Overview and Scrutiny Committee - Monday 27 September 2010 -SUPPLEMENTARY REPORTS

The following supplementary papers were not available prior to the publication of the agenda for the forthcoming meeting of Overview and Scrutiny Committee.

5. SHARED SERVICES UPDATE REPORT

Description of Service Models.

6. EQUITY AND EXCELLENCE: LIBERATING THE NHS - HEREFORDSHIRE'S RESPONSE

Draft Response to the White Paper and associated consultation documents,

OVERVIEW AND SCRUTINY COMMITTEE **27 SEPTEMBER 2010**

EVALUATION OF ORGANISATIONAL MODELS

There are 9 potential organisational models for delivery of shared services.

The original evaluation in March 2010 considered 4 models:

- Joint procurement – each partner procuring the services separately from a single provider
- Lead Provider/commissioner – where one partner provides and/or commissions services on behalf of the others
- Joint venture – where the partners set up a new joint venture organisation to provide/commission services on behalf of the partners
- Strategic partnership – where the partners enter into a partnership with a strategic private sector partner to deliver the services

The original evaluation identified a joint venture as the preferred option.

The original joint venture model has been subsequently been considered and there are 2 sub-options for a joint venture; a corporate (company) model or non-corporate (unincorporated partnership). Those 2 models have been included separately for purpose of re-evaluation.

Joint Procurement	Each partner procures the services separately but in an integrated way and a single provider is appointed to provide services to all partners.
Lead Provider /Commissioner	One partner provides or commissions services on behalf of the others
P/P partnership	The partners enter into a formal contractual partnership that operates separately as an unincorporated body with the terms of the arrangement between the partners being set out in a partnership agreement.
P/P SS entity	The partners set up a separate company in which they all have shares and which they control collectively by being members of the Board and operates separately. The company's Memorandum and Articles of Association set out the terms of the arrangement.
Private Sector Strategic Partner	The partners jointly procure a private sector strategic partner to deliver services to the partnership. The arrangements would be set out in agreements between the partners including the private sector strategic partner.

There are also an additional 5 mutual or social enterprise type models that have been considered as part of the re-evaluation.

Table 2

Model	Employment
Charity	The partners could establish a partnership organisation with charitable status to deliver the services, although the services would need to be delivered through a separate trading company in order to receive income for the provision of services. The shared services organisation's overarching purpose would need to be charitable.
Industrial and Provident Society (IPS) (community benefit)	The partners would sponsor the formation of an Industrial and Provident Society (regulated by the Financial Services Authority) for the benefit of the community. A society for the benefit of the community is a form of corporate body which can carry on a trade or provide services. Its members are not liable for losses but it must operate for the benefit of the community at large and it cannot distribute profits and there has to be special reason for it being set up in this way rather than as a company. NHS bodies cannot participate.
Cooperative (IPS)	This is similar to a community benefit IPS (above) but is set up for the benefit of its members
Community Interest Company	This is another type of company which chooses to submit itself to the additional regulation and whose profits are not distributed to its members but for the public benefit principles for which it is established. It's members have limited liability in relation to its activities.

The evaluation process is establishing which model or models are the most appropriate for the delivery of the shared services. There may be more than one appropriate model depending on the services. Nothing has been ruled in or ruled out and the Committee is asked to consider these options and provide input into the evaluation process. There will be a firm recommendation to the Cabinet in October.

RISKS ASSOCIATED WITH ALL MODELS

There are risks associated with all models:

	Risk	Consequence
1.	PCT abolition	Future role of PCT in partnership Impact on business case Will what replaces PCT impact adversely Assets and liabilities on dissolution
2.	HHT future direction	Foundation trust status? Or not? What if HHT is not FT by 2014 deadline? Acquisition by another FT? Private sector acquisition?
3.	Lack of long term commitment	Changes to landscape may mean that HHT (FT) or LA (LA partnership initiatives) may be less committed to this partnership
4.	Changes to Foundation Trusts	FT off balance sheet No longer treated as part of public sector Consequences – tax status, pensions, procurement Teckal consequences – less than 10% notional sales to HHT – viability and impact on business case
5.	Teckal consequences	If Teckal company established and exemption subsequently lost – all public sector customers will then need to go through procurement
6.	GP Consortia participation	Will GP consortia participate Teckal consequences
7.	Challenge	Competitors heightened awareness to commercial nature of arrangements Private sector challenge
8.	TUPE	Staff may transfer back to partners as services cease to be drawn down but • On different terms and conditions • May be different staff • Contractual entitlements to non public sector pension provision • TUPE may not apply as organisations change or disappear • Last man standing takes the costs
9.	Loss of revenue	Loss of PCT and other business as consequence of changes

