Camden

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Rt Hon Andrew Lansley
c/o White Paper team
Room 601
Department of Health
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Dear Andrew Lansley,

Thank you for the opportunity to comment on the proposals outlined in the NHS White Paper; Equity and Excellence: Liberating the NHS. This response reflects the views of Camden Council (including the views of the local Health overview and scrutiny committee), but also considers the impact on our service users and local partnerships with the NHS, particularly with reference to the joint working interface for adults and children. As well as the specific responses to consultation questions, we feel the following issues are significant for successful implementation of the proposals.

Strategic direction and accountability - The development of PCTs brought a local steer to help to manage the complex relationship and market that exists in health and social care. We are concerned that without this there will be a lack of strategic direction at a local or regional level. This brings the risks of increased spend if the efficiencies achieved through collaborative planning are lost.

Scrutiny provides the local accountability of providers and commissioning decisions which has proved particularly valuable. However we are concerned that the proposals to combine the scrutiny functions with oversight of commissioning through the proposed health and wellbeing boards would be a conflict of interest. The combination of executive and non-executive relationships and functions in these Boards could create irresolvable complexities.

Public Health – Transferring responsibilities for public health to Local Authorities is welcomed. However, the absence of the public health white paper and information about the funding allocation and responsibilities make it difficult to assess the full impact on Local Authorities and areas.

We would like to see sufficient discretion for implementing the statutory functions in whatever management arrangements suits local structures and resources.

Co-terminosity – Councils and the NHS have developed close working relationships, with benefits for service users and business efficiency. Critical to this have been shared geographical boundaries. Consortia which cross parts of boroughs would make the health and social care landscape more complicated. We encourage much stronger guidance to consortia to establish themselves with reference to borough boundaries.

Joint commissioning and integrated working – We strongly advocate a duty on GPs and councils to work jointly and provide integrated services with social care; without this duty the needs of social care service users may be marginalised. Our experience is that joint commissioning can improve outcomes especially for vulnerable service users with complex needs with cost benefit to the council and the NHS.

GP consortia should be statutory organisations capable of forming such partnerships with Local Authorities and should be strongly encouraged to assume s75 Health Act responsibilities.

Focus on health outcomes and health inequalities – The outcome framework is welcomed, but there should be more emphasis on how GPs would be held to account for delivering against health inequalities outcomes across the population. The cost of administering an extensive outcomes framework should also be noted, particularly where these are attached to financial incentives.

Finances – It is critical to have a clear, equitable and transparent allocation of resources to GP consortia. Where there is substantial divergence from current funding, reductions should be phased to minimise sudden adverse impact on service users.

Although it is unclear how GPs would prioritise within the current budget constraints and the support that they would have to make financial (rather than clinical) decisions, the fixed management allowance needs to be adequate to perform this function.

The White Paper makes no proposals for the capital resources of PCTs. There needs to be a clear plan for the management of PCT estates which allows future flexibility to change providers by detaching site ownership from service provision.

Supporting children and families - Children have regular access to a wide range of public services through their every day lives. Children's health provision therefore should be considered in the wider context of children's services and joint working.

It is important that GP commissioners have an overview of local services working to improve children's outcomes, much of which would be outside the scope of GP services e.g. mental health resources in schools. The relationship between GP consortia and Children's Trusts is not clear in the proposals, and is an important aspect of health support.

The decision to commission maternity services at a regional or national level needs to continue to allow for local flexibility and decision making. The rationale for these services being excluded from the local budget is also unclear.

PCT and SHA functions - The White paper has focussed on commissioning functions to the detriment of the many other PCT and SHA functions. There needs to be careful planning for the future management of these functions and adequate funding. Transitional costs related to redundancies or TUPE also need to be adequately funded. We also feel that retaining excellent and experienced staff during the transition period will represent a significant challenge for local health organisations.

The philosophy and constitution of the NHS is much valued but we feel that there is the potential for this to be compromised with the proposal to extend regulated markets to include a wider range of providers. We urge the government to

sufficiently protect the core principles of the NHS in the final bill, including ensuring that health services continue to be clearly accountable to the community.

As lead member I would hope that the Health Bill will seriously consider Camden's very relevant concerns regarding the reorganisation of local health services which would impact on local services.

