Overview and Scrutiny Committee
Chairman Councillor Jerry Miles

11th October 2010

The White Paper Team – Consultation responses
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Dear Sirs

Harrow Council response to 'Equity and Excellence: Liberating the NHS' and the accompanying consultation documents.

I am pleased to enclose Harrow Councils response to NHS consultation Equity and Excellence: Liberating the NHS'.

The proposals put forward in the White Paper represent both opportunities and challenges for Harrow. The plans to bring Public Health into the remit of the local authority is welcomed but there will be a number of challenges to the changes proposed in terms of developing relationships with GP consortia, evolving the role of LINks to HealthWatch and ensuring that there is real democratic accountability of the Health and Well-being boards.

We await the imminent Public Health White Paper, the outcomes of this consultation and the details in relation to the plans for implementation. Harrow is already making progress in considering how the proposed changes will affect the borough so as to maximise the potential benefits and minimise the scope for adverse effects.

Harrow's response was developed following an initial briefing on the White Paper to the Health Overview and Scrutiny Sub Committee. The response is derived from a workshop held on 24th September involving cross-party Overview and Scrutiny committee councillors, the Cabinet Member for Adult Social Care, Health and Well Being, council officers and representatives of

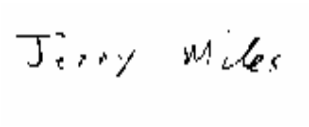
Harrow's health partners. The workshop focused on the White Paper and five of the accompanying consultation documents. We are grateful for the contribution of the colleagues who attended this workshop.

Harrow believes this consultation is a step in the right direction but given the complexity and longer term impact of the proposals, more information and discussion about how things will work on the ground is required before any final decisions are taken.

We welcome the opportunity to make further contributions and work with the Department of Health and other local authorities and key partners as the plans progress.

Appendix 1, as attached, details Harrow's response to the overall White Paper and the consultation documents.

Yours faithfully



Councillor Jerry Miles
Chairman, Overview and Scrutiny Committee

Councillor Paul Osborn
Vice-Chairman, Overview and Scrutiny Committee

Councillor Margaret Davine
Portfolio Holder, Adult Social Care Health and Wellbeing

APPENDIX 1

The response detailed below has been pulled together following feedback and discussions that were captured at the Health White Paper workshop that was held on 24 September 2010 which consisted of Harrow Overview and Scrutiny councillors, the Portfolio Holder for Adult Social Care, Health and Wellbeing and key officers from within the council and across partnership agencies including LINks and Harrow PCT. The contributors to this response hold extensive local and national knowledge on health related issues and more specifically have a real understanding of the borough along with knowledge of the residents which we serve. The response detailed below is a summary of the council's response.

Questions relating to the *'Local Democratic Legitimacy in Health'*, '*Commissioning for Patients'* and '*Transparency in Outcomes'* consultation documents are particularly relevant to the council and have been responded to in the most detail.

Liberating the NHS: Local Democratic Legitimacy in Health and the Overall White Paper

A number of the proposals put forward in the Health White Paper represent opportunities which we welcome. Nevertheless, the significant changes along with the ambitious timescale in which to implement the changes proposed in the White Paper and accompanying consultation documents also raises some concern. How local authorities will ensure a leading role in the Health and Well-being Boards, in ensuring the effectiveness of the Overview and Scrutiny function, and in managing the establishment of HealthWatch is co-ordinated, will be of paramount importance.

Public Health

The strengthened role and transfer of Public Health to local authorities, with a clear role in leading on the integration of public health, social care and health improvement is very much welcomed. The proposals offer the opportunity for greater transparency, involvement and accountability at a local and national level for health services. The proposals also build on the current structure in Harrow where we have a joint Director of Public Health with Harrow PCT.

