

**HAMPSHIRE COUNTY COUNCIL****Decision Report**

<b>Decision Maker:</b>	Cabinet
<b>Date:</b>	27 September 2010
<b>Title:</b>	Hampshire County Council response to the 'Equity and Excellence: Liberating the NHS' White Paper consultation
<b>Reference:</b>	1998
<b>Report From:</b>	Director of Adult Services

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## **1. Executive Summary**

- 1.1. The purpose of this report is to provide an overview of the proposals in the 'Equity and Excellence: Liberating the NHS' White Paper and its supporting documents and to propose a response to the consultation for Hampshire County Council.
- 1.2. This White Paper sets out an enormous programme of change for the NHS. It maintains the founding principle of the NHS 'free at the point of use' but emphasises the intention to engage much more with patients, in line with the long-standing disability principle: 'There will be no decisions about me without me'.
- 1.3. The three-year change programme set out in the White Paper will have major implications not only for the NHS but for local authorities, for the private health sector, and for voluntary and community organisations.
- 1.4. The plans set out in the White Paper include devolving the majority of NHS commissioning to be undertaken by new GP consortia, setting up a national, independent NHS Commissioning Board and abolishing Primary Care Trusts and Strategic Health Authorities.
- 1.5. The Department of Health will in future focus on improving public health, tackling health inequalities and reforming adult social care. Responsibility for local health improvement is to transfer to local authorities who will employ the Director of Public Health.
- 1.6. A Health Bill setting out the required legislative changes, and a White Paper setting out the programme for public health, are planned for Autumn 2010. As regards adult social care, the Government plans to bring together the conclusions of the Law Commission and the independent Commission on funding long-term care into a further Social Care White Paper in 2011.

1.7. Responding to the White Paper consultation documents is just a preliminary step. The White Paper's implications will mean a major programme of change for the County Council, Hampshire Primary Care Trust, GPs and other professionals in health and social care across the county. Cabinet members and other councillors will be briefed on the developing health agenda, and their involvement will be crucial in ensuring the success of the reforms.

## **2. Contextual information**

2.1. The White Paper was published on 12 July 2010 and consultation closes on 5 October 2010. In summary, the most significant proposals in the White Paper are:

- a) the creation of an independent national statutory NHS Commissioning Board organisation which will be accountable to the Secretary of State but free of 'day to day political interference' to provide national leadership, ensure quality improvement and that the NHS delivers;
- b) the devolvement of power and responsibility on a statutory basis of the bulk of NHS commissioning from Primary Care Trusts (PCTs) to local consortia of GPs which will be in shadow form from 2011/12;
- c) the establishment of a Public Health Service, which will integrate the Health Protection Agency, nutrition element of the Food Standards Agency as well as Public Health Observatories. Public Health will be responsible for resilience, emergency planning, vaccination, screening and health improvement, and potentially other functions;
- d) the transfer of public health budgets from PCTs to local authorities. The health improvement funding may include a health premium rewarding local authorities for tackling health improvement challenges among disadvantaged communities, and targeting public health resources on those with poorest health. The budget is expected to be ringfenced;
- e) there will be a local strategic coordination role for local authorities and new statutory responsibility to take on a number of functions including patient and carer involvement and the oversight of commissioning of local NHS services, social care and health improvement through a new Health and Wellbeing Board;
- f) public and patient involvement will have its fifth change in seven years with Local Involvement Networks (LINKs) transforming into a new consumer champion, HealthWatch, operating at both national and local level;
- g) the new local HealthWatch will continue to promote patient and public involvement and seek views on local health and social care services to inform commissioning, but it is also proposed that it would perform a wider role, so that it becomes more like a 'citizen's advice bureau' for health and social care and takes over the role of advocacy provision and handling for NHS complaints;

- h) the abolition of both strategic health authorities by 2012/13 and primary care trusts by April 2013 with direct management from the Department of Health centrally prior to that;
- i) commissioning, finance and quality will be regulated through three bodies with new or reshaped roles: the NHS Commissioning Board, Monitor and the Care Quality Commission (CQC);
- j) all NHS trusts will be required to become foundation trusts or a social enterprise by 2013, gaining greater independence and financial freedoms; and
- k) a refocusing of the Department of Health on adult social care, health inequalities and public health, moving away from direct running of the NHS.

