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The Health White Paper

Equity and Excellence: Liberating the NHS

A response

A response to the Coalition Government's White Paper for the NHS, focused on issues of public engagement and accountability.

By Mike Cooper for Tamarind Chambers

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TAMARIND CHAMBERS
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Tamarind Chambers was established by Mike Cooper and Diana Coman in 2010 from a desire to promote effectiveness and innovation in community involvement. Tamarind offers a menu of advice, training and support on engagement, communications, consultation, scrutiny, accountability and governance, for public, private and third sector organisations. Members of Tamarind Chambers bring together their broad experience and knowledge to deliver high quality and tailored programmes and strategies to enable individuals and organisations to meet the economic and social challenges they face.

About the author

Mike Cooper is an independent, self-employed, advisor and consultant working to support and promote the development of community engagement, scrutiny and governance in the public, not-for-profit, voluntary and community sector, specialising in the fields of health and social care.

Mike was an elected Borough Councillor for 17 years, and for three years Leader of the Council. He has extensive knowledge and experience of the whole range of local government services and in particular of social care and the interface between the local authority and the NHS. As an independent consultant since 2002, Mike has worked with a wide range of local authorities, NHS bodies and voluntary and community organisations, to help them develop the relationships between them and with their stakeholders and improve the engagement of patients and the public; he has helped to make local authority scrutiny of health and social care more effective and to establish and develop Local Involvement Networks (LINks).

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1 Introduction

The Coalition Government published its Health White Paper, *Equity and excellence: liberating the NHS*, in July 2010, along with a set of associated consultation papers.

This is a response to the Coalition Government's proposals for the NHS set out in the White Paper.

It focuses on aspects of the White Paper affecting public engagement and accountability. It is particularly relevant to the perspectives of participants in public and patient involvement mechanisms including Local Involvement Networks, scrutiny bodies and local authority councillors, local voluntary and community organisations, patient and carers groups.

This response has been informed by listening to a range of stakeholders, including patients, LINk participants, councillors and local voluntary and community organisations during the consultation period, and our experience, as elected councilors and community activists, and working to support and promote the development of community engagement, scrutiny and governance in the public, not-for-profit, voluntary and community sector.

Note on usage of words 'patients' and 'public'. When we use the word 'patient' we refer to all who use or need services, in line with the Department of Health definition that includes all current patients, those who should be patients but may not have access to services, all past patients and potential future patients; which effectively means everyone, making no distinction between current patients and the wider public. When we use the word 'public' we refer to the public in their role as citizens. The distinction between patients and public is therefore between the interests of individual service users and the interests of the whole community.

2 Summary and main concerns

2.1 The aims of the White Paper

We welcome the broad aims set out by the White Paper, to;

- put patients and public first, making the NHS more patient-centred and giving citizens a greater say in how it is run;
- make improvement in quality and healthcare outcomes the primary purpose of all NHS-funded care;
- bring greater autonomy, accountability and democratic legitimacy to the NHS; and
- cut bureaucracy and improve efficiency, making the NHS less fragmented and releasing efficiency savings to reinvest in the NHS.

But we believe that the White Paper leaves serious questions as to whether the proposals contained in it are always an effective way of achieving these aims.

The White Paper says it wants the NHS to be more 'responsive', but it less clear on what and who it should be responsive to and how it will be made responsive.

The White Paper says it wants to 'give citizens a greater say in how the NHS is run', bring 'greater democratic legitimacy to the NHS', make professionals and providers 'more accountable to patients and the public', devolve power and join up health and social care; all developments that are greatly needed.

Transparency, involvement and accountability – to individual patients and the wider community as citizens and taxpayers – need to be embedded at every level of the NHS, from national, through local commissioning, to individual service delivery.

However, there are significant gaps in the White Paper's proposals in terms of how they will bring effective local accountability, scrutiny and democratic legitimacy to NHS services, and in particular how citizens, as opposed to patients, will have a voice.

2.2 Autonomy and freedom

We welcome the focus on greater autonomy and freedom for commissioners and providers to respond to the needs of patients locally, in place of central government direction; and the promotion of social enterprise and the potential for greater employee and public engagement this can bring, but recognise that this requires transparency and accountability.

We are concerned that encouraging a market-based approach and competition between providers will hamper cooperation in the interests of the community and stifle transparency and prevent effective scrutiny. Autonomy and freedom must be tempered by transparency and effective local accountability. (See section 3.7 for more details.)

2.3 Governance

The White Paper is insufficiently clear about the governance arrangements for the proposed GP Consortia (GPC). More rigorous governance requirements should be placed on GP Consortia to ensure they are transparent, accessible and accountable to their local community, with a system that protects against conflict of interests and provides checks and balances and challenge that include non-professionals.

(See section 3.9.2 for more details.)

2.4 Local accountability

We strongly support the aim of increasing local accountability in the NHS, in place of the current central accountability through Strategic Health Authorities (SHAs) and the Department of Health to the Secretary of State. We see no real loss from the abolition of SHAs, and do not regard PCTs as great examples of accountable, transparent and well-loved local institutions; but we are not convinced that the proposals for GP Consortia will be much of an improvement in terms of accountability to the local community.