In terms of the councils current direction of travel in the provision of health and social care services, the proposals for GP commissioning could also make it easier for 'personalisation' to work more cohesively across health and social care. The proposals will hopefully bring councils closer in line to develop specialist planning across the board as councils are best placed to serve their local communities. In order to ensure this, it will be important that local authorities are sufficiently staffed and skilled to support this new role, in essence the resources to implement this must follow along with further detail and guidance.

The consultation document 'Local Democratic Legitimacy in Health' re-emphasises the aspirations that the local authority must play a pivotal role in the future commissioning of health services and we commend this. The proposals indicate that budgets will be allocated based on three separate settlements for local authorities out of which Adults and Children Services will be funded, a ring fenced Public Health budget and also allocation to go to GP consortia. The more these budgets can be flexibly used, the better as allocation with separate budgets can sometimes be a barrier to integration and could lead to conflict as budgets are cut in this current economic climate. The Public Health budget should also be locally flexible and not constrained to be spent on national outcomes. The changes

should be approached with a primary focus on the delivery of programmes that will impact on residents. How budgets will be allocated need to be clearly set out.

It is not clear what comprises Public Health in terms of the services which will transfer to the local authority. We feel it is essential that the health economy includes all aspects of health care and includes Children's Trusts. It is important for the Government clearly highlight in the Public Health paper that is due out at the end of the year what is within the Public Health work stream and what part of the Public Health budget will be ring-fenced.

GP Commissioning

The White Paper represents a major culture change for GPs, health bodies and the local authority. The proposal to put GPs at the heart of commissioning services is one of the fundamental changes proposed and we feel one of the most challenging. The opportunity for GP's to be closer to Public Health is very much welcome. However, there are a number of concerns. GPs experience of working in consortia is limited at present and the White Paper forces them to work together, how this will pan out has yet to be seen. As with any significant change in service, there will be some that welcome the opportunities whilst others will be less enthusiastic.

How GPs will be brought into the system and developed into the role that is envisaged for them within the timescale that has been set will be a real challenge. Some GPs have a good understanding of local need from the perspective of their individual practices and local area but how this knowledge and expertise will be developed for some GPs reluctant to take on this new role is also a concern. The development of GP consortia will require a robust transition plan in order to develop the right infrastructure to support effective commissioning. Local authorities should be paramount in leading/supporting the commissioning role through the Health and Well-being boards.

To ensure their effectiveness we feel that the Health and Well-being boards must be politically led. The proximity of councillors to the community places a democratic imperative on the need for local authorities to play a key role in the commissioning of services.

The importance of addressing health inequalities should be embedded into the implementation plans. The transfer of Public Health to the local authority should strengthen action in this area and a jointly prepared Joint Strategic Needs Assessment (JSNA) that will inform commissioning plans will hopefully mean there is more likelihood of an agreed basis from which to commission services. However, this is on the basis that the GP consortia don't commission services from a data set provided by an alternative source.

In line with this, it is important to emphasise it will also be essential that as PCT's and SHA's are abolished the skills offered by PCT and SHA staff and the wealth of expertise they have garnered should not be lost. GPs will need to find suitable support to commission and manage their contracts. Plans also need to be clearly set out regarding how the statutory roles and responsibilities of the PCT are reallocated.

Health and Well-being Boards

Membership on the Health and Well-being boards should be statutory in order to ensure that GPs participate and embrace the relationship with the board. Nevertheless, the role that is envisaged for the Health and Well-being Board needs to be clarified in order to ensure that it has corresponding powers. There is some concern about how GPs will be held to account sufficiently by the Health and Well-being board as the new arrangements

give the Health and Well-being Board two different and somewhat conflicting roles: holding local agencies to account for health outcomes; and being a forum for joint working and collaboration – keeping this in balance will be a key task for the board.

Overview and Scrutiny
It will be essential that health Overview and Scrutiny maintains its focus in championing public interest and ensuring democratic accountability independent of the Health and Well-being boards in order to ensure it is responsive to public needs.

