

AS PROVIDED FOR UNDER SECTION 100B(4)(b) OF THE LOCAL GOVERNMENT ACT 1972, THE CHAIRMAN IS OF THE OPINION THAT THIS REPORT SHOULD BE CONSIDERED AT THE MEETING AS A MATTER OF URGENCY, BY REASON OF SPECIAL CIRCUMSTANCES. THESE CIRCUMSTANCES ARE THAT THE NHS WHITE PAPER AND CONSULTATION DOCUMENTS HAVE REQUIRED DETAILED CONSIDERATION AND THE PROPOSED RESPONSES, WHICH HAVE ONLY RECENTLY BEEN FINALISED, NEED TO BE REPORTED TO MEMBERS AS SOON AS POSSIBLE.

PAPER NO. **10-629**

WANDSWORTH BOROUGH COUNCIL

ADULT CARE AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 8TH  
SEPTEMBER 2010

EXECUTIVE – 13TH SEPTEMBER 2010

Report by the Chief Executive and Director of Administration on the White Paper: *Equity and Excellence: Liberating the NHS*

SUMMARY

Background: A White Paper setting out the Government's proposals for a fundamental restructuring of the NHS was published on 12th July 2010. Consultation documents on various aspects of the White Paper were published later in the same month.

Policy: Since 1993, the Council has had a policy that it should be the commissioning body for health services in Wandsworth. The proposals in the White Paper do not adopt this model, but they nevertheless greatly increase the influence of local authorities within the NHS. The primary role for commissioning health care will be assigned to GP commissioning consortia, but local authorities will be given lead responsibility for public health (alongside a new national Public Health Service) and will be required to establish Health and Wellbeing Boards to integrate health and social care commissioning and public health programmes.

Issues/proposals: Members are asked to agree the proposed responses to the consultation documents and to support the recommendation that the Council seeks early establishment of a Health and Wellbeing Board and works with GP leaders to establish ways in which the Council can support GP Commissioning Consortia.

Supporting information: Copies of the White Paper and the supporting documents have been placed in the Members' Room and are available at

<http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm>

Conclusions: Overall, the proposals give local authorities a more central role in the NHS than they have ever previously enjoyed

1. **Recommendations.** The Adult Care and Health Overview and Scrutiny Committee are recommended to agree the responses to consultation set out in Appendices One and Two and paragraphs 19 and 23, and to support the recommendation in Paragraph 2.
2. The Executive are recommended to agree that:

- (a) The Council explore with the PCT and the GP Leads of the Locality Commissioning Groups the possibility of establishing a Health and Wellbeing board in line with the model set out in the White Paper; and
  - (b) The Council explore with the GP leads of the Locality Commissioning Groups the ways in which the Council would be able to support GP commissioning consortia in performing their roles.
3. If the Overview and Scrutiny Committee approve any views, comments or additional recommendations on the report, these will be submitted to the Executive or to the relevant NHS body as appropriate for their consideration.
4. **Introduction.** In July 2010 the Government issued a White Paper setting out its plans for the National Health Service. This was supported by the publication of four consultation documents and a report of the review into NHS Arm's Length Bodies. The present paper summarises the proposals, suggests responses to the consultation documents, and makes recommendations for action by the Council in preparation for the new NHS structures.
5. **The White Paper.** *Equity and Excellence: Liberating the NHS* was published on 12th July 2010. The key proposals are:
  - (a) that an NHS Commissioning Board is established to take responsibility for allocation of funding and to oversee commissioning of health services;
  - (b) that responsibility for commissioning NHS services is transferred from PCTs to GP commissioning consortia;
  - (c) that responsibility for health improvement is transferred from PCTs to Local Authorities, with oversight from a national Public Health Service; and
  - (d) that PCTs and Strategic Health Authorities are abolished.
6. **The NHS Commissioning Board.** The main responsibilities of the NHS Commissioning Board will be as follows:
  - (a) to allocate NHS revenue funding between GP commissioning consortia;
  - (b) to assess and hold to account commissioning consortia;
  - (c) to hold contracts for GPs, dentists, community pharmacies and opticians; and
  - (d) to directly commission some services including national and regional specialist services and maternity services.
7. The Secretary of State will issue a brief 'mandate' for the NHS Commissioning Board, setting out priorities for improvement. This is likely to be for a three year period, with annual updating. It will be subject to parliamentary scrutiny and will provide the basis for the accountability of the Commissioning Board to the Secretary of State.
8. **GP commissioning consortia.** All GPs will be required to be members of a consortium. Consortia will be geographically based so that they are able to commission locality-based services and to facilitate co-operation with local authorities. Consortia will have an accountable officer, and may decide which activities they undertake themselves and which they buy in from other bodies (which may include local authorities, private and voluntary sector providers). Consortia will hold contracts with providers but may choose to work together through a lead commissioner model, for example in relation to large teaching hospitals. There is no specific guidance on the size of consortia, but they are expected to be