2.2. Four supporting consultation papers have been published setting out in more detail the proposals in the White Paper. These are:

- a) *Increasing democratic legitimacy in health*, which seeks views on how local democratic participation in health can be increased and how the NHS can work more closely with local government to make sure local services are joined up;
- b) *Commissioning for patients*, which sets out proposals for putting local consortia of GP practices in charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board;
- c) *Transparency in outcomes: a framework for the NHS*, which seeks views on the proposed NHS Outcomes Framework, which will support the delivery of better health outcomes, for which the NHS Commissioning Board will be accountable; and
- d) *Regulating healthcare providers*, which sets out proposals for more autonomous healthcare providers and for the role of the proposed economic regulator.

### **3. Impact and opportunities for Hampshire County Council**

- 3.1. It is very positive for the County Council that central government clearly recognises the need for greater democratic accountability in health services. Together, elected members, the Director of Public Health, Adult and Children's Services will all be involved in the new local authority functions with NHS commissioners through a duty of partnership, led by a new statutory Health and Wellbeing Board which would bring together all the key partners locally across health, local government and the new local HealthWatch.
- 3.2. The County Council will in future be taking the lead for Hampshire's Joint Strategic Needs Assessment, building partnership for service change and priorities, and integrating partnership working. This is good news for Hampshire's service users and carers as it will allow

much more joining up of services across different organisations to provide a better experience for the individual.

- 3.3. There are significant opportunities for the County Council to be a key partner in the joint commissioning of services with the new GP consortia. The County Council has expertise in Adult and Children's Services that would facilitate more effective and efficient provision of community health and care services.
- 3.4. It is our intention to engage with GP commissioning consortia about opportunities to work together and potentially joint commission community care and health services.
- 3.5. Local authorities can make a very significant contribution to the public health agenda through their range of services and the plan to shift responsibility for health improvement to local government is a welcome challenge.
- 3.6. Given the population size of Hampshire and the number of neighbouring authorities, there are implications for both Adult and Children's Services in developing new joint commissioning relationships both within County Council boundaries and beyond. There is no requirement for GPs to form consortia (or clusters) in groupings that fit within local authority boundaries. Given the positioning of local general hospitals and existing patient flows, there is a real risk for Hampshire that there will be added complexity and relationship management issues. There have been very significant benefits for Hampshire in having one coterminous PCT with which to work, as the County level is the natural geographical focus to manage system wide working across health and social care.
- 3.7. Having said that, over the years, Adult Services has been developing good relationships with GPs and GP lead commissioning groups. There is a real opportunity to further develop these relationships and to share expertise from within Adult Services. In addition, there are opportunities for the County Council to offer support to GP consortia, during and after transition, for example, commissioning, service user and carer involvement and other specialist expertise, back office functions, accommodation and other shared services.
- 3.8. It is important that the County Council responds quickly at local level to the NHS reforms and engagement with health colleagues, including through existing GP practice-based commissioning clusters, is already underway. The County Council established a Health and Wellbeing Partnership Board in June 2008 and the intention is to build on the already good relationships and successes of this current partnership arrangement, along with the Hampshire Senate and District-level Health and Wellbeing Partnerships.
- 3.9. The Government's proposed timetable indicates that GP consortia should be established in shadow form in 2011/12 and we will want to offer support to our health colleagues to achieve this. There is an expectation that arrangements to support a shadow Health and

Wellbeing Board should begin in April 2011. This will be a good mechanism for ensuring that local government and GPs begin to shape the necessary changes together. It is recommended that Cabinet give approval for work to commence to put in place the arrangements for a shadow Health and Wellbeing Board. This newly revised partnership board will be a key forum for members to influence health commissioning.

#### **4. Responding to the consultation**

- 4.1. A summary of the proposed key messages the County Council might wish to give in response to the White Paper proposals is contained in Appendix C.
- 4.2 The detailed questions contained in the four supporting consultation documents (listed in 2.2 above) are then set out in Appendix D with a proposed response where the County Council wishes to comment. *Increasing democratic legitimacy in health* and *Commissioning for patients* are the two consultations most pertinent to local government, so a more detailed response is given for these than for the other two consultation documents.

#### **5. Finance**

- 5.1 The financial risks to the County Council of the NHS reforms are at this stage unquantifiable. Risks may become clearer after the Comprehensive Spending Review on 20 October 2010 and when the Health Bill and Public Health White Paper are published in the Autumn. Although the Government has committed to protecting health spending, there will in reality be a real terms reduction in funding of the NHS.
- 5.2 In the short term, there are some implications in terms of the current contract for the LINK which expires in March 2011 and for which the Government has not yet announced ongoing funding in advance of the creation of the new arrangements for National and Local HealthWatch organisations. The estimated cost of either extending the current contract for the LINK or retendering it are up to £300,000 per annum based on the current contract value.
- 5.3 Hampshire County Council has a number of existing partnership arrangements with Health, including with the PCT. It is not certain that these arrangements with the PCT will continue with the replacement GP commissioning consortia. Joint funding is at risk for children and adults who have both health and social care needs, as are efficiencies from joint commissioning.