Having considered the document in detail It is also felt that the consultation document somewhat contradicts the White Paper in its view on the role of scrutiny in health in future. The consultation document asserts that local authorities must maintain an effective health scrutiny function. However, it is not appropriate for this role to be undertaken by Health and Well-being board which will also be commissioning services. Overview and Scrutiny has matured since its introduction and now plays an effective investigative, policy development role not just criticising service providers. Overview and Scrutiny has also been involved in a number of successful topic based reviews addressing commissioning strategies and reducing health inequalities. In particular, Harrow councillors on the Overview and Scrutiny Committee have also been key in safeguarding the interests of the public surrounding the sudden closure of GP practice in Pinner. If the scrutiny function passes to the Health and Wellbeing board, this expertise will be lost and independence, potentially compromised.

Along with the conflict of interest posed in the proposals that Health and Well-being boards should hold the responsibility for scrutiny of services commissioned, there are also ultimately capacity constraints that will impact on the Health and Well-being board should their role encompass scrutiny as well.

National Commissioning Board
Despite the emphasis on more local ownership, the National Commissioning Board represents a centralisation of decision making. It will be important for the board to maintain flexibility to allow local commissioners to provide services relevant to meet local need. It is also worth bearing in mind that having the GP consortia held to account at a national level will not really be sufficient as this has not always been possible even on a local level through PCT's. The Health and Well-being board which GPs will also sit on will not be the body that will be able to do this effectively.

It is understood there will be local branches of the National Commissioning Board. How local will these be and how accessible will they be for local Health and Well-being boards? The paper also requires some clarity over how the NHS Commissioning board will operate in relation to regional and specialist services.

Monitoring
The inclusion of social care quality standards to the work of NICE will hopefully help to develop more coherent joint working arrangements between health, public health and social care. The focus on outcomes as opposed to targets may to some extent meet the Government's aim of reducing bureaucracy. It will be important to ensure that the local authority also develops its own local outcome measures based on needs and expectations of local people. The outcomes focussed targets will hopefully help to focus on patient safety and patient experience which will inform commissioning priorities.

HealthWatch
The HealthWatch arrangements envisaged by the White Paper have raised some concerns. It is expected that the move from LINk to HealthWatch will be a seamless transition; however there are a number of issues to be considered in relation to this. In terms of funding, there will be a gap in funding for HealthWatch in year 2011/2012. As the new responsibilities that sit within the remit of HealthWatch are very different to those which the LINk is currently responsible; will there be adequate resources to manage the expanded remit? In respect of this, many LINk organisations have also yet to realise their role in fully engaging with the communities they serve and yet HealthWatch is expected to carry the weight of responsibility for public engagement and accountability. The leap in responsibility for many authorities may in turn be a step too far.

The council is not wholly in favour of HealthWatch providing advocacy and complaints services as consideration needs to be given to how this will sit with the complaints service currently operating in the council. It is felt that HealthWatch should not have responsibility for investigation of complaints but their role as advocates of residents both individually and collectively is important.

Whilst it is acknowledged that HealthWatch should be bringing intelligence to the Health and Well-being boards, it should be ensured that their role as community champions is not be compromised by their role in participating and contributing to the Health and Well-being board.

The Information Revolution and Patient Choice
Amongst the positive elements of the White Paper are plans to increase patient choice. Choice in service means service users will be empowered to make their own decisions about their own health care and we welcome this. The proposals indicate that patients are at the centre of the plans which will lead to an 'explosion of information' which will suit the more I.T savvy patient. There will be much more information available regarding trusts and patients' views on their services and so this will inform patient choice.

However, with the information revolution significant investments and in turn safeguards need to be put in place. It must be ensured that the information that will be available will be sufficient to assist patients with informed decision making. Caution should also be exercised because choice in an environment where an open market and competition is proposed, may also imply that there may be service providers not up to scratch and there are implications in this for the capacity for 'favourites' and the future viability of the non-favourites. The desire for greater choice may also be compromised if GPs are more incentivised to favour the cheapest provider. Choice in service is nonetheless important – service users must be empowered to make their own decisions.