big enough to manage financial risk – for example, the random fluctuations that may occur in the number of patients requiring specialist hospital treatment.

9. **Public Health.** Details of the proposals for public health will be presented in a further White Paper, to be published later in 2010. Directors of Public Health are to be employed by local authorities, but will be jointly appointed with the Public Health Service. There will be earmarked funding for local authorities for their health improvement roles, and centrally defined objectives.
10. **The consultation documentations.** The four consultation documents are:
  - (a) *Local democratic legitimacy in health*, describing the new arrangements for user and public engagement and the role of local authorities;
  - (b) *Commissioning for patients*, providing further details of the proposed organisation of commissioning;
  - (c) *Regulating healthcare providers*, covering changes to the regulation of NHS providers; and
  - (d) *Transparency and outcomes*, setting out proposals for the new NHS outcomes framework.
11. **Health and Wellbeing Boards.** The main focus of the consultation document on local democratic legitimacy is on the establishment and roles of Health and Wellbeing Boards. It is proposed that there should be one such board for each upper tier local authority. The main roles of the Board would be:
  - (a) to assess the needs of the local population and lead the statutory Joint Strategic Needs Assessment;
  - (b) to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
  - (c) to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense. This includes the possibility of the Board taking responsibility for ‘place-based’ budgets on cross-cutting health issues, with older people’s health, mental health and substance misuse being identified as possibilities; and
  - (d) to undertake a scrutiny role in relation to major service redesign. The statutory functions of Health Overview and Scrutiny Committees will transfer to Health and Wellbeing Boards, although local authorities will be expected to put in place arrangements for scrutiny of the work of the Health and Wellbeing Board.
12. It is proposed that membership of the Health and Wellbeing Boards should include elected members and officers of local authorities, representatives of GP Commissioning consortia, representation from the local HealthWatch and representation from the NHS Commissioning Board when relevant matters are under discussion. The elected members of the Board will decide who is to chair it.
13. **HealthWatch.** The same consultation document also covers the future of Local Involvement Networks (LINKs). These will be renamed HealthWatch, but will continue to be commissioned by local authorities and to have responsibility for promoting patient and public involvement and seeking views on both health and social care. They will be given

the opportunity to take on responsibility for independent complaints advocacy, for which additional funding will be offered. HealthWatch England will be established as a statutory part of the Care Quality Commission to provide a national voice for HealthWatch.