Liberating the NHS consultation on proposals – Herefordshire's response

The response that follows is in four sections addressing each of the subsidiary consultations in turn beginning with '*Commissioning with Patients'* followed by '*Increasing Democratic Legitimacy in Health'*, *'Regulating Health Care Providers'* and finally *'Transparency in Outcomes'.* The drafts reflect the input gained from the stakeholder event held on 9th September, but the flipchart summaries from those sessions are also appended *(Annexe 2)* for your information.

It should be emphasised that these are very much working drafts. Board Members are asked to consider the drafts both from an overall 'Herefordshire' perspective as well as any NHS Herefordshire-specific aspects which they may wish to draw out.

Introduction

The intention of the Government White Paper *Liberating the NHS* is to create an NHS which is much more responsive to patients and achieves better outcomes, with increased autonomy and increased accountability.

CONSULTATION 1: COMMISSIONING FOR PATIENTS

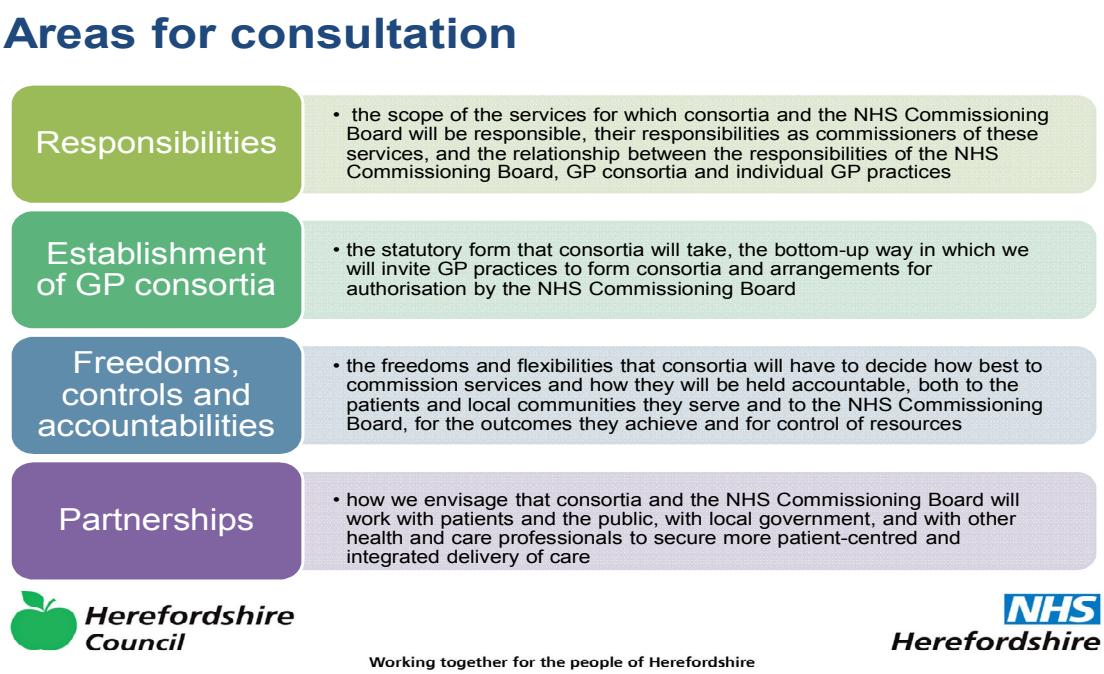
The consultation document *Commissioning for patients* provides further detail on proposals to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. GPs, practice nurses and other primary care professionals are already supporting patients in managing their health, promoting continuity and coordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, it is intended to build on these foundations.