The commercialisation of services being promoted through Monitor could also reduce the level of collaboration and cooperation amongst health professionals and this could be detrimental to the greater good of patients. This approach could lead to more fragmented NHS services and greater inefficiency.

Conclusion
Whilst some elements of the White Paper are viewed very positively, we are keen that the changes should not derail some of the good work already underway in the borough such as the Integrated Care Organisation and the re-ablement agenda. The plans also require a great deal of change in terms of investment, resources and planning within a very tight

timescale, it will be essential to ensure that patient care isn't compromised as a result of implementing the White Paper. Lastly, the capacity of the voluntary and community sector to take on an increased role as deliverer of services (bearing in mind the potential reduction in their funds) is also an area of concern in which we require more information and detail.

Detailed below are responses to some of the individual consultation questions.

Strengthening public and patient involvement:

1. Should local HealthWatch have a formal role in seeking patient's views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Local HeathWatch should have a formal role in seeking the views of patients on whether the NHS constitution is upheld as long as the additional funding that has been earmarked matches the new responsibilities proposed for HealthWatch. HealthWatch also needs to have an effective link with the council's Overview and Scrutiny function that currently has a key role in ensuring that the NHS constitution is upheld.

2. 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?

This role is very different to that which is currently carried out by LINk and it will have a substantial financial impact on the work of HealthWatch. Although financial support has been earmarked some further consideration needs to be given to how it will operate in practice. Thought also needs to be given to how it sits alongside other services such as the council's complaints services, PALs etc.

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

The message about the new statutory requirements to commission and manage HealthWatch needs to be clearly highlighted to local authorities, many of whom may currently be pre-occupied with pressing budget decisions to be made. The new responsibilities for HealthWatch need to be highlighted in order for local authorities to consider how they can be most effective in providing this service in line with the other services they provide.

Improving integrated working:

6. Should the responsibility for local authorities to support joint working on Health and Well-being boards be underpinned by statutory powers?

The requirement for joint working should be supported by statutory powers in view of the fact there will be some organisations not used to partnership working and as there is the potential for some services to be commissioned privately, the requirement to meet in partnership will help to forge key relationships and a local community focus for commissioning both adults and children's services.

7. Do you agree with the proposal to create a statutory Health and Well-being boards or should it be left to local authorities to decide how to take forward joint working arrangements?

It should be a statutory requirement to have a Health and Well-being board in order to ensure, health, public health and social care commissioning services and GP consortia are joined up.

8. Do you agree that the proposed Health and Well-being board should have the main functions described in paragraph 30?

The investigation with regards to major health reconfiguration is not the only function carried out by local authority health scrutiny. It is important to retain democratic accountability with regard to the Health and Well-being board, as per paragraph 50 and this should be carried by Overview and Scrutiny.

9. Is there a need for further support to the proposed Health and Well-being boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Emphasis should be placed on developing local joint strategic needs assessments that fit local needs. The additional support to the Health and Wellbeing boards will be dependent on the expertise of those sitting on the board and how it is administered.

10. If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to co-operate through Children's Trusts?

The work of the Health and Well-being board should be interlinked with the duty to co-operate through Children's Trusts in the sense that some of the work of the Health and Well-being board could be used to inform the Children's Trusts. The structure of Children's Trusts will also need to be reviewed in order to ensure there isn't duplication with the introduction of Health and Well-being Boards. Local Safeguarding Children's Boards will also need to consider how they will work in partnership with GP consortia and this will be particularly critical for more vulnerable children and young people such as those that are highly mobile, disabled and also Looked After Children. It should be ensured that children and young people do not fall through any gap in service provision.

As the document also points out, should there be matters of concern to a Local Safeguarding Children's Board, these matters could then be referred to the Health and Well-being board and in turn escalated further to the NHS Commissioning Board local branch if required.

