

“Equity and Excellence: Liberating the NHS.”

This document sets out the responses of Kent County Council to the four subsidiary papers to the NHS White Paper and also comments on the Achieving Equity and Excellence for Children engagement document and also draws upon the report of the Review of Arms length bodies.

“Local Democratic Legitimacy in Health”

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?

Yes. It is important that the public and patients are at the heart of all decisions about the commissioning and delivery of health and social care and HealthWatch would be an excellent vehicle to facilitate this.

It would have been helpful to have more information about what responsibilities are envisaged for HealthWatch England and the links between a local HealthWatch and HealthWatch England and other links with the Regulators.

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?

Yes. In the current system, responsibilities for ensuring the voice of the public and patients are heard and acted upon is scattered across a wide range of organisations. This has led to confusion for those trying to get help or comment on the care they have received and is a time-wasting and expensive duplication of effort. The “citizen’s advice bureau” role outlined for HealthWatch would not only unify organisations into a coherent whole from an organisational perspective but would bring much needed clarity to the public.

We would like to build on the proposals in the White Paper to include Local Authorities have the ability to commission a whistle-blowing service. KCC is also considering the commissioning of an external scrutiny function to have oversight of the Health and Wellbeing Boards (or local equivalents)

The White Paper has not been clear about where responsibility for dealing with complaints themselves will lie. Feedback in Kent has told us that the public already find it difficult to know where to start their complaint. This is exacerbated when, as is already too common, a patient wishes to complain that between their GP, the consultant to who they were referred and the treatment they eventually received, they do not feel they had the integrated service they needed. Reviews of the Health

complaints services have generally been far from positive; the transformation of the NHS should be a good opportunity to resolve these long-standing issues.

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

The Equity and Excellence White Papers set out welcome proposals on freeing up commissioners and providers to ensure that services are responsive to the local population. One of the key elements in delivering locally responsive services is to ensure the public have a variety of way of making their voice heard and being supported to do so. Local Authorities need to be able to commission public engagement through a range of organisations that best reflect the voice of the local population on any particular issue. In addition to commissioning the LINKs, local authorities may also want to commission voluntary organisations that have chosen not to ally themselves with the LINKs, private survey companies, local media firms etc. It is vital that Local Authorities have the freedom to commission what is best for the population they serve and are not forced into a one size fits all contract.

The White Paper wording of “LINKs will become HealthWatch” has been interpreted differently in and across organisations. We need assurances that the commissioning freedoms described throughout the White Paper will also be afforded to Local Authorities.

Whilst statutory frameworks can become stifling a set of guidelines might be helpful. These guidelines might include issues such as whether the commissioning and management of the day-to-day operations of HealthWatch should be at arm’s length to service provision such as public health and social care, the need to strike a balance between political views and other public representation, the need to ensure that voluntary organisations are representing the views of the people they are set up to serve etc.

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

To make freedoms and flexibilities work fully there needs to be an overhaul of current regulations. Limited take up as suggested in paragraph 23 is because there are still significant barriers for full joint commissioning. These barriers include funding streams, 'ring fenced budgets, regulations / legislation and governance which make it difficult for joint commissioning.

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

Freedoms and flexibilities should go beyond joint commissioning and focus on making a reality of personalisation. For example:

- People on direct payments cannot purchase services from Local Authority's in house services
- There needs to be a period of reflection and learning in regards to the Personal Health Budget pilot programmes. Can Direct Payments be extended to health care needs? It is our view that an arbitrary split will hinder the development of integrated community services between health and social care.

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

In the early days of new partnerships and new roles and responsibilities for health across a range of organisations, it may be a useful spur to have statutory powers to underpin joint working. The statutory framework should spell out the minimal obligations regarding collaboration but without prescribing the form. If there are to be statutory powers, then a range of organisations should be consulted on how these should work and a date of review for the arrangements built in to ensure they are working to the advantage of all stakeholders, but most importantly the public.

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?

We agree that there should be a statutory obligation to carry out the functions of a Health and Wellbeing Board including a reciprocal duty for GP Consortia to attend and contribute especially while the new arrangements are becoming embedded. For some Local Authorities there are already a range of Boards and other structures that could more effectively and more inclusively carry out these functions rather than set up separate structures, especially in a "slimmed down" public sector and particularly in two tier local authorities. We ask that it is left up to each Local Authority to determine how and where the Health and Wellbeing Board functions are carried out. Legislation could cover the role of scrutiny and referral, the need to hold meetings in public, to ensure there is good public voice at the meetings, to demonstrate that it is delivering the outcomes demanded by the population, etc. However, there needs to be freedom and flexibilities to set up Boards in the best way for the residents, organisations and stakeholders in an area.

Q8. Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Yes – along with a requirement to involve local communities and Healthwatch in these functions.

It would be useful to clarify that the Health and Wellbeing Boards (or local equivalents) are to ensure that the functions it is responsible for are carried out, rather than carrying them out themselves. Some tasks, such as producing the

JSNA are too detailed for a high level Board to concern themselves with directly, but the Board should satisfy itself that assessments have been properly carried out and the resulting JSNA truly reflects the needs of the population. Similarly the Board must ensure there is appropriate joint commissioning and partnership rather than doing it itself. These are important distinctions to make as too much direction in the minutia of commissioning will call into question the independence of the scrutiny function that will later be called in to examine it.

A further set of functions KCC advocates for the Health and Wellbeing Board is oversight of major changes proposed by local healthcare providers, such as proposals to merge or demerge, shed parts of their organisations etc. It is vital, especially during the transition period, that the freedoms proposed in the Regulation of HealthCare providers consultation document are balanced by the need for robust public accountability. The ambition of “putting patients and the public first” will not be achieved if healthcare providers can reduce local choice to suit their organisational needs without considering whether this is in the public interest.

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 already adequate support for creating JSNAs through groups such as LGA, ADASS etc. In Kent and across organisations, there is already a body of knowledge / experience to take this forward.

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?

We would prefer to have the freedom to develop our own relationship between the Health and wellbeing Board and our Children’s Trust arrangements in Kent. We are currently reviewing the operation and structure for our local strategic partnership and would want to develop these arrangements in line with the outcomes of this review.

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 consultation document already allows for Health and Wellbeing Boards to be set up across boundaries where appropriate, and this makes sense. As outlined in question 7, Local Authorities will need freedom to set up structures to carry out the functions of Health and Wellbeing Boards to suit their own area. However this is done, it will need to allow for some health care, trauma, maternity, cancer etc spanning districts within a Local Authority area or crossing upper tier local authority boundaries

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

Yes, though again there must be the flexibility to ensure that each Board has the representation that is right for it, rather than be given strict rules for membership. If there is statutory legislation to underpin the powers of the Board, then they could include a requirement to ensure and demonstrate the Board has representation from the public and those responsible for commissioning health and social care, public health etc rather than being too prescriptive as to exactly who should attend.

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

Good practice guidelines would be helpful especially if backed up by case studies as the new arrangements become more settled. It could be a requirement of the Board for them to include dispute resolution as part of its governance; this could include requests for help to the Independent Reconfiguration Panel, peer review etc. A further option is a less formal appeal to CQC, Monitor or other regulator for help and advice. The good practice guidelines should make it clear that only as a very last resort should there be appeal to the Secretary of State for Health

Some form of incentive from the Department of Health or acknowledgement from the Inspection or Audit services for authorities who successfully deal with disputes locally may also be helpful.

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)?

It is important to note the difference between scrutiny and the power of referral to the Secretary of State for Health. The transfer of HOSC statutory powers to the Health and Wellbeing Board (or local equivalents) should not be taken as meaning that non-executive health scrutiny will cease and local authorities must not be prevented from maintaining effective local health scrutiny. The important role that non-executive Members have and will continue to play in overview and scrutiny should be acknowledged and local authorities should have the flexibility to establish the most appropriate systems to carry this out.