## 6. Performance

- 6.1 The Care Quality Commission will continue with its quality role, licensing and inspecting health and social care providers. In addition, it will include the newly created independent consumer champion, HealthWatch England
- 6.2 Monitor, the existing regulator for foundation trusts, will have an expanded role as an economic and competition regulator for both health and social care.
- 6.3 The White Paper signalled the Government's intention to reduce the burden of regulation across health and social care, announcing that it will undertake a significant review, with a view to making major reductions. This is important, since there is the potential for an increase in bureaucracy from the new arrangements, as social care commissioning will be assessed by the Care Quality Commission, with public health having a separate assessment process, through the Public Health Service. The arrangements for assessment and the outcome frameworks need to be aligned at national level.
- 6.4 *Transparency in outcomes: a framework for the NHS*, one of the four ancillary consultation documents to the White Paper sets out the performance framework by which the new National Commissioning Board will judge the performance of GP commissioning.
- 6.5 Performance outcome frameworks for public health and social care are due to be produced in coming months as part of the integrated cross-service approach promised for the Comprehensive Spending Review. It is disappointing that these outcomes framework have not been published together, as this limits the opportunity to view and comment on them in the round.

## 7 Recommendations

It is recommended that:

- 7.1 Cabinet gives approval to responding to the NHS White Paper consultation as proposed in the documents at Appendices C and D.
- 7.2 Cabinet gives approval for work to commence to put in place arrangements for a reconstituted transitional Health and Wellbeing Board to meet the Government's requirements, building on the current health and wellbeing partnership arrangements, with a further report to Cabinet in early 2011 setting out plans for the new Board and other workstreams relating to the implementation of the NHS reform programme.
- 7.3 Cabinet gives approval for the County Council to work in partnership with the PCT to manage the transition and to seek to work with GPs to support their new commissioning responsibilities.

**CORPORATE OR LEGAL INFORMATION:****Links to the Corporate Strategy**

<b>Hampshire safer and more secure for all:</b>	yes
Corporate Improvement plan link number (if appropriate):	
<b>Maximising well-being:</b>	yes
Corporate Improvement plan link number (if appropriate):	
<b>Enhancing our quality of place:</b>	yes
Corporate Improvement plan link number (if appropriate):	

**Other Significant Links**

<b>Links to previous Member decisions:</b>		
<u>Title</u>	<u>Reference</u>	<u>Date</u>
<b>Direct links to specific legislation or Government Directives</b>		
<u>Title</u>	<u>Date</u>	

**Section 100 D - Local Government Act 1972 - background documents**

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

DocumentLocation

None

## **IMPACT ASSESSMENTS:**

### **1. Equalities Impact Assessment:**

The Department of Health has completed an initial equality impact assessment of the White Paper. The proposals have the potential to have significant impact with regard to outcomes for a number of already disadvantaged groups. Hampshire's consultation response includes comments on equalities issues where appropriate.

### **2. Impact on Crime and Disorder:**

The County Council has a legal obligation under the Crime and Disorder Act to consider the impact of all decisions it makes on the prevention of crime. The proposals in this report have no impact on the prevention of crime.

### **3. Climate Change:**

- a) How does what is being proposed impact on our carbon footprint / energy consumption?

No impact has been identified as this is a response to a Government consultation process.

- b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

The Government's White Paper and supporting consultation documents do not cover these issues.

## Appendix C

### Hampshire County Council: response to *Liberating the NHS* Summary of the key messages

#### 1. Overall comments

- 1.1 The White Paper proposals are radical and the timetable is going to be challenging. At the same time, the need for greater democratic influence over the NHS system is very welcome, and local authorities will want to embrace the opportunities to lead on joint commissioning and integration of services in their area, working closely with local GPs and other partners. Local authorities can make a huge contribution to the public health agenda and the plan to shift responsibility for health improvement to local government is welcome.
- 1.2 We support the notion of bringing together local authority members and officers, public health professionals, GPs and other commissioners, plus local Health Watch to help tackle health improvement and to join up commissioning in Hampshire. One of the core purposes of the Health and Wellbeing Board will be to give accountability, impetus and authority to joint working across health and social care. Creating a statutory duty of partnership and a statutory Health and Wellbeing Board will assist with making change happen, as long as the Board has some means of enforcing cooperation, where necessary.