Yours sincerely

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Adult Social Care & Health

London Borough of Camden
Response to the White paper Equity and Excellence: Liberating the NHS

1. Liberating the NHS: Local democratic legitimacy

1.1 Strengthening public and patient involvement (Q1, 2, & 3)

We welcome the emphasis on greater public and patient involvement in all levels of decision making within the health service. This would also open opportunities for looking at the advocacy role across health and social care, and the legislation should encourage wider coalitions of user groups to give a greater critical mass of representation and active participation in decisions about services, as well as cost effectiveness

It should also be noted that there has been considerable change in the delivery of these services, with LINKs being a relatively new organisation, and not embedded in many areas. The transition arrangements from LINKs to HealthWatch needs ensure continuity of the 'patients' voice'. Success of HealthWatch would rely on appropriate funding (allocation of resources was not identified in the consultation paper), sufficient breadth to enable engagement with a range of vulnerable groups and an appropriate remit being identified.

A further element to be considered is the extent to which HealthWatch would have the capacity or be taking on the much valued role of Patient Advice and Liaison Services.

In moving from LINks to HealthWatch there is some concern that there would be an increased emphasis on health, rather than the broader remit of health and social care which is currently the case.

1.2 Improving integrated working (Q4 to 7)

Camden's well established relationships with the NHS are helped by the fact that the PCT is co-terminus with the local authority. Joint commissioning arrangements are in place; integrated service delivery for physical disabilities and brain injuries, mental health, learning disabilities and intermediate care, hospital discharge; successful partnerships with Children, Schools and Families to support transition to adulthood.

Integrated working in other areas has demonstrated better outcomes for individuals in receipt of services and has the advantage of enhancing shared performance targets and service development models e.g. Delayed Transfer of Care, Complex Case Management, Admission Avoidance etc. Further efficiencies could be achieved through lead organisations having a single governance structure for inspection, reporting and accountability.

We welcome the government's recognition that Local Authorities are the most appropriate local bodies to lead on health improvement and promoting integration. However the legislation should be strengthened in two ways:

- to require Local Authorities and health commissioners ie GP consortia to pool resources and integrate any service that would bring about the maximum impact in respect of health outcomes as demonstrated by the JSNA.
- to ensure duties on NHS commissioners to take part and commit to a collaborative approach and for health and well-being boards to have the necessary 'influence' over NHS commissioning.

Current Health Act flexibilities have provided some freedom to Local Authorities and NHS commissioners to find the best fit to address their local commissioning requirements. Joint working between health and social care and partners in the

voluntary and community sector is essential in order to deliver effective, personalised services and to reduce duplication. Integrated working is central to effective services for children and families including sharing of information and shared assessments. It is widely accepted that joint working improves user experience and outcomes by removing organisational barriers between different services. Therefore greater consideration should be given to requiring GP consortia to participate in s75 lead commissioning and other joint working arrangements.

If there were a statutory duty for health partners to work in collaboration with the local authority specifically via a health and well being board, and this is removed for Children's Trusts (as proposed by Department of Education), it would also be important to ensure that children's health outcomes are appropriately prioritised within partnership working at this level.

1.3 Health and wellbeing boards (HWBs) (Q8 to 12)

The creation of health and wellbeing boards on a statutory footing would be a significant change for the way that services are co-ordinated and developed collaboratively at a local level. Boards should be flexible enough to involve other partners to reflect local need, such as third sector representation. Given the wide scope of the services that would fall under this remit, the organisation of HWB would need to be carefully structured to ensure that due attention is given to:

- Safeguarding (for children and adults)
- Input of a wide range of health professionals (not just GPs) into the decision making process
- Ability to call all partners to account against local priorities (including compliance with priorities identified in the JSNA)
- Democratic role, and the added value, but additional complication, of having boards with both executive and non-executive members
- Structure of commissioning, and role of the Board in relation to this

The interface with the role of Children's Trusts needs to be seen within the context of changes to the statutory footing of these arrangements, but also the need to make decisions about the health of children with the wider children's landscape.

1.4 Overview and scrutiny (Q13 to 17)

The scrutiny function currently conducted by the Health Overview and Scrutiny Committee is a well used role in Camden, allowing Councillors to have an overview and influence upon the decisions that affect residents. This has helped generate an environment of increased transparency and accountability of commissioning and other decisions. It would be a novel approach to have executive and non executive members on the same decision making body and it is unclear how the proposals to "subsume" scrutiny functions into the Health and Wellbeing Boards takes into account the relationship between elected members and officers. Therefore whilst there needs to be compliance with the JSNA and a commonality of direction, we strongly suggest a clear distinction between scrutiny and the role of the HWB with sufficient local flexibility regarding arrangements for scrutiny of HWB decisions.