14. **Response to consultation.** The full list of consultation questions contained in the consultation document on local democratic legitimacy, and proposed responses, are attached at Appendix One. Members are recommended to endorse the proposed responses.
15. **Commissioning for Patients.** The consultation document on commissioning focuses primarily on GP commissioning consortia, describing their establishment, responsibilities, powers and accountability. It is suggested that Practice Based Commissioning Groups might form the basis for establishment for GP consortia and that they may begin to develop in shadow format within the current financial year. As noted in paragraph 8 above, there will not be specific criteria for the size of commissioning consortia. There will also be flexibility in relation to governance arrangements, subject to requirements over audit, accountability and reporting. These include the requirement to appoint an accountable officer and a chief financial officer, although the latter may be shared with other consortia. Consortia will be able to buy in external support for activities such as needs analysis, procurement and contract monitoring. This may come from local authorities, private sector or voluntary sector organisations. They will be subject to authorisation by the NHS Commissioning Board before they are able to take on full commissioning responsibilities.
16. The consultation questions raised in this document, and proposed responses, are attached at Appendix Two. Members are recommended to agree the proposed responses.
17. **Regulating healthcare providers.** The third consultation document focuses on the organisation and regulation of healthcare providers. It sets out the Government's proposals in relation to the future of Foundation Trusts and for the regulation of healthcare providers. There is a commitment to continue with the previous Government's policy of encouraging all NHS Trusts to move to Foundation Trust status, and states that all Trusts are expected to become Foundation Trusts within three years. In the event that any NHS Trusts are unable to develop satisfactory plans for this, the Secretary of State will use powers introduced by the previous Government that would effectively strip them of their autonomy and allow another Trust to assume control of their assets.
18. It is proposed to allow Foundation Trusts some additional freedoms, including abolishing the cap on private income, ending statutory controls on borrowing, and allowing more flexibility in relation to governance arrangements, including the right to change their constitutions and offering the possibility of different governance models including staff-only membership. The Care Quality Commission will continue to be responsible for registration and inspection of all providers of health and social care services. Monitor, which has hitherto been the body responsible for oversight of Foundation Trusts, will become the economic regulatory body for all healthcare providers. It will set prices for NHS-funded services and, together with the Care Quality Commission, will be responsible for licensing providers of NHS services, including setting special license conditions where this is appropriate. It will have a responsibility for promoting competition between providers, including preventing anti-competitive behaviour by both providers and commissioners and work with the Office of Fair Trading and the Competition Commission to regulate mergers. Monitor will also support commissioners in maintaining continuity of essential services, both through the licensing regime and the use of special administration procedures to maintain services in the event of insolvency.

19. **Response to consultation.** A set of detailed consultation questions is included in the consultation document. As this is not an area of Council expertise, it is recommended that the Overview and Scrutiny Committee does not submit a full response, but makes a general comment as follows:

*Over the past decade there has been a tension in policy on the NHS between an avowed promotion of competition and market solutions and a bureaucracy that favours centralised planning. This has been particularly evident in large-scale strategic developments such as Healthcare for London, which have moved seamlessly from the identification of preferred models of treatment to selection of specific locations and providers through a bureaucratic rather than a competitive process. The present Government's policy represents a decisive move in favour of the competitive model. Essential elements for this to succeed include a level playing field between Foundation Trusts and other healthcare providers, including the opportunity for Foundation Trusts to borrow and invest without seeking central approval. It also entails a risk that providers may fail, and thus arrangements for securing the continuation of essential services when this happens. All of these elements are present in the proposals set out in the consultation document, and it is, accordingly, to be welcomed.*

20. **Transparency in Outcomes.** The remaining consultation document sets out the Government's proposals for measuring the performance of the NHS. The NHS Outcomes Framework is intended to provide a balanced scorecard, including internationally comparable indicators, against which the NHS will hold the NHS Commissioning Board to account. The focus will be on the outcomes, rather than the structures and processes, of care. The Outcomes Framework will comprise five domains: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health or following injury; ensuring people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm. Within each domain there will be an overarching indicator or set of indicators, as well as specific outcome indicators for a number of areas identified as priorities for improvement. The framework will be supported by a set of Quality Standards, to be produced by the National Institute of Health and Clinical Excellence (NICE) setting out an authoritative definition of high quality care for a range of care pathways or services. Overall, NICE will be producing around 150 Quality Standards.
21. For the first domain (preventing people from dying prematurely) it is proposed that the overarching indicator should be mortality amenable to healthcare. For the other domains it has not been possible to identify satisfactory overarching indicators and thus interim proposals are made whilst more satisfactory indicators are developed. In some cases the interim indicators are not pure process indicators. For example, it is proposed that the interim overarching indicators to monitor the success of the NHS in helping people to recover from illness or injury should be the number of emergency hospital admissions for acute conditions usually managed in primary care and the number of emergency bed days associated with repeat admissions.
22. An annex to the consultation document provides a listing of possible indicators. These are rated against five criteria, two 'essential' and three 'desirable'. The essential criteria are that the indicator is a measure of health outcome and that it is significantly influenced by healthcare; the desirable criteria being that it can be disaggregated by geography and to measure inequalities, that international comparisons are available, and that it is currently collected. Out of a total of 96 potential indicators, only two are assessed as satisfying all five criteria: the incidence of MRSA and C Difficile.