#### 2. GP commissioning

- 2.1 The County Council welcomes the opportunity for closer working with GPs in their new consortia. However, the proposals are weak on the level of accountability that GP consortia will have to their local populations. The White Paper signals the introduction of a more democratic locality-based approach, however most of the leverage and influence rests with GP consortia and at the national level with the NHS Commissioning Board. There is, for example, no democratic representation in how primary care is held to account, since its official accountability line is to the National Commissioning Board. Although the proposed Health and Wellbeing Board will have a coordinating role, GPs will be part of that Board so not in a position to be held accountable by it.
- 2.2 There is no requirement that GPs form consortia that stay coterminous with local authorities. There is potential for practices to join with a variety of areas, such as Surrey, Berkshire East and Portsmouth, if they feel that it is in the best interest of their patients. Local authorities' primary concern is to deliver, in partnership, the best outcomes for their residents. Experience in Hampshire has shown that this can be done much more effectively when health and social care are operating within the same boundaries, as the critical mass of the health and social care economy across Hampshire

allows considerable economies of scale, efficiencies of process and increased leverage in the market.

- 2.3 The White Paper suggests the Government is considering exploring further the potential for 'place-based budgeting'. It is very unclear how a shared budget for spending in an area could work without GP consortia and the upper-tier local authority sharing boundaries. Local area agreements are not planned to continue, however thought does need to be given to how GPs would be held to account in any future local partnership arrangements across the wider spectrum of public sector bodies in a locality.
- 2.4 The County Council's work with different minority groups continues to show that they do not access primary care services as well or as appropriately as the general population. Given that there are inequalities in access to and satisfaction with existing NHS services, there needs to be a new model which will enable GPs to be better and more inclusive commissioners. Expertise built up in local authorities, and especially in social care, is a potential source of support for easing the transition from PCTs. We would support the suggestion in the current consultation on the Public Sector Equality Duty that GP consortia, once created, should be made subject to the public sector duties of the Equality Act 2010.

### **3. Local HealthWatch**

- 3.1 *Increasing democratic legitimacy in health* sets out proposals for additional responsibilities for what was the LINK (Local Involvement Network) and will become Local HealthWatch. However, the new proposed responsibilities seem to duplicate existing activity. For example, if the intention is for Local HealthWatch to become a 'health and social care citizens' advice bureau', it might be much more cost-effective to consider giving this role direct to CAB, since they are already set up and active in most areas and trusted by the public.
- 3.2 We are also concerned about the lack of flexibility for local authorities who could be required to commission either Local HealthWatch or national HealthWatch to provide NHS complaints advocacy. In the first instance, we would question whether NHS complaints advocacy is an appropriate role for HealthWatch: complaints advocacy is a specialist area and cannot be undertaken by lay people. Additionally, if this new role is transferred as a service that local authorities have to commission, then they should have the freedom to commission it from the best provider in their area – either through local CABx, who have the ability to provide advocacy, or other advocacy services available locally if this presents a more effective option than using HealthWatch.
- 3.3 On a practical level, Government funding for existing LINKs runs out at the end of March 2011. At the moment, the Government has not committed to ongoing funding for LINKs in advance of them becoming Local HealthWatch organisations in 2012. A commitment from the Department of Health to continue funding LINKs in the short-term would be helpful.

#### **4. Plans for a statutory Health and Wellbeing Board**

- 4.1 In principle, we support the idea of bringing together the range of partners involved, to have a statutory role in joining up local commissioning, particularly across the boundaries of health and social care. However, local authorities need to have some scope to influence how the Board works in their area in order to be effective.
- 4.2 The White Paper consultation does not make clear what the role of the Board is expected to be and whether it would be part of the local authority's democratic governance structure. Some clarity on this would enable us to respond more fully on these proposals. Democratic legitimacy in health, far from being bolstered by these proposals could be diluted, since incorporating the functions of the Health Overview and Scrutiny Committee (HOSC) within the new Health and Wellbeing Board does not allow separation within the local authority between the executive decision making function of members and their ability to hold those making decisions to account (a democratic governance or scrutiny function). There is the potential to streamline local authority scrutiny, if required, however our preference would be to retain some form of distinct health and social care scrutiny function at arms' length from the new Health and Wellbeing Board.