The White Paper with its talk of autonomy for professionals and GP Consortia being accountable to the NHS Commissioning Board, fails to establish how real local accountability will be achieved or to demonstrate how the local authority / wellbeing board will exercise its 'strategic control' or have any real say over local NHS commissioning decisions and service provision. (See sections 3.8 and 3.9.3 for more details.)

2.5 Accountability and integration

Transferring commissioning of public health and health promotion to local authorities makes these services more locally accountable and more joined up with social care and other local authority services. But the proposals to give responsibility for commissioning NHS services to GP Consortia will make public health *less* joined up with other NHS services and leave NHS and social care services insufficiently joined up.

Effective integration requires more than 'partnership' between two or more organisations with their own separate lines of funding and accountability, in which there is a tendency for the 'partners' to protect their own budgets and attempt to 'offload' responsibility onto others, especially in times of budget constraint.

(See sections 3.8.3 and 3.8.5 for more details.)

2.6 Scrutiny

Local authority scrutiny has been shown to bring value in terms of increasing local accountability, engaging stakeholders and the public and achieving real improvements to services. This should not be lost to the commissioning and provision of health services.

The power of local authorities to scrutinise NHS decisions and services on behalf of their local community should be retained so that the decisions of the health and wellbeing board and the GP Consortia are subject to independent external scrutiny, and the scrutiny of these services should be joined up with the scrutiny of public health and social care. (See section 3.9.4 for more details.)

2.7 Real local accountability

Real local accountability and service integration would be achieved by giving local authorities a real level of responsibility and accountability for commissioning *all* health services for residents of their area, by making GP Consortia and local primary and specialised services directly responsible and accountable to the local authority.

This would give local authorities an ability to affect commissioning decisions and actual health outcomes across social care, public health and the NHS; enable effective integration by way of joint budgets; bring truly joined up decision-making; and make the NHS directly accountable to the local community through the local authority's accessible and democratic decision-making and scrutiny arrangements.

3 An analysis of the proposals in the White Paper

3.1 Patient and public voice

We welcome the White Paper's commitment to creating an NHS that is genuinely centred on patients and carers and giving citizens a greater say in how the NHS is run. It is right that the NHS becomes more patient-centred, and that more power is given to patients ad the professionals working with them. However we are concerned that the White Paper contains rather less effective proposals for engaging citizens rather than patients, and it glosses over the potential conflict between these two aims. There can be a conflict between the interests of individual service users and the interests of the wider community as citizens and taxpayers.

Alongside developments to empower local professionals and engage patients in their care, there needs to be effective local accountability, with transparency and real power placed in the hands of people representing the wider local community, not just individual patients, and not just vested in NHS professionals.

(See section 3.9 for more details.)

3.2 An information revolution

We welcome the White Paper's to improve the quality and accessibility of information and the extension of the use of patient experience data and surveys.

Transparency and access to information is indeed an essential condition of achieving effective accountability, bit on its own it is not sufficient; patients and the public and their representatives need effective mechanisms through which they can achieve real changes in commissioning and service provision as a result of their consideration of such information.

We welcome the commitment to give patients control over their health records. GP/patient confidentiality is an essential element of the relationship between patient and GP, and patients may have sensitive medical information, such as mental health diagnoses or past medical treatment, which they quite understandably do not want shared, even with other qualified medical staff.

Sharing medical records should be done on the basis of a specific agreement by the patient of what should be shared with whom, rather than the previous assumption that all information should be shared unless the patient makes a case against it; and patients need to be given balanced advice about their options, not just the promotion of the benefits of central databases.

In the meantime, the roll-out of the previous NHS records system should be suspended.

3.3 HealthWatch

3.3.1 LINks to become HealthWatch

The White Paper says that Local Involvement Networks (LINks) will become local HealthWatch; the Consultation Paper *Local democratic legitimacy in health* says 'LINks are not being abolished'.

We welcome the statement that LINks will not be abolished; despite local variations, LINks are making progress and are having a positive effect on engaging their communities and prompting the improvement of health and social care services. And LINks themselves have been in place less than three years following a previous reorganisation of patient and public involvement.

We do share the concerns that many have raised over the proposed name:

- The White Paper says a lot about integration of health and social care, and that HealthWatch, like LINks, will encompass both; but the name HealthWatch could appear to exclude social care, and does not sound 'joined up'.
- LINks are beginning to become established and known in their locality, developing relationships with their partners, and money has been spent on branding.
- Plus the name HealthWatch is already used by a voluntary organisation in this field.

Given the above and the emphasis on continuity with LINks, we believe the proposed local body should retain the name LINk.

We are concerned that the proposed changes could impose unnecessary costs and organisational disruption on LINks/HealthWatch. *LINks should continue and be allowed to adapt and take on the new roles proposed for HealthWatch.*

HealthWatch/LINks should retain the open membership/participation of LINks and the requirement on LINks to be diverse and broadly representative of their community.