23. **Response to consultation.** The consultation document poses a total of thirty-five consultation questions. It is not proposed to provide a detailed response to all of these questions, but the committee are recommended to agree the following summary response:

*Overall, the shift of focus from process to outcomes is desirable and the outcome domains proposed seem reasonable. However, the change is clearly a major challenge for the NHS. The fact that so few of the potential indicators listed in the annex to the consultation document satisfy all the assessment criteria reflects very real difficulties both over linking outcomes to healthcare interventions and in developing robust systems for monitoring outcomes which may become apparent only after a patient's contact with services has ceased. If new indicators are developed, there will be inevitably be a delay whilst they are checked for robustness, and it will be some years before sufficient time series data is available to understand whether significant improvements are being achieved. Thus, it is important that not too much reliance is placed on any single indicator, and that a wide range of indicators is used to provide a rounded overview of performance that is not affected by the vagaries that may be associated with particular indicators. It is also important that there is alignment between the NHS outcomes framework and outcome measures being developed for care services, with an emphasis not just on clinical outcomes but the quality of life.*

*The greatest risks of the outcomes framework are associated with the way in which the outcomes framework is translated into performance management at the local level. In particular, whilst the NICE Quality Standards may be helpful guidance for GP commissioning consortia and Health and Wellbeing Boards, any attempt to set targets for or require central collation of the performance measures in these standards will be immensely bureaucratic and will divert local resources away from efforts to improve performance. It is important that the NHS Commissioning Board does not follow this route but instead maintains an overview of the performance of commissioning consortia, focussing primarily on health outcomes data, and only undertakes more intensive performance management where problems are identified.*

24. **The review of Arm's Length Bodies.** The fifth paper published in association with the White Paper is the report of a review of 'Arm's Length' bodies within the NHS. This is not a consultation document but sets out the conclusions of the review and a timetable for their implementation. Arm's Length Bodies are national bodies responsible for implementing Government policy and priorities within the NHS, but are outside the ambit of the Department of Health. The purpose of the review was to streamline the structures and reduce management costs. The major changes proposed are:

- (a) NICE, the Care Quality Commission and Monitor will continue but with revised remits as described elsewhere in this paper;
- (b) The Health Protection Agency and the National Treatment Agency for Substance Misuse will be abolished, with their functions transferred to the new Public Health Service;
- (c) The National Patient Safety Agency will be abolished and its core safety functions transferred to the NHS Commissioning Board;
- (d) The NHS Institute for Innovation and Improvement, the NHS 'in house improvement organisation' will be abolished. Some functions will be transferred to the NHS Commissioning Board. The possibility of other functions being carried forward through a membership organisation or social enterprise will be explored;

- (e) The work of the General Social Care Council in regulating social workers will be transferred to the Health Professions Council, which will be renamed to reflect its new role;
  - (f) The Council for Healthcare Regulatory Excellence will be removed from the Arm's Length Body sector and will become a self-funding, charging a levy on regulators; and
  - (g) the Appointments Commission will be abolished and responsibility for making appointments will revert to the Department of Health.
25. All of the above changes are scheduled to be complete by the end of 2012. Further changes affecting the Human Fertilisation and Embryology Authority, the Human Tissue Authority and the NHS Business Services Authority are expected to take place within the lifetime of the current parliament, subject to practical problems with the proposed changes being resolved.
26. **Local implementation of the White Paper.** Implementation of the White Paper will pose a particular challenge for Primary Care Trusts, which are required to support the establishment of GP consortia whilst retaining formal responsibility for commissioning, against a background of substantial cuts in their management costs. Within South West London, the management savings target for PCTs over the next two years is 56%. In order to address the risk that PCTs will become unable to fulfil their core functions, the South West London Sector organisation of the NHS is proposing that a substantial range of PCT activity be consolidated at sector level for a transitional period. Whilst this may safeguard against the risk that loss of staff leaves crucial tasks undone, it appears to be a centralisation of commissioning function and, as such, in direct contradiction to the long-term policy of devolving them to the most local level possible. The temporary bringing together of commissioning into a sector body would disrupt the partnership arrangements that have been established between the Council and Wandsworth PCT and would involve a major management re-organisation which would itself entail risk of areas of work being overlooked.
27. **The role of the Council.** The White Paper identifies three crucial roles for local authorities:
- (a) to become the lead local body for public health;
  - (b) to establish health and wellbeing partnerships to integrate plans for health care, social care and public health;
  - (c) to be a possible source of support for GP commissioning consortia.
28. Further information on the Council's new role in relation to public health will be provided in the White Paper to be published later this year. However, the Government is encouraging the formation of GP commissioning consortia and Health and Wellbeing Boards in shadow form, prior to the passage of the relevant legislation. Wandsworth is in a good position to adopt such an approach, given the recent agreement between the PCT and the Council on the need for further integration of their work (as described in Paper No. 10-407). The Council already has skills in needs analysis, which will be enhanced by the transfer of public health responsibilities. The Council also has a strong record of procurement and contract monitoring and that would be in a good position to support local GP commissioning consortia in these areas.