#### **5. Public health and reducing inequalities**

- 5.1 It is very positive that the potential of local government to make a difference to the public health agenda has been recognised. The provision of basic, essential public health services started off in local authorities after all, although the new public health agenda is now more around health improvement and behaviour change, with national arrangements being proposed for the more clinical elements of public health. It is important that sufficient funding comes to local authorities to discharge these new responsibilities effectively.
- 5.2 We already have a jointly appointed Director of Public Health, working across the PCT and local authority, and welcome the decision to locate the Director of Public Health within the local authority under the new arrangements. We can see how this will enable wider resources to be harnessed and integrated to improve health outcomes locally.
- 5.3 Local authorities' role in the new public health arrangements will be important in ensuring that equalities issues are considered and that outcomes for disadvantaged groups improve.
- 5.4 It is likely that GPs will need support to be better and more inclusive commissioners, with a clearer understanding of equality issues. This is an area where local authorities, in particular social care departments, have expertise that could assist GP consortia.

## Appendix D

### Response to the NHS White Paper consultation questions

All of the consultation questions for the four papers are listed below for information. Not all questions are relevant to a local authority, therefore suggested responses are provided just to the applicable questions where the County Council has a view.

#### 1. Local democratic legitimacy in health

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_117721.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_117721.pdf)

**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?**

The NHS Constitution sets out what staff, patients and the public can expect from the NHS. Thus, it seems an appropriate role for Local HealthWatch to continue to take an interest in this. However, the formal role should sit with the proposed Health and Wellbeing Board: Local HealthWatch's role is to gather concerns and evidence.

**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?**

We are concerned that the enhanced role of local HealthWatch will duplicate a number of services that are already provided in our communities. If the ambition is for Local HealthWatch to become a health and social care citizens' advice bureau (CAB) then arguably it might be better to have the freedom to commission this from other organisations, such as CABx since they are already set up and active in most areas.

Additionally, we do not think that the NHS complaints advocacy role sits best with Local HealthWatch. Both complaints advocacy and seeking the views of patients and the public require particular skills that generally sit with professionals rather than lay members. Local Authorities already commission advocacy services and these or CABx may be able to undertake this work if funding is available, thus avoiding duplication and making better use of existing services. Alternatively this work could be directed through a local office of the Health Service Ombudsman.

Local authorities need the freedom to commission complaints advocacy separately

from local HealthWatch.

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

Local authorities need an adequate budget to complete any commissioning processes and fund local HealthWatch; and a set of clear expectations about what outcomes it is expected to deliver. They then need the freedom to determine what is the best model for the area, commissioning the most appropriate provider, e.g. that may be to commission a coordinator of a network of networks, to address the lack of inclusivity of many existing LINKs rather than a 'host' which risks becoming the organisation itself. There is also a need to clarify the relationship between national and local HealthWatch and between adjoining areas' Healthwatch organisations which may need to work together.

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

The Department of Health should grant a general power for local authorities & GP Consortia to act on each others' behalf – perhaps subject to the proposed Health and Wellbeing Board's approval and agreement that the arrangements to manage outcomes and risks are appropriate – or a general power for local authorities to contract on behalf of GP Consortia. It would be helpful if there were more flexibility in the system to shift resources more easily between the community and acute settings. There should also be a requirement on GP consortia to work with local authorities to consider jointly commissioned community-based services.

The Department of Health should ensure there is a rationale for GP Consortia geographical boundaries – which should be coterminous with local authorities unless there is a good reason why not. We recommend a duty on GP consortia to consult local authorities on boundaries and commissioning arrangements. Consortia should support population sizes that make sense for an area – e.g. larger for county areas – closer to 300-400,000.

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

In order for joint commissioning and integrated working to be effective, a duty to share information, particularly management information, is required. This is emerging as a real issue/barrier for local authorities, particularly where they are working with a range of providers who currently do not want to share what they see as commercially sensitive management information.

A specification to use common data sets for population-based data to support commissioning through the Public Health Service would be helpful.

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

Yes, statutory powers are needed. Evidence shows that formalising requirements increases compliance. It also legitimises engagement. Any statutory power needs to also compel partners to engage. A duty on GPs to cooperate with local authorities and the Public Health Service, and power for the local authority to scrutinise GP commissioning strategies in advance of implementation, would ensure regular engagement of GP consortia and provide a clear governance framework.

**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?**

Yes, having a statutory board, with partners having a duty to cooperate and with scrutiny arrangements on a statutory footing, will give automatic legitimacy. Many areas have already developed local mechanisms to pursue progressing joint working arrangements. These should be built upon. We are however of the view that beyond that there should be maximum flexibility for local authorities to determine the details of how the Health and Wellbeing Board would work best in their area.

The relationship between the Health and Wellbeing Board and the Children's Trust is not outlined and would need some clear outlining. Our preference would be that the Children's Trust remains the engine room for children's joint working but that there are clear accountabilities between this and the Health and Wellbeing Board.