Some consideration should be given to transitional arrangements. It may be sensible to encourage shadowing arrangements from the current Health Overview and Scrutiny Committees. It is important that public and patient voice, both through elected representatives and through voluntary organisations and other routes continues throughout the transition and beyond.

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

Robust governance arrangements – see Question 13

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?

- Self assessment focussed on agreed outcomes for the Board
- Public and patient involvement, through HealthWatch
- Clear work plans & business plans that focus on outcomes for the public
- Regular audits of Board Activity by external auditors
- A mechanism to delegate the authority to scrutinise to either sub or overarching scrutiny panels or Boards
- External scrutiny should form part of each year's scrutiny plans, especially where services are commissioned or delivered by the Local Authority.

It is unlikely that one set of prescriptive measures will work equally well for all regions or organisations. Guidelines and the sharing of evolving effective practice will be helpful and probably more successful in running scrutiny successfully

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?

- It is important that the JSNA focuses on all disadvantaged groups and from this robust priorities are established by the Board which are reviewed.
- The impact on Health Inequalities should be assessed; commissioning and delivery plans should focus on reducing the gaps between the least and most disadvantaged.
- Major initiatives, service reconfiguration etc should be subject to Impact Assessments

Q18 Do you have any other comments on this document?

The importance of the voice of the public, whilst made of paramount importance in some of the consultation papers, has not always seemed consistent. For example, much has been made of public voice in the need to scrutinise commissioning decisions. However there is no mention made of how this might also apply to the role of healthcare providers. Indeed, the Regulating Healthcare Providers consultation paper suggests that the public need not be represented on the Board. Our concerns would be greatly lessened if at least during the transitional period governance changes as well as service changes were still regarded as matters for local deliberations.

The issues of safeguarding and patient safety are overlooked. In this paper there is only a passing reference to the children's safeguard board and there is little indication of how vulnerable adults will be protected. We look forward to this omission being addressed during the transitional period.

“Liberating the NHS: Commissioning for Patients”

Responsibilities of GP consortia

1. 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?

GP Consortia will become engaged with this agenda by being involved in the process of decision making from the start (i.e. as Consortia begin to be formed). It is imperative that GP's and the Board begin talking early-on in the transition phase. Not only to positively engage but equally, so that the Boards' requirements can be clearly set out and the expectations of each party managed. The LA should have involvement in these early stages as they have significant knowledge and experience in commissioning practices and the engagement process. The LA should be present throughout the development stage as they will be a key stakeholder long after the PCT and SHA's have disbanded.

The Board should consider regional consultation with practices to establish how they want the commissioning of services to be implemented in order to ensure a strategic element to service provision and therefore good value for money. It would also be beneficial if the Board began a process of information gathering, assessing issues such as levels of specialist knowledge – for example, in relation to mental health or drug and alcohol commissioning - and the extent of public access to data resources.

The NHS Commissioning Board should promote the use of the Joint Strategic Needs Assessment (JSNA) (and we fully endorse proposals that the LAs lead on these). It would also be helpful if the localised Outcomes Framework reflected the commissioning plans that are based on the JSNAs

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

There needs to be integration between the commissioning cultures of the NHS Commissioning Board and GP Consortia e.g. mutually constructive strategic aims, effective sharing of information and effectual access to existing services through reduced bureaucracy. This would allow for efficient commissioning decisions relating to smaller contracts. We are assuming that the Health and Wellbeing Boards will ensure that commissioning plans are coherent across their region.

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

In Kent, drug and alcohol treatment services are currently commissioned by the authority-based Drug and Alcohol Action Team. This arrangement has worked exceptionally well and provided a service driven by effectiveness, value and a focus

on the service user. Under the proposed arrangements, this service should remain within the local authority in order to continue to be effective and driven by value. DAAT are looking forward to sharing learning from its commissioning experiences with GPs and it would be delighted to do the same for the NHS Commissioning Board

Children and young people's services such as CAMHS could be commissioned through partnerships with local authorities. They could work with children's services joint commissioning units.

LAs have significant experience and understanding of the opportunities and limitations found in collective commissioning arrangements. In Kent significant work has been underway for some time with PCTs and other partners in the area of joint-commissioning. As such, LAs would be a good local source of information and guidance to GP Consortia interested in pursuing such arrangements.

4. 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?

Primary Care dentists and other specialists should sit as part of special interest commissioning groups to inform commissioning plans. In addition, Consortia could adopt the practice-based specialist interest model whereby Practices could sell the services offered by GPs with specialist interest areas to other Consortia within a localised geographical area (or if suitable across geographical boundaries).

The specialist interest group would ensure commissioning services deliver a holistic package to patients such as dental or ophthalmic representation. In addition, the needs of children and young people need to be considered holistically to minimise expenditure and maximise outcomes. Consideration should be given to linking NHS reforms with the development of services for children with SEN and disabilities emerging from the recent OfSTED review.

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

The design and monitoring of contracts will be an essential part of Consortia's commissioning responsibilities. LAs have experience of contract management (and re-tendering) which it could share with Consortia. Establishing a common template and specification on outcomes would inform practice decisions. Consortia could commission procurement expertise from LA's. However, for LAs to provide GP Consortia with commissioning support the DH will need to develop guidelines on the market entry requirements for LAs.

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

There are advantages and disadvantages to GPs monitoring what GPs deliver: peer review of work undertaken can be extremely positive and beneficial to service development, but there is a potential conflict if GPs are self-regulating. We agree that there is a need for additional scrutiny through the Health and Wellbeing Board

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

The introduction of best practice guidelines to ensure transparency and fairness in service development and to facilitate improved integration and effective partnerships between GP Consortia, the NHS Commissioning Board and LAs would be helpful.

Consortia should be required to be transparent in their financial dealings without breaching confidentiality – a sensitive balance must be maintained to ensure public trust in Consortia whilst not exposing practices to undue risk. Openness and honesty around finances and spend will encourage dialogue with patients in the local area.

We have commented in the Transparency and Outcomes response that the outcomes framework needs to be strengthened to ensure that the public have access to easily understood information that will help them make the choices right for them

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

All commissioning bodies must ensure that their financial decisions are transparent and clear. For example, it must be clear what tariffs are being imposed and what services are required to be delivered. Commissioning bodies must also state how contracts will be monitored; how outcomes will be measured; and outline any penalties which may be incurred in advance. This system would also allow for the easy identification of duplication i.e. if local Consortia are doubling up on the payment for services, such as under the old ‘unbundled tariff’ scheme.

Good reporting systems and the open sharing of information are essential to develop effective working relationships between partner organisations.

The Commissioning Board could look to identify methods of best practice and guidance e.g. from American models, that could be used to inform the development of effective commissioning relationships. Bodies could also look to examples of private commissioning to support their work.

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

Local authorities hold vital information regarding the local area, particularly in regards to health inequalities so the NHS Commissioning Board should encourage or direct the Consortia to engage with the LAs. This will enable both parties' to determine what synergies can be forged between locality models and any proposed structure and priorities.

Establishment of GP Consortia

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

Essential to the governance of GP Consortia will be a clear best practice framework setting out how GP Consortia will be accountable within their local communities. This should include the publication of commissioning spend, and the process by which public or other agencies can comment or influence the commissioning outcome.

There also needs to be a mechanism which allows partner agencies to call GP Consortia to account if their actions are having unintended or adverse consequences. For example if GP Consortia commission services which adversely drive-up elective surgery in another locality.

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

Consortia should have significant flexibilities to include practices that are not part of their geographically discrete area. The inter-operability of practices and Consortia is key to providing effective 'value for money' commissioning arrangements.

This, combined with an analysis of the strategic aims of different Consortia, would lead to a reduction in the likelihood of commissioning duplication, especially in common service provision e.g. stoma, children with severe and complex needs, HIV and cancer care, and would avoid wasting resources (both in terms of time and money). To support this approach, clarity is needed over whether the NHS Commissioning Board will provide an analytical function and a summary of what services are provided by which Consortia.