29. Prior to the White Paper, the PCT had established three Locality Commissioning Groups, which had developed locality commissioning plans. GPs provide the clinical leadership of these groups, and the Council's Children's Services and Adult Social Services Directorates are engaged, with senior managers participating in all three groups. These groups may now provide the nucleus of GP commissioning consortia. It seems desirable that this should be explored, as rapid progress may enable a more rapid move to full implementation of GP Commissioning, avoiding the need for a transitional period of sector-led commissioning. It is therefore recommended that:
- (a) The Council explore with the PCT and the GP Leads of the Locality Commissioning Groups the possibility of establishing a Health and Wellbeing board in line with the model set out in the White Paper; and
  - (b) The Council explore with the GP leads of the Locality Commissioning Groups the ways in which the Council would be able to support GP commissioning consortia in performing their roles.
30. **Conclusion.** The NHS White Paper puts forward a programme of fundamental changes in the governance of the National Health Service. It represents a decisive move from a centrally planned service to one in which local commissioning consortia purchase care from providers which operate in a competitive markets. Implementing these changes will represent a major challenge, especially at a time when any growth in NHS funding will be very limited. However, the commitment to reduce centralisation and the imposition of process-led targets is very welcome. Within the new structure, local authorities will have a more central role than they have ever previously had in the NHS, not only regaining the public health leadership function that was lost in 1974 but also taking responsibility for the establishment of Health and Wellbeing Boards that will be at the centre of local NHS planning and potentially playing a significant role in supporting GPs in their new commissioning role.

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3rd September 2010

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Chief Executive and Director of  
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### **Background papers**

No background documents were relied upon in the preparation of this report

All reports to the Overview and Scrutiny Committees, regulatory or other committees, the Executive and the full Council can be viewed on the Council's website (<http://www.wandsworth.gov.uk/moderngov/uuCoverPage.asp?bcr=1>) unless the report was published before May 2001, in which case the committee secretary [jrichardson@wandsworth.gov.uk](mailto:jrichardson@wandsworth.gov.uk) (020-8871-6022) can supply it, if required.

**Consultation questions in *Local Democratic Legitimacy in Health* and proposed responses**

*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?*

Their general role in monitoring user experience of the NHS is sufficient, and specific reference to the NHS Constitution is unlikely to add value.

*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?*

This additional role has the potential for enabling the work of HealthWatch to become more rooted in user experience, and the possibility of adopting it, together with the associated funding stream, is welcome. However, it may be that not all local HealthWatch groups will be in a position to perform this additional role. Access to a centrally contracted complaints advocacy service should therefore continue to be available, as it is unlikely to be cost-effective to contract a free-standing complaints advocacy service for a single local authority area.

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

Maximum local flexibility will allow local authorities to ensure that local priorities are embedded in service specifications and contract monitoring. The essential underpinning for this is early notification of funding allocations for the contract period.

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

The main impediment to the development of integrated working has been the separate funding allocations and accountability frameworks for the NHS and local government. Robust health and wellbeing partnerships, with a clear leadership role for locally elected Councillors, offer the opportunity to address this and provide a single governance framework for cross-cutting health and social care issues.