3.3.2 Powers of HealthWatch

HealthWatch should continue to undertake the LINk role of promoting patient and public involvement and seeking views and feeding those views into local commissioning, and should retain the functions and powers of LINks:

i. LINk powers to enter and view apply to places where publicly funded care is provided; there is a duty on NHS providers to enable entry, and PCTs are directed by the Secretary of State to ensure through their contracts that independent providers enable entry. The switch to GP commissioning should make no difference, as long as GPs, as commissioners, place this responsibility on independent providers via their contracts.

   A formal duty should be placed on GP commissioning Consortia (GPCs) to put appropriate terms in their contracts with independent providers so that they allow entry by authorised representatives of HealthWatch.

ii. LINk powers to ask questions and make recommendations to 'services-providers' are backed by the duty to respond placed on Trusts, PCTs and local authorities – which does not currently include GPC; but current Department of Health guidance says that 'services-providers' are commissioners, which would imply that GPC would be covered

   To ensure LINk powers to ask questions and make recommendations to 'services-providers' are available to HealthWatch, GPC should be placed under the formal duty to respond and to put appropriate terms in their contracts with independent providers so that they are required to respond.

iii. LINk powers to refer social care matters to local authority Overview and Scrutiny Committees (OSCs) appear to be retained by HealthWatch; but the power to refer NHS matters to an OSC, and thereby 'escalate' an issue to an independent body with specific powers, will be lost under

the White Paper proposal to remove the local authority's statutory health scrutiny powers; HealthWatch will be able to refer matters to the proposed health and wellbeing boards responsible for strategic and joint funding matters, but they will not provide independent scrutiny and challenge of NHS commissioning.

(See section 3.5 for comments on the proposed additional roles for HealthWatch.)

3.3.3 HealthWatch boundaries

The implication is that local HealthWatch will have the same geographical area as the LINk, which generally corresponds to the relevant local authority area. This would be preferable for joint working with local authorities, accountability and clarity for local residents.

HealthWatch should retain coterminosity with local authority boundaries.

However, GPCs will not have the same boundaries as HealthWatch, or retain the boundaries of PCTs. GPCs boundaries will not follow a nationally prescribed pattern and patients will have choice of GP; so GPCs need not be contiguous and may overlap and change over time.

A local HealthWatch may have to engage with a number of GPCs and may be faced with a very fragmented pattern of commissioning; GPCs are likely to have to engage with more than one HealthWatch.

Guidance should be given to HealthWatch and GPCs to ensure that HealthWatch can effectively engage on behalf of their communities, without placing unrealistic expectations on GPCs, eg by requiring a GPC to engage with any HealthWatch where it commissions for a certain proportion of the HealthWatch population and/or by way of a requirement for joint relationships and meetings.

3.3.4 Funding and accountability of HealthWatch

The White Paper proposes that local HealthWatch will be funded by and accountable to its local authority.

Local authorities currently hold the budget and contract for the LINk Host. LINks are required to be accountable to their local community, but this is poorly defined, and some participants have complained about a lack of effective accountability and the difficulty of tackling LINks / Hosts that are not performing.

Concerns have been raised that the White Paper proposal would compromise the independence of HealthWatch. However, local authorities operate a scrutiny function that can effectively scrutinise and oppose the executive and fund many other organisations that maintain their independence!

It is in the interests of local accountability and guardianship of public money that the funding for local HealthWatch comes from its own local authority. Making HealthWatch clearly accountable to its local authority would improve local accountability for the activities of and use of public resources by HealthWatch.

In addition, HealthWatch should retain accountability directly to its local community, for example by retention of the requirement on LINks to produce an annual report.

It is understood from the White Paper and statements from the Department of Health that local authorities will be able to choose to contract directly with local HealthWatch (as opposed to funding a separate Host organisation), or with a Host organisation or make other arrangements.

If HealthWatch itself is to hold a budget and employ staff itself, rather than have a separate Host, it will need to have some different structures from a LINk, and it may not want to take that on, although it would not mean that much of the established governance of LINks need change.

Whether the local authority contracts directly with HealthWatch, a Host organisation or by some other arrangement should be left to the local authority to determine, in consultation with its HealthWatch / LINk and other local stakeholders.

3.3.5 Transition from LINks to HealthWatch

Current LINk/Host contracts come up for renewal in March 2011, whilst HealthWatch will not be in place until January 2012. But it is not yet clear how LINks will 'become' local HealthWatch, and how they will continue to carry out their activities and represent their communities in the transition.

LINks should become shadow HealthWatch, continuing to operate through the transition and taking on any additional roles, and will require funding until the new contracts for HealthWatch are in place.

3.3.5 HealthWatch England

The White Paper proposes the establishment of a national HealthWatch England; many involved with LINks bemoaned the lack of a national voice for LINks.

We welcome the establishment of HealthWatch England as a body that can provide an additional, national voice for patients and the public; a new forum to bring together information from local HealthWatch, build the bigger picture, and pass views on; as well as offer support and advice to local HealthWatch.

However we are concerned that HealthWatch England should not become an obstacle or filter for the views of local HealthWatch to pass through, or try to meddle in or direct local HealthWatch.