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

No – Consortia should be configured according to the demographics of different areas. Consortia boundaries should be determined by the needs of the communities they serve, not by the size of the population they cater for. However, there is a

balance to maintain between serving the community and providing an efficient administrative service.

Freedoms, controls and accountabilities

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

Clear regulations and outcome expectations as evidenced in the JSNA will help Consortia to establish the guidelines within which to commission services. Local Authorities have long experience in practical commissioning and would be well placed to provide commissioning support services to local GP Consortia.

Currently, PCTs can use the Framework for procuring External Support for Commissioners to gain easy access to expert suppliers. If this Framework is going to continue and be accessible to GP Consortia, KCC would recommend that Local Authorities be considered for expert supplier status. If the framework is to be replaced, then we would ask that Local Authorities not be barred from providing these services.

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

GP Consortia will need transparent and comprehensive advice on what support is available such as: private company comprehensive package of commissioning provision including monitoring activity data, brokering with pharmaceutical companies and drug manufacturers, vis-a-vis a more bespoke package of tailored services offered by LAs including legal advice.

All LAs have developed sophisticated commissioning arrangements as required in the implementation of Children's Trusts. These would be useful to Consortia and KCC would welcome the opportunity to work with Consortia on this.

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

As the level of risk is not yet known, it is extremely difficult to offer a response to this question before roles with individual Consortia have been established.

More detail is needed to establish which body would be accountable if, for example, commissioning failures arise that harm individuals

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

The JSNA should establish what services are required. Consortia should be measured against delivery of outcomes against the needs and should be accountable to both the NHS Commissioning Board and the Health and Wellbeing Board if unable to provide evidence of this.

Consortia should be transparent in their financial dealings, without breaching commercial confidentiality. A good balance must be maintained to ensure public trust in Consortia whilst not exposing practices to undue risk. Public scrutiny will provide transparency.

An effective safeguard will be the introduction of a governance and accountability framework to ensure transparency and fairness in service development, and to facilitate improved integration and effective partnerships between GP Consortia, the NHS Commissioning Board and LAs.

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

The key emphasis must be on flexibility, relevance and outcomes for patients so that the indicators can be evolved on a 'fit for purpose' basis. Key to this is that each outcome framework reflects what is important to people in the area, i.e. localised outcome frameworks.

There would also need to be some indication of who will be collating the information which Monitor and CQC will collect. Currently this is a large piece of work undertaken by the PCTs, it is difficult to see how the GP Consortia will collate this information.

The framework should also take note of the need to increase investment in services for children and young people to create a truly preventive and cost effective NHS.

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

This would be dependent on the method by which outcomes are to be measured, and over what time periods. There needs to be an equitable system which does not penalise consortia serving the poorest populations. The proposal that GPs are paid on outcomes would need to ensure that outcomes are population based rather than patient list based, i.e. that GPs are rewarded for serving the needs of all the people in their catchment area .

The provider incentives to attain results as outlined in the White Paper are to be 'paid according to the costs of excellent care, rather than average price'. This means that providers who deliver excellent care in line with commissioner priorities will be eligible to receive a 'quality increment.'¹ There is a danger that an outcomes

¹ 'Equity and Excellence: Liberating the NHS', Crown Copyright, 2010 p. 25, 3.18-3.20.

focussed payment system could result in those Consortia which have the greatest level of resources being rewarded with higher payments.

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

Currently there is a wide variation in how well GPs engage with public health issues. We hope that the NHS White Paper and the imminent Public Health White Paper will set out a clear expectation and incentivisation for GPs to become more active in preventative health care.

LAs could ask for a commitment (formal or informal) from Consortia to put equal access to healthcare at the centre of their commissioning decisions. This issue could be an integral part of the accountability framework.

Partnerships

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

See below (Q21).

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

KCC is already setting up conferences and workshops with GP Consortia and the PCTs at which all partners can share experiences to ensure that when engaging with the public local priorities are always at the heart of our commissioning decisions.

KCC has a solid background engaging with other stakeholders, members of the public and patients. It has a good understanding of how to best involve and work with our community partners. For example, West Kent Adult Social Services and West Kent PCT previously organised a number of events designed to strengthen its engagement with the local BME voluntary sector as part of the commissioning process to build capacity. The feedback and learning from these events gave ‘us a better understanding of the needs of minority communities in relation to health and social care needs and...this knowledge [has]...inform[ed] commissioning activities. It [has also given]...us a better understanding of the best way to engage these different communities.’²

Another good example is Kent Teenage Pregnancy Partnership who conducted a large piece of research to explore young people’s perceptions of sex and

² ‘Engaging BME Communities in West Kent’ as part of the ‘culturally competent support’ stream sent to KASS by Maidstone and Malling Adult Services on 29-06-10.

relationship education and sexual health services. This enabled KCC to influence other partners and shape services accordingly.³

We hope that GP Consortia will capitalise on the conferences and workshops and together we can continue this work to ensure that all of Kent's population have proper input into commissioning decisions

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

Kent Health Watch has been successfully gathering feedback and passing it onto the appropriate service areas in health and social care since it was launched. This could be developed into the HealthWatch Programme, as outlined in the White Paper. In addition, Patient Participation Groups (PPGs) create a connection between practices and their patients, allowing for open, constructive discussion and analysis of service provision, and offering an alternative perspective on many of the topics relevant to general practice. This relationship can be strengthened by increasing the breadth of engagement with the local community and integrating the feedback obtained by the practices into Consortia-wide frameworks.⁴

By their nature PPGs are a mechanism which at different times can represent the patient population to the practice, and vice versa (the practice to the wider community). The PPG role could be developed to gauge customer satisfaction with Consortia's and the effectiveness of targeted services. Such an arrangement could form the basis of an early warning system, flagging issues with the provision of services before issues develop.

23. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

A formal and ongoing feedback process ought to be developed to obtain feedback from local people and partners re: equality of opportunity and outcome. Widespread consultations asking local people for their opinions would work, as would developing partnerships currently within health and social care (such as older persons forums). Ownership of this process should be joint between the GP Consortia and Health and Wellbeing Board.

We would expect the Health and Wellbeing Boards and the JSNA would have a key role in ensuring that GP Consortia do not avoid commissioning high-cost specialised service e.g. Learning Difficulties or Physical Disabilities, in order to conserve limited resources.

The needs of diverse population groups including children and young people, homeless, mentally ill, etc. should also be considered. As set out in our response to

³ CHSS, Billings, 2007

⁴ The ways in which this information is subsequently used and the manner in which it informs corporate developments should be fed back to the forums/groups consulted to ensure community engagement with future initiatives.

Achieving Equity and Excellence for Children, we would caution against too much reliance on internet feedback as this will exclude the more disadvantaged groups. Where there are specialist teams who oversee this work, this should be harnessed. For example, KCC firmly believe that the Drug and Alcohol Action Team (DAAT) should remain within the local authority. By commissioning services for the prison population (the county has 11 prisons), as well as for the general population the DAAT ensures that all its service users, however vulnerable, are in the best possible position to achieve equality of opportunity and outcome.

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

As mentioned above, in Kent we are already ensuring that GP Practices are having the opportunity to start engaging with KCC and the local districts. From these conferences and workshops together we can identify how we can build on our understanding of the local commissioning requirements in the area.