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

As above – the key limitation is not the absence of legal flexibility but the separate funding and accountability arrangements. Further integration of these arrangements between the NHS and local government will support further integration. A possible enhancement would be a single performance framework for the Health and Wellbeing Board, instead of separate performance management arrangements for its constituent bodies.

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

Yes. Whilst statutory arrangements for joint working should not be unduly prescriptive, a requirement that all parties contribute to joint working arrangements may be helpful.

*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?*

Whilst there should be maximum local flexibility, a basic statutory underpinning may be of use.

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

The functions appear reasonable ones. It is to be hoped that over time the remit of the Board will extend from 'promoting' integration and partnership to fully integrated planning and commissioning of services. Achievement of this will depend upon closer alignment of local

government and NHS funding and accountability structures, with a less centralised NHS structure allowing GP commissioning consortia greater freedom to work with local authorities on locally determined priorities.

*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?*

There is no shortage of guidance on Joint Strategic Needs Assessments, and production of further guidance on this or similar topics is not a priority.

*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?*

There will inevitably be some overlap between the two partnership arrangements. This will be best dealt with at local level through the agreement of protocols, exchange of information, and some common membership.

*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 vast majority of the work that is likely to come to Health and Wellbeing Boards can be appropriately managed at Borough level. Whilst there are some issues that may be better handled over larger areas, these should be identified at the local level rather than determined centrally.

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

There should be flexibility for membership to be determined at the local level. The range and number of members proposed appears on the large side. The model most likely to work within our local context would be for a fairly small number of voting members, including elected Council members, representatives of the GP consortia, and HealthWatch, but a wider range of advisers.

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

Some form of mediation arrangement may be necessary. However, use of this should generally be a last resort, and should largely be avoided through clear delineation of roles and responsibilities and continuity of membership on all sides. Closer alignment of funding and accountability arrangements will also help to reduce the likelihood of disputes that cannot be resolved locally.

*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)?*

If the Health and Wellbeing Board is to assume the roles of the Overview and Scrutiny Committee, it would be essential to have in place measures that ensure that elected local authority members cannot be outvoted by other members of the Board on scrutiny issues. It would not be acceptable for the majority of locally elected members to express concern over a proposed service change, but to be over-ruled by members who are not elected by the local community and who may have been involved in the preparation of the proposal.

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

As above, closer alignment of funding and accountability arrangements will help to achieve local resolution. Escalation of disputes to the national level is less likely to occur where there is common ownership of the problems and challenges that are being addressed, and all parties have been involved in the development of plans.

*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?*

The approach to scrutiny will probably differ between local authorities. This should not be regarded as problematic but as a reflection of the different organisational cultures and traditions. Central prescription of any particular form of scrutiny would be unhelpful.

*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 best safeguard against adverse effects is a transparent decision-making process with clear democratic accountability.

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

Overall, the proposals for increasing democratic legitimacy represent a very substantial advance. However, there will still be challenges in resolving tensions between the expectations of the local community, as expressed through elected Councillors, and those of GP commissioning consortia who will bring a detailed knowledge of the health care needs of their patients. In general, it may be expected that elected Councillors will take a leadership role in determining the acceptability of strategic plans, whilst the GP commissioning consortia are likely to be best placed to advise on the changes needed to achieve best value and ensure that the needs of their patients are met.

It should also be noted that there are certain groups who may have relatively little contact with their GPs. At one end of the spectrum, healthy young adults (especially males) may have very little contact of any kind with the health service. At the other end, some people with long-term conditions may have more contact with hospital medical staff than with GPs. It is important that the needs of these groups are taken into account by GP consortia. The understanding that local authorities have of their population may assist with this.

**Consultation Questions in *Commissioning for Patients* and proposed responses**

*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?*

The key to a successful relationship will be good communications. This would include good information from the NHS Commissioning Board to GP consortia on the services commissioned and their performance, and the opportunity for GP consortia to feed back to the NHS Commissioning Board on their experience of services. Whilst arrangements for specialist commissioning should be on a risk-sharing basis, it is important that they do not encourage GP consortia to regard nationally commissioned services as ‘cost-free’. This would fail to reward consortia that developed preventive approaches and would introduce a perverse incentive to refer to specialist nationally commissioned services where locally-commissioned services are capable of meeting the need.