The relationship between HealthWatch England and local HealthWatch should be 'bottom-up' with HealthWatch England receiving information from and offering support to local HealthWatch, but not 'filtering' the views of, or attempting to 'direct' or exert control over, local HealthWatch.

Concerns have been expressed over the proposal that HealthWatch England be a part of the CQC, even an 'arms-length' part, rather than an independent body. LINks were told (rightly) that their role is not 'inspection'.

To maintain clarity of their roles, it may not be appropriate for HealthWatch England to be part of the CQC, which is the national quality inspectorate.

3.3.6 Referral of issues to Care Quality Commission (CQC)

Currently a LINk can refer matters to the Care Quality Commission (CQC), independently of its local authority. The White Paper proposes that local HealthWatch be able to refer matters to HealthWatch England independently of its local authority; and that National HealthWatch England can refer matters to the CQC.

If local HealthWatch will still be able to refer matters directly to the CQC, then the proposed referral to HealthWatch England is of benefit, being additional, and not a 'filter'. Otherwise it would represent a centralisation of control and loss of local HealthWatch power.

Local HealthWatch should retain the power to refer issues directly to the CQC.

3.3.7 HealthWatch and health and wellbeing boards:

The White Paper proposes that local HealthWatch will have a formal position on the proposed new health and wellbeing boards.

It is welcome that formal recognition is being given to the role of HealthWatch, but the exact nature of the role needs to be considered; being a member of the board brings with it a collective responsibility for decisions of the board. To play an effective part without losing their independence, many LINks have negotiated a 'place at the table' of local authority scrtutiny bodies, partnership boards and Trust boards without being a 'member'.

The health and wellbeing board should be required to give a place at the table and access to its agenda and papers to local HealthWatch, without making the local HealthWatch representative a 'member' of the board, thereby allowing HealthWatch to maintain its independence and ability to challenge the board.

3.4 Other patient and public involvement issues

3.4.1 Duty on NHS bodies to involve patients and the public

NHS bodies – Trusts, PCTs and SHAs – are currently under a statutory duty to involve patients and the public. The White Paper states that the duty to involve patients and the public and to engage the public in their areas in commissioning will apply to the GPC. When services are jointly commissioned, the duty to involve currently remains with each of the commissioning bodies.

A duty should be placed on NHS and social care commissioners, including GPCs, to ensure through their contracts that independent providers enable effective patient and public involvement, in the same way that NHS bodies are currently required to do.

A duty should be placed on local, regional and national NHS and social care commissioners and providers to involve the public and their representatives locally, including local HealthWatch and local authority overview and scrutiny bodies, and not just talk to HealthWatch England. Where services are jointly commissioned that duty to involve should remain a responsibility of each of the commissioning bodies.

(See also sections 3.3.2 ii and 3.8.3.)

3.4.2 Public and patient involvement (ppi) groups

The White Paper states that ppi groups attached to specific services/providers will continue and be encouraged to join their local HealthWatch.

This is a welcome restatement of the current situation with LINks.

3.5 NHS information, advocacy and complaints services

3.5.1 Services to support individuals and provide complaints advocacy

The White Paper proposes that local authorities will have responsibility for commissioning services to support individuals in exercising choice, in particular for people who lack the means or capacity to make choices, and to provide NHS complaints advocacy (replacing the current Independent Complaints Advocacy Service, ICAS); and can commission local HealthWatch to do this.

Giving responsibility to local authorities for commissioning services to support individuals and provide complaints advocacy provides improved local accountability for those services.

We recognise that involvement in supporting individuals and in complaints advocacy could enhance HealthWatch's understanding of local issues and inform their primary role of involving patients and the public. HealthWatch, like LINks currently, should have access to anonimised data about the needs and experiences of those that have been given support and about complaints received from whoever provides these services.

Pursuing the interests of an individual service user or complainant could come into conflict with the interests of the whole community; and individual confidentiality must be maintained when acting on behalf of an individual service user or complainant. If HealthWatch takes on this new role it could be a distraction from its primary role of working on behalf of the whole community, and could undermine service users' confidence in the complaints system.

There is a potential conflict between HealthWatch's primary role of involving the whole community and this proposed role of pursuing the interest of individuals.

Services to support individuals and provide complaints advocacy should be commissioned by the local authority from other organisations in the community that are already providing related services and would be better able to provide them, and whose independence would give patients greater confidence.

The organisations providing these services should be required to provide commissioners, local authority scrutiny committees and local HealthWatch with summary anonimised data about the needs and experiences of those they support and complaints received.

3.5.2 NHS patient information services

The consultation paper says that the Patient Advice and Liaison Service (PALS) will continue within individual NHS organisations, whilst HealthWatch will 'build on the role of LINks in picking up community concerns and feedback', but the extent of the role of HealthWatch 'is still being considered'.

The provision of advice and information to service users is an important part of the role of care providers; it is distinct from the role of HealthWatch of engaging and representing the whole community, and could be a conflict with and/or distraction from that role.

All providers of publicly funded health care should be required to provide an information and advice service to users, and to provide commissioners, local authority scrutiny bodies and local HealthWatch with summary anonimised data.