**Q8. Do you agree that the proposed Health and Wellbeing Board should have the main functions described in paragraph 30?**

We agree with the first three functions. With regard to the fourth, although we strongly agree that undertaking a scrutiny role in relation to major service redesign is a crucial function for the local authority, we disagree that the board should lead on this.

The Health and Wellbeing Board will include lead commissioners of local services: these same people cannot scrutinise their own commissioning and service redesign decisions. It would be more appropriate for the Health and Wellbeing Board to consider referring a matter for member led scrutiny, using the existing Health Overview and Scrutiny Commission (HOSC) process: local authority Cabinet members and full Council can already do this. We strongly support the ambition of this paper to increase democratic accountability in health, and statutory scrutiny by elected members is an effective means of achieving this. This should include GP consortia and local Health Trusts.

Our preference as stated is to retain a separate health and social care scrutiny

function. However, if the decision is taken that the HOSC should be subsumed within the new Health and Wellbeing Board, then local authorities at least need the ability to set up a scrutiny sub-committee of the Health and Wellbeing Board – on a statutory footing – made up of those who neither commission nor provide.

**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?**

The current JSNA guidance was published on 13 December 2007 and would benefit from being updated, as would the dataset, to provide a better balance between health, social care and children and young people.

**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?**

Children's Trusts have the overarching responsibility for strategic planning intent and priorities for children and young people. It would therefore be paramount that strong links are made between the Trust and the Board. JSNA guidance should encompass incorporating a chapter on children and young people to inform the Children and Young People's Plan. The work of the Trust and Board should be informed by one another.

**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?**

The County Council deals with this issue on a regular basis across a range of thematic partnerships and networks and has a good track record in this respect. In relation to democratic accountability, for example, HOSCs currently have requirements placed on them to work together on cross-boundary issues and local practice in Hampshire has been to involve district councils in matters referred to the HOSC as appropriate. There is also scope for any district to refer a matter of concern to the HOSC. This flexibility enables elected members to scrutinise a range of health and wellbeing issues that impact on local communities and is already established in legislation.

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

We agree that the upper-tier Local Authority should lead the Board and determine its chairmanship. Very little has been said in the consultation about how the

governance within each GP consortium would work, but we certainly agree that an accountable person from each applicable GP consortium would need to be a statutory partner on the Board. Beyond this, there should be maximum flexibility to determine who sits on the Board.

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

The key to this lies in the governance arrangements, which is why the Health and Wellbeing Board should be on a statutory footing, with both commissioning and providing organisations under a duty to cooperate. Additionally it needs to be clear that GP consortia will be accountable to the communities they serve through elected local councillors. This is not present in the current proposals and is one route through which democratic engagement can be enhanced in the new arrangements. HOSCs already have a duty to seek to resolve issues locally and have a good track record for doing so.

**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)?**

No, we believe there should be a separation between commissioning and scrutiny and would favour retaining the Health Overview and Scrutiny function (see response to Q8).

Whatever the arrangement, there needs to be clarity about the accountability of the Health and Wellbeing Board to the local authority's scrutiny function.

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

There should be a duty on all providers of services funded by NHS money (including foundation trusts, voluntary and private providers) to cooperate. As a minimum, the current requirements relating to the NHS and local government scrutiny need to be preserved. HOSCs already have to demonstrate that they have considered an issue from the perspective of those affected rather than specific individuals or communities and evidence the reasons for any referral.

**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?**

We believe that HOSCs should be left as they are to fulfil this function. If this is not possible, an alternative may be to consider the establishment of a health and

wellbeing scrutiny committee as a sub-board of the Health and Wellbeing Board, with the actual commissioners/decision makers sitting on an executive. It is important that there is a clear distinction between the executive and non-executive roles of elected Members. Either way the mechanism needs to be light touch and work for local areas. Statutory arrangements to support this function and clarity about the associated responsibilities of the board will be essential.

**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?**

The proposals set out in the paper have the potential to have significant impact on outcomes for a number of already disadvantaged groups.

Local authorities are well equipped to work with local health partners to share intelligence and experience of the needs of the local communities, particularly disadvantaged groups, and to support GP consortia in their commissioning role.

## 2. Commissioning for patients

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_117705.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_117705.pdf)

**Q1. In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?**

By providing them with clinically safe, locally sensitive services and ensuring that sub-national specialist commissioning has a routine route of contact with the GP consortia.

**Q2. How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?**

Low volume services are often so low volume that individual GP consortia may not have any such patients, so aggregation across larger areas and support from the Public Health Service may be useful.