“Liberating the NHS: Transparency in outcomes – a framework for the NHS”

General comments

Whilst it is understood what the outcome framework is designed to deliver, the content and lack of clarity is disappointing. Although responses have been provided for each question, there are a few themes that run through, which are detailed below:

1. It appears that the actual concept of an outcome is not always evident in the proposed framework.
2. It is not clear how local priorities will be factored into a framework with nationally based and evidenced indicators. If the NHS is to become more person centred then local priorities must have much greater weight.
3. There is little in the framework to support patients and the public in making their health care choices and no mention of how patient information will be shared with patients if it is collected. For example, people may want to know the waiting times in their local A&E departments, they will want to know the outcomes of certain surgeries, the rate of infection etc. We need to engage with the public to find out what information *they* need to support choice and how *they* want to access it.
4. It is acknowledged that a fundamental part of the outcomes framework should be focussed on patient experience, their views, and the evaluation of whether their outcomes have been met within this vision. However, there appears to be little within the framework which will mean anything to the public, in terms of them holding the NHS to account and being clear what improvements to their local services and their outcomes have been made.
5. The consultation is unclear about how the social care outcome framework will dovetail with this. With the White Paper having such a strong focus on partnership, in particular with Local Authorities having a strengthened role to encourage partnership; it seems contradictory to have a framework which tries to evaluate only the effectiveness of the NHS. It will mean that indicators which may have been influenced by health, public health and social care will need to be picked apart to establish what contribution each party has made.
6. It is unclear whether there is still an intention to move towards an integrated performance framework, but it would seem to be a natural progression, rather than having duplicated indicators across multiple frameworks.
7. The suggestion that there is an increasing reliance on surveys to capture people’s experiences is valid. However, care needs to be taken to make sure that there isn’t a duplication of activity. For example: Social care is also

developing the Putting People First survey, and if there is not any streamlining, we could be surveying the same people twice.

8. The indicators are largely the same indicators as already being used, with some recommendation for surveys, albeit for the short term, but there doesn't seem to be any recommendations for identifying whether GP commissioning provides better outcomes for people, whether the services are more appropriate, whether the quality of services improves, as is intended. In addition, there isn't any mention of a domain that relates to efficiency.
9. There is a lack of clarity about how this information will be collected. With the abolition of the PCT's, which currently includes PCT based performance teams, it is unclear what mechanism would be in place, presumably not the duplication of processes across all GP consortia? This issue might be usefully addressed through a shared services approach.
10. It is not clear what level of flexibility there will be within the framework, in terms of having opportunities to influence what the areas of improvement will be, and having the ability to provide context to each indicator. It's assumed that if a national indicator is chosen as a top level indicator, because of comparisons with other countries, that there will be a built in flexibility if some areas of the country perform well at this, but know where there are other areas which, locally, need a focus. It is hoped that GP commissioning boards will not be asked to focus on PI's if they are not appropriate, rather use a bottom up approach to ensure that local risks and areas of underperformance are being tackled.
11. The selection of performance indicators are largely based on indicators that already exist. It is acknowledged that this is an interim arrangement, to enable the framework to begin quickly. This means that there is a lot more work to do to ensure that the more appropriate indicators are developed, and clarity around this would be helpful. It is hoped that health and wellbeing boards, GP consortia and Local Authorities are involved within this and the indicators are judged to be relevant, integrated, local, flexible and meaningful to the public.
12. It is absolutely critical that accountability for improved outcomes is held through the organisation, from GP consortia, Local council members and partners. To be able to do this effectively, the Health and Wellbeing boards will need to not just approve this framework locally, but have a role in terms of setting local priorities. In addition, it is not clear what involvement GP consortia will have in terms of agreeing priorities and signing up to these, but this will be equally important.

Responses to specific consultation questions

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

The key principles of; accountability and transparency; balance; inclusion of patients and healthcare professionals; promoting excellence and equality; influencing outcomes; working in partnership with other public services; developing internationally comparable statistics and the continued evolution of the framework is a sound basis on which to underpin the framework. However, it is difficult to agree that these should be the definitive principles until more is known about the individual frameworks for health, public health and social care, and how they will complement each other. Particularly, how these will be balanced in terms of compatible domains and indicators with the NHS framework.

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

Flexibility. Until more is known about the framework for health and social services the structure of the NHS framework must be flexible so that it can be amended to be fit for purpose and allow local focus to be on local risk areas. In addition, the new NHS 'agenda' is based on a model which works from the bottom-up; therefore we must make sure that we deliver a framework that can flexibly support patients' and practitioners' requirements. Patients and practitioners will have a local, pragmatic agenda when determining the relevance of the outcomes and indicators within each framework. This approach must be recognised if the new model is to be successful.

Relevance. Each principle, domain and indicator needs to be able to be contextualised. If patients and practitioners are going to 'own' the new NHS model then they need to know why certain indicators have been selected and be able to support them with local evidence. Particularly, if the 'local improvement areas' are going to be identified using these indicators.

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

We must be clear to say that the NHS Framework won't deliver equitable outcomes; it will just identify the risks and alert staff to where possible inequalities occur. Health inequalities vary across the UK, so the outcomes framework must be flexible to take account of these differences and allow regions to focus on their local risk areas. The domains, indicators and improvement areas should be driven at a local level by the Health and Wellbeing Board, GP Consortium and Health Watch Groups as they will be accountable for the delivery of these outcomes.

A local framework will inform local improvement areas for local people.

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

At the very early stage of consultation there should be representation from the NHS, public health and social services in all consultation responses. There needs to be clear expectations set out by the DH which supports this view. In addition, throughout the implementation of the framework it should be mandatory that there is representation from each body on the NHS Commissioning Board and Health Watch Groups. The meetings of the Board and Health Watch group should not be deemed quorate if there is not representation from each body.

If there are to be separate outcome frameworks, even where there is strong partnership, it is critical that the same indicators flow through all the frameworks, structured so that duplication is avoided.

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

The outcome goals of effectiveness, patient experience and safety underpin the five outcome domains.

Domain 1 – preventing people from dying prematurely (Effectiveness)

Domain 2 – enhancing quality of life for people with long-term conditions (Effectiveness)

Domain 3 – Helping people to recover from episodes of ill health or following injury (Effectiveness)

Domain 4 – Ensuring people have a positive experience of care (Patient Experience)

Domain 5 – treating and caring for people in a safe environment and protecting them from avoidable harm (Safety)

Whilst these are reasonable domains, it is not clear how they will dovetail with Social Care and Public health. There are clear areas of overlap, and we need to be certain, that there is neither duplication, nor that these domains contradict each other.

A suggestion for an additional domain would be one which focuses on Public Information, where the indicators help improve a patient's ability to make informed choices. For example, as a patient I would want to know the A+E waiting times of my nearest hospitals, I would want to know the success rate of certain elective surgeries, or the rate of infection risk. A domain which covers this off would be a welcome addition to the Framework.

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

The domains seem reasonable, although it's unclear why there is not a domain about:

Efficiency – how are we ensuring that outcomes are not just delivered, but delivered efficiently?

Better outcomes delivered as a result of the changes proposed within the White paper – people having greater choice, better commissioned and appropriate services. There needs to be indicators within the framework to evaluate how much better the service provided under this new framework has been.

It may also be worthwhile expanding on the patient experience goal by including a domain which covers a patient's negative experience of care. Patients and practitioners are at the heart of the new framework so monitoring how effectively negative outcomes are measured will be key to their ownership of the new system and their ability to effectively implement changes when something is not working.

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

The proposal that there is an overarching outcome indicator containing five or more specific improvement areas, and within that a suite of supporting quality standards developed by NICE is a fair proposal. The NHS Commissioning Board will commission Quality Standards from NICE, and GP Consortia will refer to the NHS Commissioning Board. If the involvement of NICE in this process is necessary, it must be evidenced that NICE have collaborated with NHS, Public Health and Social Care representatives throughout the development process to allow for the continued evolution of the indicator set.

However, as outlined in previous questions, the improvement areas do need to be flexible and relevant to the local region. GP consortia need to be accountable for tackling their own risks and underperformance, and not adhere to a national target or focus if it is not relevant.

There needs to be an allowance for local and national targets.

Also, it is not clear who will be responsible for collecting this data or collating it. Previously this would have been a joint responsibility between the Primary Care Trust's (PCT) and the Local Authority (LA). In this new structure who is responsible for this?

