for lunch at the hospital, were shown round a little bit, asked no questions." (Witness from Cure the NHS quoted at Paragraph 79);

Scrutiny (2)

- Lack of understanding and grip on real local healthcare issues (Section H; External Organisations, Para. 78);
- Lack of real interrogation and an over-willingness to accept explanations (Para.80);
- OSC agendas contain little evidence that the OSC took a particularly aggressive or proactive approach to their scrutiny of the local NHS (Para. 81)

Scrutiny conclusions for Councils

- Local authorities have unique powers to scrutinise NHS functions, to call for information and explanations, to question proposed plans, and to invite senior managers to attend and provide evidence.
- However unwelcome their attentions may be, they do have a responsibility to exercise these powers "positively and proactively"
- This requires informed members and well resourced scrutiny arrangements.
- Should have power to inspect providers rather than relying on local patient involvement structures and work with those structures to trigger and follow up inspections where appropriate
- CQC should expand its work with O&S committees as a valuable information resource

Conclusions

- The importance and far reaching implications of the new health agenda for local authorities
- The findings in the Mid Staffs inquiry have many implications both direct and indirect for local authorities

The New Health Landscape

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