The current Overview and Scrutiny Committee functions are also limited and are not able to require the attendance of GPs or compel them to respond. With the proposed shift to GP consortia commissioning, this should be changed in order to allow equal scrutiny.

The scrutiny role of the proposed health and well being board in relation to children's issues also needs to be clearly defined, given the overlap with other decision making

bodies but again we feel that the scrutiny function should be kept separate from commissioning functions.

2. Liberating the NHS: Commissioning for patients

2.1 Scope of GP commissioning (Q1 to 4)

The local arrangements that have been put in place through Locally Enhanced Services have helped to engage GPs and improve outcomes for people with complex needs, and this should be developed.

There is also a role for joint work around low volume / high cost services, such as for children with disabilities, people with mental health needs and learning disabilities

GP consortia should be required to take into account the needs of people who are not registered with a GP or do not engage with services e.g. homeless people, students, people with mental health issues, certain ethnic minorities and those who do not regularly visit them such as adult males, travellers.

2.2 Relationship between GP consortia and individual practices (Q5 to 7)

We welcome the proposal for GP consortia to take responsibility for improving the quality of the primary care provided by practices. This should include the quality of primary care support to vulnerable people who use social care, those with learning disabilities for example, whose particular health needs have not always been adequately met.

There should be clear accountability between the local authority and the GP consortium for the delivery of public health outcomes and for outcomes for vulnerable people, as well as accountability to the NHS Commissioning Board

There is currently a lack of consensus on how these services are developed in the future, and how they interact with polysytem models. The important focus should be on how care can be delivered better, closer to home, and links with long term case management, and the strategic role in diverting resources to the most successful and cost effective models.

2.3 Role of NHS Commissioning Board (Q8 & 9)

We are concerned about GP consortia having the capacity to deliver on the strategic planning of health services. The Commissioning Board would need to have the appropriate responsibilities, competence and power to take on this new role and the associated risks within the context of significantly reduced management resources compared to PCTs, and with due regard to the importance of local planning through HWBs. We are concerned that the proposals may contradict some of the organisational changes announced alongside this paper such as to reduce the number of arms-length organisations.

The commissioning role of GP consortia should be clearly outlined in terms of responsibilities and duties and the role of the NHS Commissioning Board should be to assess the full range of commissioning activity including leadership, effectiveness of joint working and equalities.

2.4 Establishment of GP Consortia ((Q10 to12)

It is desirable that there is co-terminosity of Local Authorities and PCTs which has generated excellent partnership relationships. Where services are currently jointly commissioned, the local authority is dealing with one organisation; depending on how consortia are formed, joint commissioning arrangements could become more complex for both commissioners and Local Authorities and therefore it is desirable for GP consortia to be aligned with local authority boundaries.

If GP consortia have the flexibility to include practices outside of a geographically discrete areas it would create a very complex health landscape across borough boundaries which would impact on the community care pathways for adults and children and negatively affect local services. Many small consortia would drive up the transactional costs for Local Authorities whereas overly large consortia would drive up transactional costs for GPs working across two or more Local Authorities.

The removal of geographical “catchment” areas for GP practices would also offer a specific challenge for areas such as Camden, which attracts people as a workplace, as well as residents. This may mean that GP practices in Camden have a higher than average number of people outside of the local area registering with practices. There would be a greater demand on resources and the impact on commissioning services such as out of hours and primary care would become more complicated.

2.5 Freedoms, controls, accountability (Q13 to 16)

GPs would require a great deal of support to make this transition. Some of this may be available from PCTs until consortia become fully operational. GPs acknowledge that financial, contract and performance monitoring would require training, and an understanding of the competencies for NHS commissioning to make decisions about any support organisations.

Whether through the Health and Wellbeing Board or through the GP consortia governance arrangements and publication of decision making processes would aid transparency.

2.6 Accountability to patients and the public (Q17 to19)

As highlighted in the Outcomes Framework, the timescales for the delivery of quality standards in 2015 would make it difficult to assess progress on many local priorities. This, combined with the effect of external factors on outcomes for patients would make the delivery of outcomes difficult to convey.

There needs to be greater emphasis on GPs meeting the priorities identified in the JSNA, including health inequalities. The NHS Commissioning Board and local governance arrangements should assess compliance with the priorities outlined in the local JSNA, rather than national priorities.