The consultation suggests that the recommended (and largely existing) indicators will be in place for the short term. It is not clear what "short term" means, or how quickly a new and more appropriate set of indicators will be developed.

DOMAIN ONE

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome to use for this domain? Are there any others that should be considered?

'Mortality amenable to healthcare' measure the number of deaths that occur from a pre-defined set of conditions that have been judged to be amenable to healthcare interventions, and so should not lead to deaths at specified ages. Therefore, this suggests that the number of avoidable deaths will be recorded. In addition to this, perhaps we should be recording the number of patients who survived because of intervention. This would allow for greater transparency in terms of measuring the outcome for both sets of results and be comparable on an international scale.

It is not clear how the influence of public health can be separated from this.

9. Do you think this is an appropriate way to select improvement areas in this domain?

If the statistics show a high mortality rate in a specific area where deaths are thought to be avoidable then this should be reported at a national level. However, the improvement areas should not be determined at a national level. The improvement area should be determined at a local level. The NHS Commissioning Board, Health Watch group and LA will have an excellent idea of the areas of improvement in their own locality; this decision should be determined by knowledge and experience, not just statistics alone.

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed?

The Framework accounts for mortality in older people in 2 ways:

- Covered by the fifth domain, treating and caring for people in a safe environment and protecting them from avoidable harm.
- suggested indicators, such as 'premature mortality from cancer' (see page 51)

11. If not, what would be a suitable outcome indicator to address this issue?

It is difficult to distinguish between health based reasons, and social and public health reasons for premature death in older people.

12. Are either of these appropriate areas of focus for mortality in children? Should anything else be considered?

The framework suggestions are: infant mortality and premature mortality from respiratory disease (0-14 years). Research from the University of Washington, Seattle found that the UK had a worse death rate – 5.3 per 1000 children – than any other country in Western Europe. In 2008, the death rate in Sweden was just 2.7 per 1000 children. The figures have been blamed on a combination of unhealthy lifestyles, poor antenatal care and a rise in the number of older mothers. It is suggested therefore, that the following indicators are included:

- infant mortality where parents are smokers
- infant mortality where poor antenatal care is identified
- infant mortality by mothers age
- infant mortality where the child is obese

It is worth pointing out that the majority of indicators suggested are traditional 'public health' areas. This again highlights the importance of making sure that the NHS,

Health and Social Services frameworks are clearly compatible and most importantly workable. Particularly if the LA's will be held responsible for the delivery of the outcomes.

DOMAIN TWO

13. Are either of these appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

These indicators are very much about treating a condition once it has developed. There also needs to be a focus on prevention of long term conditions, for example stopping smoking, but this is traditionally an area for Health. Again, there is clear overlap with Health and Social Care i.e. day to day activity affected.

14. Would indicators such as these 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?

More detailed information on quality of life for those with long-term conditions could be obtained through a PROM, or similar, for long-term conditions in general. Involving patients in this way would make sure that the indicators accurately reflect the concerns of the affected group i.e. they are not seen as a condition but as an individual. This supports the view that the framework, outcomes and indicators should evolve and be flexible. Again, however, there will be overlap with social care and Public Health.

15. 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?

An example of cross cutting topics could be the circumstances of the LTC and how this could be prevented. Again, this has significant overlap with Social Care and Public Health.

DOMAIN THREE

16. Are these appropriate overarching outcome indicators for this domain? (Domain 3, helping people to recover from episodes of illness or following injury) Are there any other indicators that should be considered?

(1. Emergency hospital admissions for acute conditions usually managed in primary care and 2. Emergency bed days associated with repeat acute admissions.)

As we are now penalising hospitals financially for repeat admission it is important that the indicators are compatible. Traditionally there has been a push to free-up beds quickly; this is exemplified in Delayed Transfers of Care. Penalising repeat acute admissions conflicts with the message that if patients are weight bearing they should be discharged. Culturally and practically there is a conflict of interests between these 2 indicators and this would need to be resolved. Currently, Social

Care has delayed transfers of care within its performance framework, so overlap would be evident here again.

All the indicators are hospital based, and do not cover community or GP based support. With the proposals outlined within the paper, it would seem sensible to demonstrate the support and specialist commissioned services that are in place to support people recuperative. In addition, this is an area where partnership working with social care is paramount, and it is not clear how this will be captured.

17. What overarching outcome indicators could be developed for this domain in the longer term?

Prevention i.e. falls and fractures, stroke etc. Again, this has cross-over with Public Health.

Integrated working and support from the community to ensure that injuries are avoided, but that people also have the choice of how they recuperate.

18. Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

The approach of using Patient Reported Outcome Measures (PROMs) for planned care, and focusing on the main causes of emergency bed days for unplanned care is a suitable approach for selecting improvement methods. However, public feedback on how their emergency care was provided and any choice that they were given would also be important, even if asked after the event.

In addition, the improvement areas should not be determined at a national level. The improvement area should be determined at a local level. The NHS Commissioning Board, Health Watch group and LA will have an excellent idea of the areas of improvement in their own locality; this decision should be determined by knowledge and experience, not just statistics alone.

19. What might suitable outcome indicators be in these areas?

The outcome indicators proposed are suitable indicators.

DOMAIN FOUR

20. Do you agree with the proposed interim option for an overarching outcome indicator?

The short-term approach involves tracking performance on a predefined subset of survey questions. Focus will be on the five themes of access and waiting; safe, high quality coordinated care; better information, more choice; building closer relationships; and clean, friendly comfortable places to be. This approach can be applied to surveys that are due to be conducted and published in the next year or so. This is a fair proposal; however we need to be careful that there is a concerted effort to move future development forward towards the longer approach model, and not to rely on short-term solutions that are embedded in traditional practices.

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator?

The long-term approach is to develop an overarching outcome indicator that is based on a limited set of core questions. These questions would ask patients whether they received the care and services they need, whether it met their requirements, enabled them to maintain their health etc. Currently appropriate questions are not included within the existing survey programmes, so development work on the precise indicators is required. Questions focused and guided by patients' experiences will benefit the quality and breadth of data collected. The criteria of the development are not known but it is hoped that practitioners, NHS, Health and Social Services colleagues would be involved.

It is also hoped that the development of such a survey would be combined with the development of the PPF survey, which will aim to survey all people living in the Local Authority, thus avoiding duplication.

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas? (Pg 33)

No improvement areas should be chosen at a local level and there needs to be flexibility within the framework to change the improvement areas when robust information is produced.

23 Would there be benefit in developing dedicated patient experience Quality Standards for certain services and client groups? If yes, which areas should be considered?

Quality standards will set out what high quality care looks like, so involving certain services and client groups in developing dedicated patient experience Quality Standards will be key to making these standards relevant.

24 Do you agree with the proposed future approach for this domain?

Yes, assessing how best to extend and improve national survey arrangements, standardising the approach to this work, and developing a better understanding of patient experience is a good basis from which to develop this domain. However, it is also important to assess whether the new NHS model is working, and also be mindful of the overlap and linkages with health and social care. It would also be beneficial to not just evaluate people's experience of care, but also to see what outcomes and choices they wanted before treatment and the review these to see whether these outcomes were met.

DOMAIN FIVE

25 Do you agree with the proposed overarching outcome indicator?

This is a very hospital based indicator and is concerned more with the process than the person. What about safety within GP surgeries and consortia responsibilities? Particularly preventing abuse in the community and monitoring the number of complaints to GPs.

26. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

The proposed areas of safe treatment; safe discharge/transition, patient environment, safety culture and vulnerable groups are good areas in which to focus on improvement. As previously suggested, these improvement areas need to be suggested at a local level as there may be different focus in different regions, in addition to the national ones.

27 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?