The overall aims set out in *Commissioning for patients* are:

- Empowered health professionals will be leaders of a more autonomous NHS;
- Patients and the public will have the confidence of knowing that their GP is not only their advocate in the healthcare system but part of a wider group of health and care professionals – a commissioning consortium – whose job it is to ensure that empowered patients have access to the right care, in the right place, at the right time;
- GPs will work in partnership with other health and care professionals to decide how to use NHS resources to get the best health care and outcomes for patients;
- Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically led;
- To support GPs in their commissioning role, an independent NHS Commissioning Board will be set up to lead on quality improvement, to promote patient choice and patient involvement and to allocate and account for NHS resources; and

- GPs will work with local authorities and elected councillors, who will have a lead role in ensuring services across the NHS, social care and public health are joined up and meet the needs of local people.

The key areas upon which the Department of Health is consulting in relation to Commissioning for patients are set out below.



Commissioning for Patients seek views on a number of specific consultation questions. On the 9th September 2010 Herefordshire Council's Overview and Scrutiny Committee held an event to engage a number of key stakeholders in this process. This section of Herefordshire's response addresses the consultation questions and includes the views expressed at the event.

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?**

   The National Commissioning Board could achieve this in a number of ways including:
   - engaging GPs/Practitioners in the governance arrangements for Specialised and other services outside the portfolio of GP consortia; and/or
   - devolving responsibility on a 'lead commissioner;' basis to one or more GP consortia to lead the process for a specified range of specialise services, without appropriate clinical and managerial support.

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

   See response to question 1 and by:
   - agreeing the directory of services to be defined as 'low volume';

- where these are also high cost, by establishing a financial risk pooling arrangement to spread risk; and
- being clear on the arrangements for implementing National Institute for Health and Clinical Excellence guidance in a consistent and fair way across the NHS in England.

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

   None to mention though it is unclear as to why Maternity Services have been included in the portfolio of services for the National Commissioning Board to commission, rather than GP consortia.

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?**

   By including those contractors in the commissioning process at the interface between primary and secondary care be that in involvement in service specification development, service redesign, right through to contract provider performance management.

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

   By peer review and a system of incentives to improve performance (not necessarily financial).

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?**

   A rounded perspective on both the performance of consortia in relation to secondary care referral practice and utilisation as well as on their primary care performance, in both quantitative and qualitative terms.

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?**

   Not clear as to whether this question relates to choice of primary care provider, or choice of hospital provider, consultant or team?

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?**

   By putting in place a clear and explicit accountability process between the Board and GP consortia which include regular review (quarterly/annually) and publishing the outcomes of these reviews in the public domain.

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

   See comment under question 9 regarding openness and public accountability. The Board may also wish to consider how 'lay' and 'patient' perspectives are brought into the governance arrangements for consortia, including the relationship with democratically elected Local Authority Councillors and the role of *HealthWatch*.

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

    GP consortia could have flexibility across geographical boundaries but the complexities as to how manage multiple interfaces with other key partners, particularly the interface with Local Authorities, needs to be considered. This is especially important where responsibility is delegated from Local Authorities to GP consortia to commission integrated health and adult social care and children's services in an integrated way as is currently the case in Herefordshire.

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

    Population size should be sufficient to spread risk and give commissioner leverage with providers to manage the market. This needs to be but balanced with the need to align with natural populations who have similar health and social care needs.

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

    An early decision needs to be made on the amount of management resources per head to be made available to GP consortia and a clear steer as to whether consortia may come to their own view about the constitution and organisation development for their own organisations, alongside the necessary governance arrangements. It is unclear as to whether a 'mixed economy' of commissioning expertise can be assembled i.e.

public/commercial sector given the central drive to reduce spend on 'management consultancy'.

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

See comments under question 12.

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

Yes, in broad terms. See also comment under question 2, bullet point 2.

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

There should be clear governance arrangements in terms of GPs role as providers of services and their role as commissioners through the whole of the commission cycle from needs assessment to provider performance management. GP consortia should be clear about their population's health and social care needs and evidence-based cases for investment/disinvestment/service change. Where a GP Practice or group of Practices wish to act as a provider there should be governance controls via an 'external' body to give integrity and assurance in the investment process.

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

See separate response in relation to *Transparency in outcomes*.

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

Yes, but need to be clear about how this interfaces with the primary care *Quality and Outcomes Framework*, if this continues to be in place.