3.6 Improving healthcare outcomes

The White Paper says that the NHS must be focused on outcomes and held to account against clinically credible evidence-based outcome measures, not process targets.

We welcome the focus on outcomes not processes and the reduction in top-down targets.

Managers and clinicians will still need to measure their performance and set themselves targets, but these targets should be based on locally agreed and evidence-based outcome measures; there is a place for nationally determined minimum standards, albeit few in number and clinical evidence-based.

We welcome the objective of creating a culture of open information and challenge. But believe that requires a system for independent external challenge, that involves non-professionals and does not just address individual complaints.

We welcome the establishment of a single body for upholding quality standards in the NHS and social care, by extending the remit of NICE.

3.7 Autonomy, accountability and democratic legitimacy

We welcome the objectives of 'shifting decision-making as close as possible to individual patients', and 'liberating professionals and providers from top-down government control, so they can shape their services around the needs and choices of patients'.

The White Paper says that it is to be matched by increased accountability to patients and democratic legitimacy, but we do have concerns that the specific proposals described in the White Paper will not be effective in achieving this. (See section 3.9.)

We welcome greater autonomy for local commissioners and providers and enabling local decision-makers to tailor services to meet the needs of their patients. But this autonomy and freedom must be balanced by good governance, transparency and effective local accountability, as the best way to mitigate against the potential pitfalls it brings.

The White Paper states that the powers of Ministers over day-to-day NHS decisions will be limited.

We welcome this, as the NHS does suffer from too much central control and the objective of increased autonomy and local accountability will not be achieved if it is competing with strong central accountability to Whitehall.

We recognise the potential conflict between localism and the desire for equity and fairness across the NHS, and therefore that there is a need for mechanisms to ensure that local decisions are fair and transparent, and for there to be national minimum quality standards, as proposed through Monitor, the Care Quality Commission and NICE; but we believe that this should not be allowed to undermine the desire for locally responsive services.

We believe that locally responsive tailored services are good; but a 'postcode lottery' is bad. The key factor in achieving the former rather than the latter is real local accountability, so that local differences are a result of transparent assessment of needs and deliberate and accountable local decision-making.

There needs to be an open and constructive debate about how to balance the desire for locally responsive services against the need to ensure equity and fairness across the NHS, and the role of national minimum standards.

Greater freedom and autonomy could conflict with the objective of making the NHS less fragmented, breaking down barriers and improving working across boundaries.

Encouraging a market-based approach and competition between providers may hamper cooperation in the interests of the community and the sharing of good practice, and stifle transparency and prevent effective scrutiny.

There is a particular risk at a time or financial constraint that competition focuses on driving down costs rather than seeking improved quality of care.

If commissioning does not properly take account of the needs and preferences of all groups in the local population, rather than just responding to the most engaged or vociferous, the market could create greater not smaller health inequalities.

3.7.4 Promoting social enterprise

The White Paper says that the government wants to promote social enterprise and give NHS staff a greater say in the future of their organisations.

We welcome the promotion of social enterprise and the effective involvement of employees; but we also believe that organisations claiming a role in the delivery of publicly funded health and social care have a specific duty to their service users and the wider community, not just to their staff.

The White Paper says that all NHS Trusts will become (or become part of) Foundation Trusts (FTs).

A Foundation Trust's local accountability to its membership, in place of a Trust's accountability to Whitehall, and its two-tier governance, give the Foundation Trust greater autonomy and enable it to be more responsive to the needs of its patients, and have the potential to provide improved local accountability. However, evidence of the development and engagement of membership and of real accountability in Foundation Trusts is patchy.

The Care Quality Commission and Monitor should consider how they can assess and ensure transparency and accountability and encourage effective involvement in social enterprises and Foundation Trusts.

Social enterprises in the NHS and Foundation Trusts should be subject to the Freedom of Information Act; they should not be allowed, as some Foundation Trusts have, to refuse to disclose information that should be available to their local community and/or its representatives on the grounds of commercial confidentiality.

The White Paper asks if the cap on the amount of income Foundation Trusts may earn from non-NHS sources should be scrapped. *We believe that a cap should be maintained as a proportion of income or turnover, albeit a more generous one than currently and possibly with a degree of flexibility under the control by Monitor.*

The White Paper asks if Foundation Trusts should be allowed to 'tailor their governance to their local needs'. *We believe that there should be flexibility in governance, but within certain minimum conditions. All Foundation Trusts should be required to have a membership open to employees, patients and local residents, with a (small) minimum proportion for each category, and should be required to have a minimum*

representation of each category on its governing council and a minimum number of non-executive directors on its Board appointed by the governing council, and be required to adhere to a certain level of transparency and reporting to their membership and local community and to relevant local authority scrutiny bodies.

3.8 Commissioning NHS services

3.8.1 GP Commissioning Consortia

The White Paper proposes giving responsibility for commissioning the majority of NHS services to consortia of GPs, known as GP Consortia (GPC) – transferred from PCTs.