The role of the scrutiny functions (be they Health and Wellbeing boards or other forum) would need to have consideration for equality issues as part of the decision making processes.

2.7 Public health (Q24 to 27)

We welcome the transfer of public health functions to Local Authorities enabling us to build on the existing good relationships with public health and existing discretionary joint working arrangements. The scope of public health functions is yet to be defined, and will need to clarify the public protection as well as the health improvement functions. We would like greater clarity on the relationship between GP consortia and public health and the specific duties that GPs will be expected to contribute to and expect from public health.

Given current financial pressures on Local Authorities we would like to see sufficient discretion to fulfil the statutory Director of Public Health (DPH) function as best meets local need without prescription for specific posts or local arrangements. For example

economies of scale could mean some services are better provided in a regional level such as the London Health Observatory or that DPH functions could be addressed without a separate post in each local authority.

We are concerned to see the separation of public health and health improvement from the commissioning of services which could lead to GP consortia focusing on health treatments. There should be incentives for GPs to focus on health education and improvement programmes to reduce service demand at a later stage, where evidence supports this.

2.8 Safeguarding children- ("w*hat specific safeguarding and child protection responsibilities should be taken into account as part of local partnership*s?" and "h*ow can GP consortia best be supported and enable to play their part in local arrangements to safeguard children and young people")*

The proposals involve GPs in both direct provision and commissioning of services to patients who may live locally or in other areas. There would be a need and an opportunity to develop training and support to ensure they can identify safeguarding issues as well as providing treatment. Monitoring delivery would need to include safeguarding standards to ensure children are protected.

Local partnerships would need to ensure the accountability for monitoring performance and responding to changing needs and issues for safeguarding and child protection are in place. Any implementation plans made locally would need to include monitoring and scrutiny of the safeguarding standards across all health provision.

Local partnerships would need to consider safeguarding risks in their own areas. Key issues may be:

- Who monitors standards in services delivered on a sector basis and how does a local partnership contribute to the process.
- Monitoring the mobility of families who may register in a different area from where they live and receive other services.
- Ensuring all partners including GPs and hospitals have the right information to identify child protection issues would be important.
- Ensuring information sharing locally is robust.
- The national data system which is proposed to replace Contact Point would need to work effectively and meet the needs of local partnerships who may have GPs providing services to families living in other areas and those who move regularly.
- How are out of hours GP services provided, would they work with partners and how would their safeguarding standards be monitored.

3. Liberating the NHS: Transparency in outcomes- a framework for the NHS (Q 1 to 7)

The framework is extensive, however this leaves very little scope for the prioritisation of locally relevant outcomes, for example through the JSNA process. This framework should reflect the aspirations for local NHS services, rather than reflecting existing information frameworks.

It is unhelpful to have different outcome frameworks for similar services. Where outcomes require partnership working, these should be clearly identified and the extent to which the NHS is accountable for these outcomes, as distinct from the role

of public health, adult social care or children's services. The emphasis on integrated working should be reflected in the outcomes framework.

The stated aims of the outcome framework, which would form part of provider and GP payment systems would mean that there is a requirement to have not only substantial information, but also information that is reliable and timely. This has historically been a problem in NHS systems, and it is unclear how this would be rectified before these payments become "live". This separation may also further undermine the need to ensure that prevention services will be provided through the GP consortia commissioning budget, if they are not all delegated to Local Authorities as part of the public health allocation.

The inclusion of positive outcomes, although as yet undeveloped, is welcomed, but both the transaction costs of gathering the data to demonstrate the outcomes, and the often unreliable nature of this information, should also be noted. The timescale for the development of Quality Standards would also mean that information is not "complete" from the initial stage of these significant changes.

4. Liberating the NHS: Regulating healthcare providers (Q1 to 5)

The proposed increases to foundation trust freedoms do not reflect the additional risk for organisations that are not already assessed as 'excellent', following the inclusion of all NHS providers.

The greater flexibility in the constitution of foundation trusts, and potential mergers should be open to public scrutiny, and should form part of the decision making process. It is important that any efficiencies gained as a result are re-invested in health provision.

The 'Any Willing Provider' ethos is aimed at encouraging an increasing range of community services but it may make it difficult and act as a disincentive for third sector or small organisations to participate in the market if the contract is not proportionate to the size of the organisation.