Whilst the rationale for commissioning prison healthcare services at a national level is understood, the commissioning of healthcare at HM Prison Wandsworth has facilitated the development of a number of important links between prison and community-based healthcare for offenders, for example in mental health and substance misuse services. It is important that the new arrangements sustain these links.

The proposal that maternity services are directly commissioned by the NHS Commissioning Board is puzzling. These are high volume local services, and it would seem entirely appropriate that they are commissioned by GP consortia.

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

The main value of the NHS Commissioning Board will be to support risk sharing in relation to high cost low volume services, and to support GP consortia with commissioning expertise in those services for which it is not cost-effective for GP consortia to secure local expertise.

Under PCTs, commissioning of low volume services through large multi-district consortia has frequently been done poorly, with a lack of public scrutiny and of clearly defined accountability for matters such as consultation over significant service changes. To minimise the risk within the new system, it is preferable that as many services as possible are directly commissioned by GP consortia. Where this is not cost-effective, preferred options would be the delegation of commissioning responsibility to a lead GP consortium or commissioning by the NHS management framework within a defined risk management arrangement.

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

We have no specific suggestions.

*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?*

It is agreed that GP consortia should take account of the knowledge and experience of other primary care professionals. However, it is best that arrangements for this should be locally determined.

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

The primary tool in driving the quality of primary care offered by individual practices should be patient choice, supported by good published information on service quality and user experience and scope for popular practices to expand in line with demand. The role of GP consortia in securing performance improvement by individual practices should be in relation to performance issues that affect the commissioning activities of the consortium – e.g. unnecessarily high hospital referrals. As far as possible these should be addressed through locally agreed mechanisms set out in consortium governance arrangements. However, there will be a need for some reserve powers that allow the NHS Commissioning Board to intervene where local resolution cannot be achieved.

*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?*

Over the past few years, significant service improvements have been achieved through PCT use of Directed Enhanced Service and Local Enhanced Service agreements. It is important that giving the NHS Commissioning Board responsibility for contracts with family practitioner services does not prevent the use of contractual mechanisms to support the commissioning objectives of GP consortia. There will thus need to be mechanisms put in place that will allow GP consortia to determine priorities for improvement whilst maintaining sufficient distance from the contracting process to avoid actual or perceived conflicts of interest.

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

The two key safeguards will be a clear definition of roles (covering NHS Commissioning Board, GP consortia and individual practices) and maximum openness so that rationale for commissioning decisions is understood and patient choice is informed.

*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?*

It is important that the NHS Commissioning Board relationships with GP consortia are characterised by trust, so that consortia are provided with resources that are helpful to them and entrusted to make best use of them. It is important that consortia do not have to submit excessive reports to the NHS Commissioning Board and are subject to intervention only when there is evidence that a consortium is failing to achieve intended outcomes and local measures to achieve improvement are not working.

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

In the context of existing NHS culture, the greatest challenge for the NHS Commissioning Board will be learning to refrain from micro-management. However, it is likely that there will be a lot of documentation and policy that GP consortia need to adopt, and that it will save unnecessary duplication of effort if the NHS Commissioning Board develops models that GP consortia can adopt or adapt.

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

Clear decision-making processes and financial accountability are essential. GP consortia will also need to have secured the support necessary to undertake commissioning, to have reached agreement over risk management, and to have defined the way in which they will relate to their member practices and to the local authority and Health and Wellbeing Board. However, as far as possible we would wish to avoid an unduly prescriptive approach to GP consortia governance arrangements.

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

It will be much easier to develop integration between public health, healthcare and social health if GP consortia are working for a population that aligns with local authority boundaries. Allowing practices to join a consortium when they are not located in its area would impede this, especially if they are based in a different local authority area.

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

On the whole, rigid rules are to be avoided. Consortia will need to be big enough to manage risk. However, they should also be genuinely local bodies, so serving an area no larger (and possibly smaller) than existing PCTs. There would be significant advantages in coterminosity between consortia and local authorities.