We recognise that GPs can bring greater clinical input to commissioning and have the potential to bring decision-making closer to their patients.

If GPCs are to take responsibility for a significant part of NHS commissioning, this needs to be within a framework of clear and effective local accountability and real powers for local authorities / health and wellbeing boards to shape commissioning decisions and the services that result, not just object to decisions from the sidelines after they have been taken.

There is an assumption that GPs are best placed to get the best service for their patients; this is likely to be the case where there is a good relationship between the GP and the patient, but not all GPs are equally good, and not all patients have a good relationship with their GP.

There is a potential conflict of interest between a GP's responsibility to their individual patients and the Consortia's responsibility to the wider community; and between commissioners' role as guardian of interests of service users versus their role as custodian of (limited) public resources.

This could affect the relationship between the GP and the patient, with GPs coming to be seen as rationers of service, undermining patients trust in the GP's ability to act in their best interests.

We are concerned that many GPs have said that they do not want to take in the proposed GP Commissioning role. The success of the proposals requires the active engagement of GPs. The Government needs to guard against a situation where the quality of commissioning decisions, and hence services that are provided, becomes dependent on there being enough GPs locally with an enthusiasm for taking on the commissioning role, or that certain practices or groups of patients within a GPC loose out because their GPs are insufficiently engaged in the commissioning process.

3.8.2 The NHS Commissioning Board

The White Paper and the Consultation paper *Commissioning for patients describe* GPCs as being accountable to the NHS Commissioning Board – despite other parts of the White Paper saying that its aims are to bring greater accountability and democratic legitimacy to the NHS.

We believe the primary accountability for local NHS commissioning decisions, and hence of GPCs, should be local, and to their local authority / health and wellbeing board, and that effective local accountability will not be achieved if it is competing with strong central accountability to the NHS Commissioning Board.

3.8.3 Commissioning of NHS services not proposed for GPCs

The White Paper proposes that some services currently commissioned by PCTs, and therefore under some level of local accountability and scrutiny, will not be commissioned by GPCs, but by the NHS Commissioning Board:

- Services of GPs themselves; currently commissioned by and accountable to PCTs.
- Primary dental, ophthalmic and pharmacy services; currently commissioned by and accountable to PCTs.
- Specialised services (low volume, high cost services that cannot be effectively commissioned by individual local commissioners); currently jointly commissioned by PCTs working together, with those PCTs remaining responsible and accountable for those services.

Transferring the commissioning of these services to the NHS Commissioning Board represents a centralisation of decision-making, reducing local accountability and the role of local authority scrutiny and HealthWatch.

There should be effective local accountability for primary NHS services (GPs, dental, opthalmic and pharmacy); an obvious way to do this would be to give real responsibility and accountability for these services to the local authority and/or the proposed health and wellbeing boards by giving them the formal commissioning role, and retaining the local authority's powers of health scrutiny over these services and the involvement of local HealthWatch.

Specialised services should be commissioned by bottom-up cooperation between locally accountable commissioners, not central imposition, ie should be by GPCs, local authorities or local health and wellbeing boards working together, and therefore locally accountable and under the scope of the local authority's powers of health scrutiny and local HealthWatch.

3.8.4 Public health services

The White Paper proposes that local authorities will have responsibility for public health and health improvement, promoting integration and partnership, and joining up commissioning of health social care and other services.

We welcome the joining up of public health with social care and the increased local accountability for public health, which will be achieved by passing responsibility for commissioning local public health services to the local authority.

However, the ring-fencing of public health budgets could mitigate against joining up services and limit the scope of local decison-making, undermining accountability.

We are concerned that the proposal that Directors of Public Health are jointly appointed by local authorities and new National Public Health Service represents a residual centralisation of control and inability of Whitehall to 'let go'. If this means that Directors of Public Health will retain an accountability to the central Department of Public Health, this will compete with and undermine effective local accountability of public health services.

Giving responsibility for NHS services to GP Consortia, who receive their funding from and see themselves as primarily accountable to the NHS Commissioning Board, whilst giving responsibility for social care and public health to the local authority, will actually make public health less joined up with other NHS services and leave NHS and social care services insufficiently joined up.

3.8.5 The local authority and health and wellbeing board

We welcome the objective of the White Paper to give local authorities the lead role in ensuring improved integration, more 'joined up' services and clearer accountability.

But we are concerned that the role of 'strategic' decision-makers and elected members on the health and wellbeing board and their relations with the GPC and other services are not clear. The proposals do not demonstrate how they will exercise their 'strategic control', have any real say over local NHS commissioning decisions, or affect local service provision.

The White Paper says a role of the local authority is 'building partnership for service changes and priorities.' We are concerned that this sounds like a process of 'selling' proposals to stakeholders, not enabling real involvement or influence.

The White Paper says that the health and wellbeing board may commission joint services where both parties agree. But what if they cannot agree? We are concerned that the proposals do not show how disputes can be resolved locally, or give any real authority to the health and wellbeing board.

It is also unclear if the health and wellbeing board will take over responsibility for existing joint funding and partnership arrangements.