11. How should local Health and Well-being 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?

It is likely that chairs of Health and Well-being boards will meet with neighbouring local authorities. Perhaps a pan London/ regional level quarterly meeting could also be established and possibly co-ordinated by the NHS Commissioning Board, London Councils/ the GLA on a London wide level and possibly by the LGA for a wider regional level. Health and Well-being Boards could also work across local authority areas within the existing partnership structures already in place such as the Local Strategic Partnership.

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

The proposed membership seems sufficient but this in turn raises questions about how the Health and Well-being Board will also carry out its 'overview and scrutiny' function. There should be a separation between commissioning of service and ensuring the Health and Well-being board is accountable.

The overview and scrutiny of the decisions made by the representatives on the Health and Well-being board must be carried out by elected members not participating in the decision making process. This should be done by the existing formal Overview and Scrutiny function which is made up of non-executive members.

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

Commissioners and local authorities will need the right approach to working together in order to resolve disputes locally. The views of other relevant stakeholders besides commissioners such as Overview and Scrutiny and HeathWatch could also be used to help find solutions to disputes. The National Commissioning Board is too far removed to provide support in these instances.

14. 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)?
15. How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

The logic behind the decision to transfer the statutory referral function and scrutiny regarding major service reconfiguration is understood, it is more likely that through partnership working the most effective decisions regarding major reconfiguration will be reached. However, it is critical that the local authority Overview and Scrutiny function is retained in relation to ultimate oversight of the decisions being made by the Health and Well-being board if resident's interests are to be safeguarded.

16. What arrangements should the local authority put in place to ensure that there is effective scrutiny of the Health and Well-being board's functions? To what extent should this be prescribed?

Whilst we acknowledge the transfer of statutory powers in relation to major reconfiguration seems logical, we would emphasise that the existing local Overview and Scrutiny function, which is tried and tested, should be retained to provide effective scrutiny of the Health and Well-being Board and other deliverers of health and social care.

17. 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?

An equalities impact assessment of needs should be carried out to ensure that no one is disadvantaged by the proposals.

Consultation - Liberating the NHS: Commissioning for Patients

Commissioning services is part of the day-to-day work of councils and the PCT, however commissioning led by health practitioners is something that a number of GPs will need support with as many are not experienced in delivering and commissioning services. Most GPs will in essence become community leaders and will be required to think about the health and social care needs of whole populations not just those with whom they come into contact.

Consideration of this consultation document ultimately raised more questions than answers. Commissioning for patients will need to be drawn and pulled together from a broad range of agencies and sources such as data and evidence based on information such as the JSNA. It will be important to be confident that the commissioning is being done properly and the information it is based on is up-to-date.

How we ensure decisions are made in the best interests of patients even given an assessment of JSNA is a key concern. There are conflicts of interest and dilemmas that may arise between individual patient care requirements and issues for the greater good of the locality as a result of the need to ensure we commission localised services.

In view of increased patient choice, commissioning decisions cannot just be based on local demographic and epidemiological information as some of our residents may choose to use GP facilities closer to their place of work and similarly some of our GP practices/consortia may provide services for non-Harrow residents. Some guidance and further consideration should be provided in terms of how we measure this in respect of service planning and commissioning. In addition to this, we may face similar issues should consortia not be co-terminus with borough boundaries for example consideration needs to be given to how this will work across borough boundaries in the case of services such as Alexandra Avenue polyclinic where a number of patients from Hillingdon also currently attend. Guidance should be issued on how such challenges can be managed and resolved.

There are concerns that the new arrangements could possibly lead to a postcode lottery and this could lead to increased disputes around geographical boundaries in relation to accessing services. This may also be emphasised by the size of individual consortia, the smaller the consortia the more of a lottery and in turn less power they will have.

Maternity services and health visiting service, which are viewed as very local services have been identified as services that will be commissioned nationally, there is a concern that these services should be commissioned locally.