Historically, there has been a tendency for NHS commissioning organisations to merge in pursuit of management efficiencies and strengthening capacity, yet the benefits from such mergers have rarely matched up to the claims. Thus, once GP consortia have been defined, there should be rules that limit opportunities for reconfiguration and mergers.

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

The core of commissioning is essentially very simple: understanding the needs of the population, making purchasing decisions that reflect those needs, and monitoring the services delivered to ensure that they match the specification and to ascertain how well they meet population need. GP contact with patients will be of great value both in understanding patient need and in monitoring the impact of commissioning decisions.

Local authorities are an important potential source of support for GP consortia, and have skills and knowledge that are complementary to those of the GPs, including an understanding of the needs of the whole population, including skills in demographic analysis and experience of both procurement and contract monitoring.

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

GP consortia are probably best placed to understand their own support needs. It may be that the NHS Commissioning Board could help by preparing model service specifications and evaluation criteria.

*Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?*

The proposals for management of financial risk appear sensible. The key to management of risk will be effective financial management and reporting systems within GP consortia, but some risk-sharing arrangements will also be required.

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

The proposal for external management of procurement exercises in which GP practices are likely to bid appears sensible. In general terms, the key to demonstrating transparency and fairness is open publication of information on service quality and outcomes.

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

It is important that any commissioning outcomes framework is indeed based on outcomes, measured in terms of securing good access to high quality health care, and eschews the process-focussed approach adopted in World Class Commissioning assurance.

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

Yes. It is important that practices are incentivised to support the work of GP consortia and rewarded for successes achieved through consortia.

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

GPs generally have a strong commitment to tackling health inequalities. The best approach to ensuring that GP consortia work to reduce unavoidable health inequalities is to provide them with information on inequalities, including feedback on the impact of commissioning decisions. Centralised performance management on this issue will engender bureaucracy but is unlikely to generate significant benefit.

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

A starting point is to ensure that Local HealthWatch and patient participation groups are offered timely engagement in decision-making. It would be preferable to move away from the practice of appointing 'token' representatives to sit on interminable planning groups to approaches that engage with a wider range of participants on a more focussed and specific task.

Many local authorities have extensive experience of commissioning market research into services they provide and commission. This expertise could be made available to GP consortia wishing to commission market research into experiences of health care, providing access to opinions of patients who choose not to become involved with organised participation groups and networks.

*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?*

Councils and Local Strategic Partnerships have mostly established arrangements for working with a range of community partners including those that have been seen as 'hard to reach'. GP consortia should build on these arrangements rather than duplicating work that has already been undertaken.

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

The changes in arrangements for patient and public involvement between 2003 and 2008 both disrupted arrangements for user engagement and led to the loss of volunteers who had devoted time and effort to ensuring that the user voice was heard in health services. It is, therefore, important that the transition between LINKs and HealthWatch is better handled, enabling the additional roles to be adopted without disruption to existing arrangements for participation or discontinuity of membership.

One challenge for LINKs and Patient Participation Groups is that their memberships are typically skewed towards people who have reached retirement age and have the time to attend meetings. Web-based social networking provides a means of engaging with people who have more limited time to participate, and it may be helpful to support HealthWatch to develop this approach.

*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?*

Key to ensuring that implementation promotes equality of opportunity is the development and use of good monitoring data. One of the valuable functions that may be undertaken by scrutiny committees is reviewing developments for possible negative impacts.

*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 will be equally keen to make links with GPs, especially those who are likely to take a lead role in GP consortia. It is important that discussions on the issues identified take place as soon as possible. A shadow Health and Wellbeing Board may provide a useful framework to underpin these conversations.

*Where 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?*

A key challenge in the development of partnership arrangements and pooling of budgets has been the separate accountability and resourcing of local government and the NHS. The proposals in the White Paper do not fully resolve this. It is therefore important that the NHS Commissioning Board works with consortia in a way that supports them in fully engaging with local priorities, rather than implementing a centralised performance management system that cuts across local agreements.

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

Whilst multi-professional involvement in commissioning will undoubtedly be beneficial, it is preferable that it is promoted through evidence of the enhanced commissioning outcomes that can be achieved, rather than through central diktat.