**Q3. Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?**

Probably not, by definition.
<p><b>Q4. How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?</b></p> <p>By actively participating in GP commissioning consortia.</p>
<p><b>Q5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?</b></p> <p>By jointly commissioning community-based health and social care with local authorities. Also, by providing their commissioning plans to the Health and Wellbeing Boards to ensure appropriateness for the local authority populations.</p>
<p><b>Q6. 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?</b></p> <p>Perhaps having a lead NHS Commissioner to develop the relationship. The GP consortia also need to develop strong relationships with their local authority and local HealthWatch.</p>
<p><b>Q7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?</b></p> <p>Ensuring that consortia are locally accountable and that scrutiny of healthcare delivery is separated from commissioning.</p>
<p><b>Q8. 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?</b></p> <p>See Q6.</p>
<p><b>Q9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local</b></p>

**commissioning?**

The NHS Commissioning Board should seek explanations from consortia where they are not entering into arrangements with local authorities for community-based joint commissioning.

**Q10. What features should be considered essential for the governance of GP consortia?**

There should be a clear relationship between GP consortia, Health and Wellbeing Boards, and the HOSC (if the latter is retained). GP consortia should also be required to demonstrate accountability to their local population, including through the Health and Wellbeing Board.

**Q11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?**

Coterminosity with local authority boundaries is a major benefit of the current PCT arrangements, and it would be problematic for councils to have to deal with perhaps several partially out-of-authority consortia. We believe there should not be flexibility to include practices out of the geographically discrete area, as it would unnecessarily overcomplicate joint commissioning.

**Q12. Should there be a minimum and/or maximum population size for GP consortia?**

Consortia need to support a population size that makes sense in their area. This will be different in a densely populated urban area from a large county area like Hampshire, where it might be appropriate for a consortium to serve at least 300-400,000 people.

**Q13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?**

By working closely with local authorities and their public health team, who have expertise in commissioning, demography etc. The JSNA should be an effective commissioning tool, and needs to develop to enable some forecasting. There is a need for GPs' commissioning arrangements to be geographically consistent with the local authority – particularly for larger areas.

**Q14. What support will GP consortia need to access and evaluate external providers of commissioning support?**

<p><b>Q15. Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?</b></p>
<p><b>Q16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?</b></p>
<p><b>Q17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?</b></p> <p>This should include outcomes for children, along with integrated outcomes for health and social care that will assist with and encourage integrated service delivery across health and social care.</p>
<p><b>Q18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?</b></p> <p>Yes.</p>
<p><b>Q19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?</b></p> <p>Through close working with local authorities and their public health team who will have the lead on health improvement, with the Public Health Service, Local HealthWatch and with the voluntary sector.</p>
<p><b>Q20. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?</b></p> <p>The duty to engage and involve the population affected by a service change already exists for the NHS. This needs to be maintained in the new arrangements for both the consortia and the NHS Commissioning Board. Local accountability for providing assurance that this has taken place should be through Local HealthWatch.</p>
<p><b>Q21. 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?</b></p>

Through engaging with local elected Members, with local authority staff, local HealthWatch and with the voluntary sector. Existing engagement channels should be used where possible to minimise duplication and to ensure efficiency.

**Q22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?**

We have commented already on the consultation 'Local democratic legitimacy in health' in relation to Local HealthWatch.

**Q23. 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?**

Evidence over the years has shown that BME people, and especially women from those communities, do not access primary care services as well or as appropriately as their indigenous counterparts. They do not access information, and get 'lost' in the system. Their capacity to be involved in decisions either at an individual level, or as a contributor to the type and quality of service can be severely impeded.

Similarly, there is significant evidence that inoculation and vaccinations for MMR are very low in Gypsy and Traveller communities, leading to significant treatable illnesses amongst these communities.

We suggest that in order to address this, local authorities and GPs may wish to work together using a community development model, targeting excluded communities, especially in those geographical areas where their numbers are low is considered. This could be overseen by the Health and Wellbeing Board.

**Q24. 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?**

Many local authorities already have a joint appointed Director of Public Health, who is well placed to shape these links, working with Directors of Adult and Children's Services, as well as with Housing and other departments.

**Q25. What can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current**

**practice will need to be preserved in the transition to the new arrangements?**

Having a statutory basis for joint working and partnership is important, to ensure credibility and effectiveness, but there needs to be flexibility for arrangements to be determined according to the needs of the local population.

**Q26. How can multi-professional involvement in commissioning most effectively be promoted and sustained?**

Multi-agency governance arrangements are the key to this.

### 3. Regulating healthcare providers

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_117842.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_117842.pdf)

**Q1. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?**

Yes, but only after they have delivered their publicly funded responsibilities. They should be barred from using public funds to subsidise private work. Further they should be able to demonstrate a 'return' to the publicly funded part of their work for the use of tax payer funded assets.

**Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?**

**Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?**

Constitutional changes should be subject to local authority statutory scrutiny as well as by Monitor.

**Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?**

Mergers or acquisitions too should be subject to local authority statutory scrutiny.

**Q5. What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?**

Their Boards should be obliged to meet in public.

**Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?**

Yes, there is a role, which should be through local authority statutory scrutiny.

**Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?**

As a local authority, we are concerned about accountability of foundation trusts to their local population, and would wish to see strengthened arrangements in this area, and the ability for more local scrutiny of decisions if required.

**Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?**

There should not be exemptions.

**Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?**

Yes, in principle.

**Q10. Under what circumstances should providers have the right to appeal against proposed licence modifications?**

**Q11. Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?**

**Q12. How should Monitor have regard to overall affordability constraints**

<b>in regulating prices for NHS services?</b>
<b>Q13. Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?</b>
<b>Q14. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?</b>
<b>Q15. Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?</b>  Where they are not delivering against their statutory requirements or at reduced quality.
<b>Q16. What more should be done to support a level playing field for providers?</b>  At the moment, the playing field is not level, in that some NHS providers have significant capital and other assets which can support their 'offer' which other smaller or independent providers may not have. This issue needs consideration.
<b>Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?</b>
<b>Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?</b>  Yes, if there are issues where a healthcare provider might be unsuccessful financially, especially resulting from its inheritance and/or where it is the only geographically accessible provider.
<b>Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?</b>

Through the NHS Commissioning Board.

**Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?**

**Q21. 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?**

#### 4. Transparency in outcomes: a framework for the NHS

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_117591.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_117591.pdf)

##### *Principles*

**Q1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?**

It would have been helpful for the frameworks for public health and social care to be published simultaneously. We would welcome integrated outcomes for health, social care and public health that will assist with and encourage integrated service delivery across health and social care.

**Q2. Are there any other principles which should be considered?**

**Q3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?**

By ensuring that the local population in its entirety, consistently measured using common datasets, is the basis and by keeping some geographical boundary to GP consortia and their commissioning, informed by the Public Health Service and detailed work over and above the JSNA.

**Q4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?**

As above.

##### *Five domains*

<p><b>Q5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?</b></p>
<p><b>Q6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?</b></p>
<p><b><i>Structure</i></b></p> <p><b>Q7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?</b></p>
<p><b><i>Domain 1 - Preventing people from dying prematurely</i></b></p> <p><b>Q8. Is ‘mortality amenable to healthcare’ an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?</b></p> <p>Yes.</p>
<p><b>Q9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?</b></p>
<p><b>Q10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?</b></p> <p>Possibly not.</p>
<p><b>Q11. If not, what would be a suitable outcome indicator to address this issue?</b></p>
<p><b>Q12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?</b></p>
<p><b><i>Domain 2 - Enhancing the quality of life for people with long-term conditions</i></b></p> <p><b>Q13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?</b></p>

<p><b>Q14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?</b></p>
<p><b>Q15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?</b></p>
<p><b><i>Domain 3 - Helping people to recover from episodes of ill health or following injury</i></b></p> <p><b>Q16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?</b></p>
<p><b>Q17. What overarching outcome indicators could be developed for this domain in the longer term?</b></p>
<p><b>Q18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?</b></p>
<p><b>Q19. What might suitable outcome indicators be in these areas?</b></p>
<p><b><i>Domain 4 - Ensuring people have a positive experience of care</i></b></p> <p><b>Q20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?</b></p>
<p><b>Q21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?</b></p>
<p><b>Q22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?</b></p>

<p><b>Q23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?</b></p>
<p><b>Q24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?</b></p>
<p><i>Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm</i></p> <p><b>Q25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?</b></p>
<p><b>Q26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?</b></p>
<p><i>General Consultation Questions</i></p> <p><b>Q27. 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 outcomes for all patients and, where appropriate, NHS staff?</b></p>
<p><b>Q28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?</b></p>
<p><b>Q29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?</b></p>
<p><b>Q30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?</b></p>
<p><b>Q31. Is there any other issue you feel has been missed on which you would like to express a view?</b></p> <p>Yes, a plea to those regulating or assessing performance (Monitor, CQC, and NHS Commissioning Board) to ensure their infrastructure and performance frameworks are aligned and promote joint working, as for example, health</p>

commissioning will be evaluated by the NHS Commissioning Board and social care commissioning will be evaluated by CQC.

***Potential indicators***

**Q32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?**

**Q33. Are other practical and valid outcome indicators available which would better support the five domains?**

**Q34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?**

***Principles for selecting indicators***

**Q35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?**