In respect of the role of GPs as commissioners and providers, financial assurances, clinical assurances, patient safety and the prescription of medication that is of most benefit to patients is real concern. It will be essential that there is robust monitoring of the way on which GP's commission and manage service. In view of this, consideration should also be given to what level and at what stage issues will be accelerated to the local branch of the National Commissioning Board (should there be one) and further on to the National Commissioning Board should problems arise.

Further detail around the requirements and accountability for GP's in relation to de-commissioning of services should also be developed as it will be important to know whether GPs will be subject to the same consultations for service developments and changes. Monitoring will be too far removed if it is at a national level.

Detailed below are responses to some of the individual consultation questions.

Responsibilities of GP consortia:

5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

GP consortia can most effectively take responsibility for improving the care provided by their constituent practices by developing external challenge methods of holding them to account, working closely with them to ensure they have a clear knowledge of their locality and patients. Set service standards and criteria must also be established.

The NHS Commissioning Board should also develop some guidelines to assist GP consortia in how they develop their relationships and ways to ensure effective and quality service provision with GPs in their consortia.

The Government also proposes to link some proportion of GP income with outcomes. How this will be measured needs to be well thought out.

6. What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

We have concerns that this is not being delivered at a local level. There must be some specific link between the Health and Well-being Board and the local area as the National Commissioning Board is too far removed.

7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

Local accountability and consultation with patients and public along with the NHS Commissioning Board's role is essential to ensure services and resources are allocated appropriately. NICE and Monitor will also be essential in ensuring transparency and fairness in commissioning of services. There must be effective use of and sharing of accurate information.

8. How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?

The NHS Commissioning Board should provide a steer and ensure the delivery of quality improvements in line with good financial management and also performance management. We would propose regular monitoring and effective links with local HealthWatch and the Overview and Scrutiny function as well. The NHS Commissioning Board can most effectively develop relations with GP consortia by having a local branch to cascade information down to.

9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

It is imperative that local branches of the NHS Commissioning board are in place in order to ensure effective local commissioning. The commissioning outcomes framework should

be developed in collaboration with NICE as discussed in the paper; this will aid the development of transparent and effective commissioning.

Establishment of GP Consortia:

10. What features should be considered essential for the governance of GP consortia?

It should be ensured that GP consortia are fully able to take on their new role, fully briefed and aware of the mechanisms to go forward. GP consortia should also draw on the expertise of other key experts involved in the General Practice such as nurses, consultants and clinical academics.

JSNA as well AS local demography and consultation with individuals and groups in the community will be essential for GPs to successfully understand their local area and commission services.

Local accountability is also crucial for the governance of GP consortia.

11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

The Government will need to consider how this will operate as without geographical discretion, there will be increased complexities relating to which public health body the consortia is in partnership with etc. Co-terminosity will be of paramount importance in order to manage relationships and commissioning effectively.

12. Should there be a minimum and/or maximum population size for GP consortia?

There should be some prescription with regards to consortia size in order to ensue consortia are a sufficient size to manage risk. Consortia should also not be too large that they monopolise whole areas but also not too small that they cannot deliver services across local areas in respect of the efficiencies envisaged.

Freedoms, controls and accountabilities:

13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?

We are not sure they can do this unless they are a sufficient size, they must develop effective links with the local authority.

However, GP consortia should begin collaboration early and PCT's, other health bodies that commission services, local authorities, the Local Strategic Partnership and the voluntary and community sector should provide advice and support with regards to this.

14. What support will GP consortia need to access and evaluate external providers of commissioning support?

GP consortia need to link to existing local and national experts.

16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Accountability locally and accurate information also developed with equalities impact assessments.

17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

The commissioning outcomes framework should focus on patient experience, patient outcome, patient choice and value for money.

18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

This needs to be considered in detail, whilst a practice would appear to be achieving in terms of commissioning priorities they may be failing to engage properly and this may affect the quality of service provision.