Significant consultation with patients and practitioners is an absolute necessity, not only at the consultation phase but as mandatory practice throughout the creation of the NHS Commissioning Board, Health Watch Groups and Consortia. This can be done via specialist interest groups, whose involvement is the NHS Commissioning Boards responsibility, and whose involvement should be monitored. Boards should be held accountable when there is not adequate representation. This collaboration should continue throughout the evolution of the framework.

The DH also needs to acknowledge the overlap with social care and health. It is important that the NHS, Health and Social Services frameworks are clearly compatible and most importantly workable. This is particularly important if Local Authorities will be held responsible for the delivery of the outcomes. Finally, but very importantly, in view of the very recent proposals around children's health care, the Outcomes Framework must take note of the need to increase investment in services for children and young people to create a truly preventative and cost-effective NHS

28. Is there any way in which the proposed approach to the NHS outcomes Framework might impact upon sustainable development?

See covering letter

29 Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

See covering letter

30 How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

The new changes to the structure will impact on delivery in a way not yet fully understood. Understanding how efficient the new model is going to be and measuring this should be key to the continued evolution of the framework, and essential if we are to understand how we achieve best value for money.

31 Is there any other issues you feel have been missed on which you would like to express a view?

See covering letter

“Liberating the NHS: Regulating Health Care Providers”

Introduction

As requested, the County Council has set out its responses below to the specific questions asked in the consultation document. However, this introduction seeks to ask some more fundamental questions about the regulation of health and social care provision in the medium to long-term.

With the Coalition Government’s stated intention of all NHS healthcare provision being governed in Foundation Trust bodies by 2013, it is clearly a major task ahead to ensure that all remaining NHS trusts acquire this status appropriately and that the authorisation process for this is one that is equitable but robust. The support previously available to NHS trusts from SHAs and PCTs to move towards FT status will diminish significantly during this period as they are downsized prior to their scheduled abolition, so there is a strong case for a single regulatory/licensing body to have this as its predominant if not singular focus during this period of change.

However, once this has been achieved, the case for Monitor as the separate, lighter-touch regulator (initially, Monitor was established as the ‘earned autonomy’ reward for the excellent amongst NHS trusts) is less compelling as, by definition, excellence becomes the norm. Also, as the Francis Report into events at Mid Staffs NHS Foundation Trust indicates, there are inherent risks from the splitting of the quality and economic regulatory functions – risks arising from the confusion of who does what as well as the risks of burdensome duplication.

There may be a superficial argument for one body being the economic regulator for both health and social care – but this consultation fails to make the case for it. The challenges to closer integration between health and social will not be overcome by the creation of a single economic regulator for them (or in the case of social care, the acquisition of an additional regulator). Nothing in the consultation paper indicates how Monitor becoming the economic regulator of social care could add value to what is currently already a mature, largely self-regulating market within the remit of OFT. Indeed, the maturity of the social care market is attributable in part to the strategic commissioning prowess of local authorities since the 1993 community care changes. The effect of this change would be counter to the policies of decentralization and would involve duplication of councils’ continuing market-shaping roles and the usurpation of some of their existing powers and responsibilities. Tellingly, there is nothing to explain what failings in the current system this change in Monitor’s role would be intended to tackle in adult social care.

We would suggest that Monitor is given the focused task of authorizing FT applications over the next 2-3 years, including licensing oversight of acquisitions, mergers and de-mergers during this period. Thereafter, we would suggest the BRE may wish to review Monitor’s regulatory functions with a view to their re-assignment to smaller dedicated units within other bodies such as CQC and strengthening the district audit/NAO role in respect of governance and risk-management audit.

One other key point we would like to emphasise is the need for public accountability for organisations who provide healthcare. As set out in our response to the Democratic legitimacy paper KCC proposes that the Health and Wellbeing Board (or local equivalent) has oversight of major changes proposed by local healthcare providers, such as proposals to merge or demerge, shed parts of their organisations etc. It is vital, especially during a potentially fragile transition period, that the freedoms proposed in this consultation document are balanced by the need for robust public accountability. The ambition of “putting patients and the public first” will not be achieved if healthcare providers can reduce local choice to suit their organisational needs without considering whether this is in the public interest

Responses to specific consultation questions

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?

Agreed. The principle will need to enshrine some safeguards to protect the public interest in ways that are proportionate and light touch. The issue in the public’s perception is often the fear that this might mark a first step in the “creeping privatisation” of ‘their’ NHS. Perhaps the best limitation to the removal of private income caps lies in governance arrangements that still require FTs to proactively engage with the public early in the development of proposals for change rather than in the financial ‘rules’ per se.

Another concern that has been expressed is that some Foundation Trusts might get so powerful that that they will be able, notwithstanding the tariff system, to ‘regulate’ the price they charge to the consortia rather than it being based on value for money principles ad/or stifle competition. This is of course a legitimate concern that strengthened economic regulation could be seen as countering this but our view is that this function could be discharged in the longer term by a small unit hosted **within** CQC and by effectively joining FTs into local discussions on commissioning pathways on a whole-system basis.

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

The current controls are somewhat arbitrary and inflexible. We agree there should be more flexibility. However if all controls were removed, how would a Government know that the borrowing is prudent? What is prudent at one point in time may turn out to be less so if economic circumstances change. The prudential borrowing arrangements for local authorities may offer a useful way forward. It is doubtful whether this can be dealt with satisfactorily in primary legislation the ongoing role of district should not be overlooked..

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

Yes. Any changes in constitutional arrangements are important by definition and therefore should be discussed with all those groups the Trust is accountable to, directly or otherwise. Therefore, local GP consortia, local HealthWatch, the local Health & Well-being Board (or equivalent) should be the prime consultees for FTs – but certainly not Monitor as the sole arbiter. This is a matter of public accountability, not regulatory detail.

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?

This question indicates anticipation of a great deal of change in the landscape of NHS provision in the short-to-medium term. Another factor at work is the very different economics of a period of limited or no growth in the next 3-4 years and the applicability of financial criteria for FT financial ‘fitness’ that were drawn up in times of significant growth.

Given all the other changes happening simultaneously, there is an argument for greater stability on the provider side which might militate against making mergers, acquisitions and de-mergers simpler, especially during the transition. However, this is an unlikely course for the Government to take so an alternative may be to make legislative provision for a more federated approach between collaborative Trusts and FTs.

On the specifics, any such mergers should be only made if local public groups (Healthwatch), local consortia and local Health & Wellbeing Boards have signed the merger off. This is as much an issue of keeping a close eye on risk-management and business continuity during the turbulence of the transitional period as a systemic, ongoing regulatory issue. Monitor is well placed to undertake a key part of this role during the transitional period.

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

See above

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 key role to be undertaken if the public are to be fully assured that it remains ‘their’ NHS. Given the current levels of mistrust, there needs to be some body to oversee Trusts and to oversee them in a way that is seen as at least semi-autonomous from ‘insider’ vested interests, to ensure that they are running effectively and to ensure that poor practice is not covered up. However, it is not necessary to crowd the market with regulators. Our view is that over time, the sole *regulator* should be CQC, with a clear focus on clinical quality and patient safety, and that safeguarding the taxpayer’s investment, governance and organisational

fitness is a matter of a more robust district audit regime, couple with that of the National Audit Office.

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

Freedoms are good as long as they are coupled with responsibilities and are accountable. Clear accountability does not equate to heavy regulation. Trusts need to be accountable to their feeder consortia/ local HealthWatch/local Health & Wellbeing Boards and above all local public groups. Arguably, the greatest 'liberation' of healthcare providers has already been achieved by dismantling the top-down micro-management from Whitehall and the bureaucratic paraphernalia of targets and PIs – consolidating and preserving this slimming-down is important.

Whilst consortia offer new opportunities for local engagement and accountability, this is potentially at a risk of fragmentation, which could put the larger providers in a position of significant dominance and running risk of the provider tail wagging the commissioning dog!