Effective integration requires more than 'partnership' between two or more organisations with their own separate lines of funding and accountability, in which there is a tendency for the 'partners' to protect their own budgets and attempt to 'offload' responsibility onto others, especially in times of budget constraint.

3.9 Governance and accountability of NHS commissioning

3.9.1 Commissioning populations and boundaries

The White Paper states that GPCs will be formed from the 'bottom up' and that the government does not want to determine their boundaries or be prescriptive about their population. GPC boundaries will not match local authority / social care / wellbeing board and other partnership arrangements.

If the principle of patients having choice of GP is maintained, then it will not be possible to ensure that GPCs will cover an area that is discrete or remain fixed over time. Neighbours, or even members of the same household, could be the responsibility of different GPCs, and the size of a GPC, in number of patients and area covered, may change.

Whilst we welcome the 'bottom-up' approach to the formation of GPCs, we have two significant concerns:

- *the mismatch between GPC and local authority boundaries complicates GPC relations with the 'strategic' decision-makers of the health and wellbeing board and elected members and could hamper joint working between NHS and public health and social care; and*
- *the lack of clear and consistent boundaries will make the proposed structure less transparent to patients and the public and make it more difficult for them to get involved.*

If GPCs become too large they could loose responsiveness, transparency and accessibility to local residents and their partners and stakeholders in local authorities and the community.

We are concerned that except at the boundaries of GPCs, the much-promoted 'patient choice' could be just an illusion, as most patients can only really change to another GP within the same GPC.

3.9.2 Governance in NHS commissioning

The White Paper says GPCs will be 'statutory public bodies'; will have an 'accountable officer' and 'chief finance officer', but that government will not be prescriptive about their internal governance.

To be consistent with the objective of creating a culture of open information and challenge, bringing greater accountability and giving citizens a stronger voice, the governance of GPCs must be transparent and accessible and include independent external challenge.

The Primary Care Trusts (PCTs) that currently have responsibility for commissioning local NHS services have established governance arrangements with a Board that includes non-executives who are required to take account of the interests of their local community. NHS Foundation Trusts (which will be all NHS Trusts according to the White Paper) have a two-tier governance with a Board and a Governing Council, accountable to a local Membership made up stakeholders and members of the local community. Whilst these mechanisms are not perfect, they are established, or becoming so, and offer an element of accountability and challenge.

More rigorous governance requirements should be placed on GPCs to ensure they are transparent, accessible and accountable to their local community, with a system of checks and balances and challenge that include non-professionals, and effective engagement with patients and the public, so they take account of the perspective of the whole community, not just respond to individual complaints.

GPCs should be subject to the Freedom of Information Act.

The White Paper says that GPCs will not provide services themselves, but practices within them will. However, this leaves a potential conflict of interests between GPs as commissioners and as service providers, in particular if GP members of a GPC are involved in profit-making organisations bidding to provide services.

To address this potential conflict, and the concerns about the GP / patient relationship (section 3.8.1), there needs to be a clear distinction between individual GPs / GP practices and the GPC.

GPCs will require robust, transparent and trusted governance and accountability in order to be able to hold powerful providers to account, on their own behalf and on behalf of the community.

Transparency and access to information is a necessary but not sufficient condition for achieving effective accountability. Patients and the public need access to information, decisions need to be taken in public and decision-makers need to be accessible and answerable to patients and the public.

Currently there is lack of clarity among the public about who is responsible for which public service, and where to go to make their views heard and if things go wrong – in particular between health and social care, NHS and local council. *We are not convinced that the White Paper*

proposals do enough to introduce the clarity and transparency required to give people confidence in the new structures and to make the desired increased 'choice and voice' and improved accountability a reality (see section 3.9.1).

Commissioning Consortia should effectively involve other health professionals such as nurses and therapists, not just GPs, and they should be formally represented at senior and board level.

3.9.3 Accountability of NHS commissioning

The White Paper with its talk of autonomy for professionals makes GPCs sound like 'stand alone' organisations. The consultation paper *Commissioning for patients* includes in the responsibilities of GPCs: 'determining healthcare needs', 'contributing to the wider joint strategic needs assessment led by local authorities' and 'determining what services are required to meet these needs'; and states that budgets will be allocated by, and GPCs held to account by, the NHS Commissioning Board.

Given these statements, it is not clear how the local authority / health and wellbeing board will exercise its 'strategic control' or have any real say over local NHS commissioning decisions and service provision.

Given the White Paper's aims of increasing accountability and local democratic legitimacy of the NHS, we are concerned that this does not give any responsibility or effective power to the local authority or the health and wellbeing board, or give any direct line of accountability between GPCs and the local authority or the health and wellbeing board.

We welcome the statement in the White Paper that the duty to involve patients and the public and to engage the public in their areas in commissioning will apply to the GPC. *This should include placing GPCs under a formal duty to respond to relevant local authority scrutiny bodies and to local HealthWatch, and to put appropriate terms in their contracts with independent providers so that they are required to involve patients and the public and respond in a similar manner*.

3.9.4 Scrutiny of the NHS

Local authority overview and scrutiny has been shown to bring value in terms of increasing local accountability, engaging stakeholders and the public and achieving real improvements to services.