19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

GP consortia should ensure that prior to commissioning services they are fully aware of their local area and all local health needs. Efforts should also be made to get the views of hard-to-reach groups. Again, we would emphasise the importance of local monitoring through HealthWatch and Overview and Scrutiny.

Partnerships:

20. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

GPs can best involve local patients through open consultation and liaison with service users, the local authority essentially through the established structures such as Overview and Scrutiny, HealthWatch etc. It will be important to alert GPs of the existing structures in place.

21. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

As detailed in the response to question 19, efforts should be made to consult with hard to reach groups and consideration should not just be given to demographic and statistical information. Local HealthWatch, other voluntary and community organisations and colleagues in the local authority should also be consulted. The Health and Well-being boards should be used effectively to compliment commissioning arrangements and ensure that information that already exists is utilised.

22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?

Strengthening and building on existing relationships should begin from now by ensuring they are fully integrated in all the plans and they are co-oridnated and joined up with one another..

23. 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 and, where appropriate, staff?

In order to ensure no-one is disadvantaged, effective local monitoring and engagement, working through HealthWatch and Overview and Scrutiny to gain the views of local people on performance in order to hold providers to account will be of paramount importance.

24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

Local authorities should work with PCTs and potential lead GPs to map what needs to be in place to support the delivery of effective healthcare and identify how and by whom this should be provided. Consideration of the infrastructure that needs to be in place should also begin from now.

It is important that the borough has quality universal services but also targeted services should be supported by evidence by developing links with local authorities and other partners. It will be of primary importance that data is brought together to influence and direct targeted services through established partnerships such as the Local Strategic Partnership.

Transparency in Outcomes: a framework for the NHS

Detailed below are responses to some of the individual consultation questions:

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?

We are in general agreement with the key principles that have been set out that will underpin the NHS Outcomes Framework as it is essentially very generic with a wide scope. The internationally comparable and evolving principles will need to be planned well and in advance to ensure that they are clinically useful. It will be important that the outcomes framework aids stability and there is benchmarking with appropriate comparators and therefore there will need to be some level of targets and monitoring.

We welcome change to the current method of performance monitoring which is cruder and more target-driven. The new framework should be more encompassing though in turn it will be harder to monitor. Although the removal of top-down targets is welcome, caution needs to be exercised in relation to the replacement of process targets with some patient reported outcome measures.

The document alludes to more autonomy for local areas to develop more local targets and improvement standards. It will be key that GPs embed these principles into their commissioning and service plans.

2. Are there any other principles that should be considered?

Some targets (e.g. a 4-hour wait maximum in A&E, an 18-week wait maximum for cancer treatment) should still be in place. We feel there is still a need for some time-fixed targets which should in turn be related to international comparisons. However, this also opens up the scope for regional variations and postcode lotteries.

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

In order to deliver more equitable outcomes, a robust JSNA will need to be carried out in order to inform the strategic policy formulations of the Health and Well-being board and their decision-making processes. Existing Health Inequality Strategies should provide a framework for the Health and Well-being Board.

Consultation with key partners on the Health and Well-being board and the local voluntary and community sector and with patients will assist in delivering more equitable outcomes. Epidemiology should also be a key consideration in the development of the Outcome Framework.

Services that aren't a priority for any one geographical area but need to be addressed nonetheless across a region or locality also need to fit into the outcomes framework. Consideration needs to be given to how this will be developed.

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Improved joint working via Health and Well-being boards will help as long as all the relevant agencies are involved and co-operating with the board.

Some co-ordination will also need to take place at a higher level to ensure the commissioning of specialist services that aren't necessarily needed often but the need for them across a region, remains.

We are concerned that GPs will not have the experience and specialist knowledge to commission for rarely seen conditions for example sickle cell. There is also great concern about the delivery of mental health services.