That said, as long as the healthcare market remains immature and dominated by NHS providers to the disadvantage of private or third sector providers, there will, paradoxically, still be a legitimate complaint by FTs that when it comes to "failure", there is no level playing field and that they are much more exposed to the consequences of failure than small niche providers.

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?

This is rather difficult to answer as the thrust of our argument is that licensing should rest with CQC – on a similar basis to the way in which they currently regulate social care providers.

The question also seems to ignore the circumstances that in a time of public finance restraint rather than growth, the current financial criteria for authorizing new FTs in the future may seriously disadvantage many would-be applicants so that they are more vulnerable to de-merger and acquisition. On the other hand, whilst lowering the threshold of the economic criteria in the interests of "equity" would meet the 'fairness' criteria, it might also increase risks of FT status being granted inappropriately, which is no-one's longer term interests.

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

No. The case has not been made that, in the longer term, only Monitor can do something that others (eg CQC) could not with only a minor adjustment of their current role, although we do believe there is a strong case for Monitor in the interim. Unfortunately for Monitor's credibility, on the occasions it might have used its licensing powers more effectively (eg Basildon and Mid Staffs) it has failed to do so. It is difficult to see how strengthening its licensing powers by the addition of concurrent powers it seeks in relation to competition legislation would have any

bearing on its effectiveness, given its omissions with regard to its current powers. Concurrency would only mean further duplication.

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

We believe that all providers should have the right to one appeal only – whatever the circumstances. However, if in the view of the regulator the matter is of such a serious nature the regulator would have the power to suspend that service until the appeal was heard. Modifications would in any event need to be proportionate and decisions should never be taken by Monitor in isolation from other parties with an interest, such as commissioners or HealthWatch.

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?

This question seems to be borne mainly of Monitor's aspiration to be perceived as another OfWat or OfGem, which are the singular regulator in their fields. If Monitor were to have a long-term future as a regulator, this would probably be the right way forward. However, for the interim role we would suggest – as FT authoriser – it would be more reasonable to see it as an NDPB, acting as an agency on behalf of DH to deliver a specific policy and costed and paid for accordingly by DH.

Q12. How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

Whilst the NHS Commissioning Board may be the best place to allocate the totality of NHS commissioning expenditure between consortia and other bodies charged with commissioning healthcare, no Government would wish to delegate the overall responsibility for deciding what resources are available to the NHS. Therefore, the responsibility for addressing issues of addressing affordability is inextricably bound up with that of responsibility for setting the budget. In this respect the price-regulation roles of Monitor and, for example OfWat, are quite different. The role of monitoring prices for healthcare services can be regulated through a combination of levers:-

- NICE sets standards upon which price are based;
- NHS Commissioning Board, with CQC support, monitors appropriate price nationally and if need be intervene/arbitrate;
- GP consortia, with the support of Health & Wellbeing Boards or equivalent will ensure a locally acceptable and affordable price can be set.

Q13. Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

Given the answer to question 12 – question 13 not valid

Q15. Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

We need to reserve our position at the moment. One of the main weaknesses of the 'boxed set' of consultations is the disconnect between the 'commissioning' paper on the role of the NHS Commissioning Board as resource-allocator (as well as commissioner) and the 'regulation' paper on Monitor's role in pricing methodology. Different parts of the DH/NHS seem to have different views and/or are working at cross-purposes, which are not clarified in the overarching paper. Since this will be a matter of the primary legislation the chances of unintended consequences are high.

Q16. What more should be done to support a level playing field for providers?

There is an argument that a level playing-field in healthcare provision is a laudable aspiration but something of a Holy Grail. On the one hand, larger providers will always tend have more 'clout' in the market place than smaller providers, new entrants or niche providers but on the other hand, with the present regulatory regime, it is more difficult for them to respond to changes in demand/clinical requirements and they are much more exposed to the consequential risks of regulatory 'failure'.

There is a danger of devising ever-more complicated "rules" at the expense of judgement and, importantly, transparency of decision-making.

Keeping regulation to the minimum allows space for responsible self-regulation.

Social care provides a good example. "Market management" of the social care market since 1993 has been most effective, it can strongly argued, when done via commissioning strategies, usually lead by local authorities, based on good information about demand and an inclusive engagement between commissioners and providers. Also, the introduction of personalisation into health care would provide another field-levelling approach, empowering the individual's choice.

Neither of these approaches, it should be noted, require anything other than a light-touch regulatory regime in the background.

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 anti-competitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

For the following reasons, we would not support this as a longer-term role for Monitor:

1. Not convinced that Monitor necessarily has a long-term role.
2. OFT already have the necessary legislative powers – concurrency would mean duplication and/or double-jeopardy.
3. Such an approach to regulation of the social care market has the potential of being disastrous and could even see an unfunded increase in prices.
4. If the aim of the coalition government is one of deregulation, any increase in regulation would have to be evidence-based rather than ‘safety first’.
5. The problem will not solely be a risk of anti-competitive behaviour by commissioners – but the role of large Trusts in stifling fair pricing and crowding out competition.
6. Finally a drive toward personalisation, choice and ‘any willing provider’ will help to shift the power of commissioning increasingly towards individuals.

It is possible that checks and balances will be needed to safeguard against the risk of GPs being perceived as commissioning from themselves in an unwarranted way – as now, the best safeguards will lie in transparency of decision-making and local accountability.

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?

For the following reasons, we believe these important aspects of service continuity are primarily dealt with as responsibilities for commissioners – GP consortia or the NHS Commissioning Board – rather than regulators:

1. we are not convinced that Monitor have a valid role in the longer-term.
2. in relation to social care, this would impinge on the statutory responsibilities of local authorities under a number of current social and community care enactments;
3. CQC already holds local authorities to account for service continuity as part of its inspection remit.

Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?

In order for the market to work effectively those commissioning services need to be sufficiently empowered and understand the need in their communities. Personalisation offers opportunities to place commissioning decisions in the hands of individuals – this is beginning to deliver results in the social care market. As the financial as well as service risk is ultimately borne by the commissioners, they have the greatest incentive for an effective approach to risk-management that may entail combinations of consortia choosing to pool risk so whilst ‘special administration’ arrangements may always be needed as a measure of last resort, there is no a priori case for their invocation to be the sole responsibility or prerogative of Monitor, who in any event would be heavily reliant on the sector as a whole coming up with a whole-systems solution to minimise disruption.

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

As said earlier, the greatest 'freeing' has probably already happened with the cuts in centrally-imposed targets and their associated bureaucracy and the reduction in the number of quangos. On the face of it freeing up the FTs offers opportunities, but there do need to be checks and balances to ensure that they are working for their community. The public fear is that, if left unchecked, some FTs will focus on their development as autonomous organisations, developing their private markets instead of meeting the needs of their local communities. Therefore the consortia, Health & Wellbeing Boards and local public groups must play an extended role in the governance of the Trusts.

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?

Proposals for this have already been outlined in the responses to the questions above, but in summary the following key factors need to be considered

- Don't overburden the market with regulators – which will cause confusion and distort the market
- Ensure local stakeholders have a key role in the governance of the trust as outlined above
- Keep alive the drive for personalisation which will empower individuals to have

Finally there is a contradiction between the White Paper and the consultation document on regulation. On page 38 of the White Paper it is stated: "Monitor will be turned into the economic regulator for the health and *social care* sectors..."

However on Page 12 para 4.5 of the Regulating Healthcare providers it is stated "Monitors power to regulate prices and license providers will only cover NHS services".

This suggests a contradiction in the powers being invested in Monitor. Furthermore, there is grave concern about Monitor becoming involved in the functioning of the well established social care market, which already has effective regulation. Finally what is proposed for shared health / social care providers – such as intermediate care?