The key benefits of effective external scrutiny are:

- independence from decision-makers and providers and the ability to challenge them and hold them to account;
- the capacity to focus on what is important to its community and not have to do everything;
- considering issues from the non-expert 'lay' perspective of patients and the public; and
- the ability to look across services.

The specific powers of health scrutiny that enable local authority scrutiny committees to examine decision making and service provision in the NHS have been one of the more successful aspects of the development of overview and scrutiny so far.

GP commissioning decisions need independent scrutiny and challenge, and challenge from the perspective of the needs and experiences of the wider community, not just by responding to individual complaints.

Local authorities that wish to retain the executive/scrutiny split will still need a separate scrutiny body to scrutinise their public health and social care functions, and this should be joined with the scrutiny of the strategic and joint decisions of the wellbeing board and the commissioning decisions of GPs and the delivery of health services. Local authorities that wish to revert to a committee structure may also choose to carry out their own form of scrutiny of these services and would benefit from and be able to use general powers of health scrutiny.

The proposed health and wellbeing board will be responsible for strategic decisions and for decisions on joint funded services, and it will include executive members; it cannot therefore provide independent scrutiny of such decisions, and should be subject to scrutiny by a separate scrutiny body of the local authority.

The decisions of the health and wellbeing board and the GP Consortia should be subject to independent external scrutiny, and in line with the aims to achieve more 'joined-up' services, the scrutiny of these services should be joined up with the scrutiny of public health and social care.

The power of local authorities to scrutinise NHS commissioning decisions and service provision on behalf of their local community should be retained.

3.9.5 Proposal for a clearer role for the local authority

The logic of a wish to improve local accountability, involvement and service integration would be to give local authorities a real level of responsibility and accountability for commissioning all health services for residents of their area, in addition to their proposed needs assessment and strategic role; by making GPCs and local primary and specialised services directly responsible and accountable to the local authority (eg via the health and well being board).

The local authority would carry out its responsibility by commissioning services from other providers, as it does with social care, including engaging with GPCs who could 'sub-commission' within a framework of real accountability to the local authority.

This would give local authorities an ability to affect commissioning decisions and actual health outcomes across social care, public health and the NHS; enable effective integration by way of joint budgets; bring truly joined up decision-making; and make the NHS directly accountable to the local community through the local authority's accessible and democratic decision-making and scrutiny arrangements.

3.10 Bureaucracy and efficiency

The White Paper aims to cut bureaucracy and improve efficiency, make the NHS less fragmented, and reduce management costs and release efficiency savings to reinvest in the NHS.

We welcome these objectives, and believe that there is scope within the NHS to reduce bureaucracy and wasted expenditure and make efficiency savings, and to redirect existing spending to achieve better health outcomes.

However, if too much management capacity is cut at the same time as the proposed changes have to be implemented, this may make it more difficult to achieve the desired efficiency savings without distracting from service delivery.

We are concerned that the changes from PCT to GPC commissioning in themselves will not achieve savings.

The desired savings and efficiencies should not be achieved at the expense of the objectives of greater patient control and citizen voice and improved accountability and democratic legitimacy.

The NHS has suffered from years of reorganisation imposed by central government, and significant management capacity and resources have been devoted to managing these changes at the expense of focusing on service delivery. *The NHS needs to reach a position of greater long-term stability with less structural upheaval if the desired reductions in bureaucracy and improvements in care are to be realised.*

4 Implementing the proposed changes

The proposals in the White Paper represent a major change in the way the NHS is run. Such significant change diverts effort and resources and can be a distraction from the delivery of frontline services. Managing the change will have a cost in terms of staff time and an impact on the capacity and focus of the organisation, diverting resources that could otherwise be devoted to the objectives of improving patient care. The publication of the proposals has already created greater instability and uncertainty right across the organisation. Time and resources also need to be made available for staff induction and training. The service cannot be 'put on hold' whilst the changes are made.

Wherever it may be relevant, government must take account of and learn the lessons of past experience – good and bad. Many aspects of the proposed changes have not been tried before and it does not appear that they will be properly tested or piloted.

It will take time for the changes to be implemented and for the service to settle down and be able to reap the benefits that they are designed to bring. To achieve the objectives of the White Paper will require a change in behaviour across the NHS, not just changes in structures; and changing behaviour will require time and the good will of NHS staff.

We recognise that, given the history of constant reorganisation in the NHS and the desire to minimise the period of instability whilst changes are made, there are benefits to completing the process and reaching a period of stability as quickly as possible.

However, we are concerned at the extent and speed of the proposed changes and believe that more time should be allowed to implement them, specifically to allow adequate information and training for staff and other stakeholders, with pilots that can be evaluated and the appropriate proposals adjusted accordingly, and giving opportunity for effective involvement of staff, patients and the public and their representatives in developing and implementing the changes.

Throughout the development and implementation of these proposals there should be effective involvement of NHS staff, patients and the public and their representatives, and the government and NHS should remain open and flexible to adapt their proposals and how they are implemented in light of experience and views received.

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