5. Do you agree with the five outcome domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?

We are in agreement with the five main domains of the NHS outcomes framework. However, a more positively phrased outcome than 'preventing people from dying prematurely' would be preferable. In addition there are no standards regarding end-of-life care, for example dying at home and outcomes for the bereaved. The domains do not feature any element of personal care or ask people to help themselves i.e. how will people look after their own health, lifestyle factors, and prevention.

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

Some reference should be made to public health and promoting well being in the outcomes framework.

Establishing HealthWatch

The Chair of Harrow LINk was in attendance at the White Paper workshop and detailed below are some of the key points the LINk raised relevant to the establishment of HealthWatch and supporting patients.

The Harrow LINk have also sent a separate response and their response was also based on feedback from a public meeting that was held on 20 September 2010. The LINk

response was developed taking into account the views of the executive committee, LINk participants and local members of the public.

Re-shaping patient services

- Harrow LINk considers HealthWatch can work with local people to ensure that their needs are known and acted on by service commissioners and providers. To achieve the proposed objectives HealthWatch must be sufficiently resourced and marketed and a statutory requirement for service commissioners and providers to liaise with HealthWatch must be in place.
- Harrow LINk believe that older people, people with a disability, people who do not speak English well, or carers for someone who has any issues or concerns with health and social care provision should be signposted to an appropriate service.
- Harrow LINk agree that HealthWatch should play a key role in monitoring health and social care services and that LINk independence is maintained and increased with secure funding.
- Harrow LINk feels that funding for HealthWatch from Government (the tax-payer) should be guaranteed as long as HealthWatch is regulated by HealthWatch England.

Having more say about your care

- Harrow LINk consider GPs (consortia), the local authority and local HealthWatch organisation can best take account of the local public's needs and reflect these in planning services provided that: there are clear responsibilities for:
  I. the timely collection and reliability of a variety of data about people's needs
  II. regular independent surveys to get people's feedback on the services used
  III. an accurate analysis of patient's health or social care information
  IV. public events involving patients and customers of health and social care services

- Harrow LINk considers HealthWatch must work with GP consortia, and this should be supported by a statutory responsibility for HealthWatch and GP consortia to work together on the commissioning and ensuring the monitoring of those services. This will require:
  I. GP consortia to work with patient groups with the support of HealthWatch to understand their needs at a local level.
  II. A statutory responsibility for HealthWatch and Local Authorities to work together to commission and monitor public health and social care services.
  III. GP consortia, local authorities and HealthWatch working for the same geographical areas as this will assist in the joint working relationship between them, however attention should be given to any cross-border working.

- The detail of the guarantees for patients and social care users about the choices they can make has yet to be fully agreed but Harrow LINk consider that patients should have the right to:
  I. choose a GP
  II. choose a hospital
  III. choose social care services
  IV. access to all relevant services

- The Government proposes to discuss patient information and choice in a consultation document, which is due to be published in late October 2010. Harrow

LINk thinks that the contents of the paper on choice and information may impact on and alter their responses to the questions in this document.

- Harrow LINk feels HealthWatch will be able to provide the best feedback to improve the health and social care services from a users standpoint.
- Harrow LINk would recommend the introduction of a suitable prevention plan jointly set by health and social care services to help people to be healthier.

Equality

- Harrow LINk supports any action where everyone is treated equally and fairly, and in line with the legislation affecting equality law.

Regulating Healthcare Providers

The development of an economic regulator which is independent of political influence could be beneficial in building specialist skills that will aid transparency in the way prices are set, promote competition and manage market failure.

The document proposes that protection of patients and the public by improving health outcomes that will be achieved through the promotion of competition and effective regulation through Monitor. However there is a dilemma in the promotion of the free market as a mechanism for delivering quality as it has the potential to increase inequality through an increased postcode lottery and a variation in terms of service provision.

The Government should also develop protocols with regards to how the National Commissioning Board will resolve disputes between the two regulators, NICE and Monitor. Some clarity also needs to be provided with regards to the relationship between the local authority, Monitor and NICE and how they will intervene in local authority decision making, should it be necessary.