ACHIEVING EQUITY AND EXCELLENCE FOR CHILDREN

Putting children, young people and their families first

1. Some interesting proposals are set out in this section. It would be helpful to have more information on the new 'maternity networks' referred to in 2.1 in order to understand how these will link with G.P Consortia and Children's Centres as they are a crucial part of local health provision and can play a key role in early intervention and prevention, both pre and post birth with vulnerable families.
2. We welcome the commitment to developing 'a coherent 24/7 urgent care service (2.3) which will make sense to families', is the intention that these would be developed within a national framework or left to local determination?
3. On 'Listening to the voice of children, young people and families' and the proposed role of local Health Watch (2.5) – and as detailed in the Democratic Legitimacy paper, Local Authorities need to be given the freedom and flexibility to make the most effective arrangements for how public engagement around health is carried out. In Kent, as I am sure is the case with other Local Authorities, there are many well-developed systems that represent the voice of children, young people and families and we would like to network these into the local HealthWatch This would both enrich the contribution of Health Watch and ensure an efficient approach to representing the voice of children, young people and families. We do have examples of good local best practice and would be delighted to provide these on request.
4. Health Watch England and the CQC would also be able to take account of local voice through dialogue with local authorities.
5. We are pleased to see acknowledgement of needs of vulnerable children and young people. Many local Authorities will already have commissioned advocacy services for children with additional needs. The issues are less around advocacy and more around **sufficient capacity** in relation to CAMHS and speech and language therapy. (2.8)
6. We welcome the move to providing choice so that children and young people can access treatment and care in age-appropriate settings. This is a particular issue for teenagers who fall between the provision in children and adult settings (2.12).
7. We strongly agree with the establishment of the right to register with any GP. The development of "specialist" practices needs to be carefully monitored to ensure geographical spread, and ease of access for all, including the most vulnerable (who are less likely to be mobile or take the initiative) and those in rural areas. It is hoped that the Health and Wellbeing Boards could take a

strategic overview of health provision across their area taking account of evidenced need and priorities within specific localities. (2.14).

8. We presume that the pilot of individual budgets for disabled children and their families will be reflected in the SEN Green Paper (2.15) and look forward to its publication.
9. We agree that information alone is not enough (2.22) and fully support the crucial role of Health Visitors. We would like to explore in more detail the important role of GP Consortia and Health Visitors in the context of changing expectations around Children's Centres.
10. Most local authorities, including Kent, already have strong relationships with voluntary, community and private sector partners and commission them to provide a range of services – from direct provision of services to advocacy, mediation, support and information related to children's services. HealthWatch and Health and Wellbeing Boards (or local equivalents) need the freedom to build on and link with the arrangements already in place for children's services. (2.23)
11. We support the idea of a national signposting service (2.26) and agree with the importance of good information sharing arrangements. We feel that an area that is not being addressed sufficiently at this stage is the sharing of any relevant information around the parents/carers so that a holistic family based approach can be implemented around a child or young person.
12. We welcome the greater voice for children and young people nationally, especially those of the most disadvantaged sectors of our communities. We would like to see more emphasis on growing local leaders in communities to really galvanise local areas to rise to the challenges of changing behaviours. You have mentioned internet feedback, and whilst this is positive, it must be recognised that many disadvantaged families do not have access to the internet at home, and do not access computers in community settings. Feedback from these parents needs to be facilitated by our third sector partners as they are an excellent interface with local communities and we should use them more in formal consultation.
13. The introduction of personalised budgets is welcome and we have seen the benefits of families being able to drive the decision making in their own and their children's care. However thought needs to be given to how local authorities can be supported to manage this expensive transition of allocating funds to families whilst maintaining services through central commissioning for those families who choose not to take up the initiative. This is especially important in the current economic climate where there is no slack in budgets. As detailed in the Democratic Legitimacy consultation response, there needs to be a period of reflection and learning in regards to the Personal Health Budget pilot programmes for adults that should inform how best to introduce this for children.

14. We welcome the focus on advice being available to adolescents and the profiling of Gillick Competence. Confidentiality remains a key concern for young people and your highlighting of this will be a good lever for those trying to implement policy at local level across the many different settings and services that young people access.
15. Your profiling of the need to share data is excellent. Although local data sharing agreements are becoming the norm there remains an anxiety amongst professionals about sharing data. Where this is for the good of the child or young person this should become the norm rather than the exception.

Improving Outcomes for Children and Young People

16. The move to evidence based outcome measures is welcomed and fits with the approach being taken across children and young peoples' services more broadly. We agree that payment should reflect outcomes but would welcome more clarity on where accountability will lie for poorly performing services and for decisions around closure or replacement? Greater clarity on this aspect of the performance framework and on ultimate accountability when a provider "fails" needs more thought and consultation. (3.1).
17. We fully endorse the overarching quality and experience themes set out in 3.9 and would like to recommend adding Young carers to those listed. We see it as crucial to reflect consideration of adult's needs as parents and carers in any quality standards around services for adults.
18. The proposals around local budgets, particularly as set out in 3.11 remain unclear. We look forward to more detail around future funding of Children's centres and the inter-relationship between funding of G.P. consortia, Children's Centres, community health services and CAMHS.
19. Kent has worked with PCT colleagues on the Health Joint Strategic needs assessment and Health colleagues have been involved in discussions around priorities for our Children's Trust work and CYPP based on a root cause analysis of presenting intractable problems for our most vulnerable children and young people in Kent. Any discussion and agreement on the alignment of outcomes needs to be set against this backdrop in order to support improvements around integrated working and beneficial impact for children, young people and families.
20. We welcome the proposals on training and education and look forward to the results of Professor Munro's review of child protection. If the government were to develop a common set of principles for all children's workers it would be excellent – so much time and funding is wasted providing additional training to children's workers when this could be integral to their core training, an example of this is confidentiality or adolescence and risk taking (sexual health and substance misuse).

Clear accountability, local autonomy and cutting bureaucracy.

- 21.** We look forward to engaging in the development of “the largest social enterprise sector in the world” and influencing the development and operation of a clear accountability framework (4.1).
- 22.** From experience, schools do not conform to one model or educational/health philosophy. Whilst many Head Teachers fit the description set out in 4.14, some struggle with the tension between keeping a primary focus on improving educational outcomes for their children and young people and managing the interface with partners to ensure that the important “wellbeing” needs around children’s development are met.
- 23.** We welcome the “strong strategic role” for local authorities as champions for greater equality, fairness and opportunities for all pupils and the role in “co-ordinating wider health and welfare services for all vulnerable children”. The approach taken will not only vary according to the local configuration of schools and services, they will vary according to the funding available and the impact of the Comprehensive Spending Review on funding for preventative services. The majority of our preventative services for children, young people and families in Kent are currently funded via grant. (4.15)
- 24.** We are eager to work with emerging G.P. Consortia to address the challenges we all face during transition and to facilitate relationship building with wider children’s services. A number of G.Ps are already engaged with our local planning and delivery arrangements around our Children’s Trust and we expect this to become much wider as our relationships grow. As mentioned in our Commissioning for patients response, KCC is setting up a series of workshops and conferences with GPs, PCTs and other stakeholders to start building up our new relationships and identifying new ways of working. We would welcome encouragement to G.P. consortia as they form, to engage with the local authority as we are able to provide support during transition. (4.18). In our response to the Democratic Legitimacy paper, we are also suggesting that there should be a statutory duty for Local Authorities to carry out the functions of the Health and Wellbeing Boards and a reciprocal duty for GP Consortia to attend and contribute.
- 25.** KCC is keen to help with the issues raised in paragraph 4.20, facilitating the pooling of expertise across consortia in the commissioning of specialised services, or in taking on delegated responsibility for commissioning of children’s services. We would be pleased to take on this commissioning role in Kent.
- 26.** We would prefer to have the freedom to develop our own relationship between the Health and wellbeing Board and our Children’s Trust arrangements in Kent. We are currently reviewing the operation and structure for our local strategic partnership and would want to develop these arrangements in line with the outcomes of this review.