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

See separate response in relation to *Transparency in outcomes*.

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

By involving the relevant advocacy organisations in the commissioning process and being clear about the role of *HealthWatch* in relation to commissioning organisations.

20. 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?

See comment under question 19.

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

See separate response in relation to *Transparency in outcomes*.

22. 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?

See separate response in relation to *Transparency in outcomes*.

23. 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?

The role of GP consortia in relation to the proposed health and Well Being Boards needs to be acknowledged. In Herefordshire, we already have a Health and Social Care Programme Commissioning Board which is co-led by the Chief Executive (Council and PCT) and the Clinical Chair of the Practice Based Commissioning Executive.

24. Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

Herefordshire already has a history of integrated commissioning and provision and would be willing to share learning and experience in relation to these arrangements. Health and social care commissioning must be integrated to realise the potential for effective and economic integrated care delivery.

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

No additional comment to make.

CONSULTATION 2.: LOCAL DEMOCRATIC LEGITIMACY IN HEALTH

The supplementary document Local Democratic Legitimacy in Health provides further information on proposals for new local and national governance arrangements to increase local democratic involvement and accountability for health services. The overall aims and objectives of this paper are:

Aims

- To give local authorities a stronger role in supporting patient choice and ensuring an effective local voice
- To promote more effective NHS, social care and public health commissioning arrangements
- To provide local leadership for health improvement

Objectives

- Strengthened patient and public involvement through the creation of a new local HealthWatch replacing the local LINks and to act as a local consumer champion, to promote public and patient involvement, to perform a wider citizen's advice bureau role and to sign post patients and public to services
- Improved integrated working delivering services designed abound the needs of the patient and the public through the creation of a new Statutory Health and Wellbeing Board within the local authority to lead the local JSNA, to promote partnership and integration, to support joint commissioning and pooled budgets and to undertake the local health scrutiny function
- Health improvement led locally by local authority by transferring responsibility and funding for local health improvement to the local authority and creating a new national Public Health Service to integrate existing health improvement and protection bodies

Local Democratic Legitimacy in Health seeks views on a number of specific consultation questions. On the 9th September 2010 Herefordshire Council's Overview and Scrutiny Committee held an event to engage a number of key stakeholders in this process. This paper documents the responses to the consultation questions from the event.

Strengthening Public and Patient involvement

The first set of questions focused on the government objective of strengthening public and patient involvement

Q1. Should local HealthWatch have a formal role in seeking patients' views on whether the local providers and commissioners of NHS services are taking account of the NHS Constitution?

Yes, there are links between the consumer champion role of the new Local HealthWatch and the NHS Constitution and therefore, logically it would be well placed to do so.

Q2. Should local HealthWatch take on a wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individual's to exercise choice and control?

Whilst supporting the strengthening of patient and public involvement and the role of the new local HealthWatch, the feedback made the following points:

- If the new local HealthWatch is to be successful it must be properly resourced with finance and workforce, noting the continuing need to involve local volunteers
- That any new arrangements should build on LINks and not undermine the work of the dedicated volunteers who have supported that important service
- A concern that skills and capacity would need to be built to take on the new enhanced roles
- That the new arrangements should be developed through a process of evolution not revolution – we should guard against "throwing the baby out with the bathwater"
- There needs to be greater clarity about the various roles and how local HealthWatch links with PALS

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

The local authority and Local HealthWatch will need to clarify roles and responsibilities to avoid any potential conflict between commissioning and monitoring/championing and scrutiny roles. Also need to be clear about the "citizen's advice bureau" role.

Improved integrated working and creation of local Health and Wellbeing Boards

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

There should be emphasis on local partners determining arrangements that work within that locality but with a framework for arrangements between localities and cross boundary or out of locality commissioning and provision.

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

Local partners should be free to choose arrangements including formal and informal partnership structures that are tailored to local needs.

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

Yes but not prescribed so as to prevent existing arrangements from continuing or to prevent local partners determining what best suits the locality.

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?

The new arrangements have a strong potential to work effectively but consultees raised following issues:

1. Must building on Herefordshire's strong building blocks and ensure that existing relationships building up over a number of years are maintained – a change in local structures may undermine established working arrangements.
2. Must allow flexibility – local may mean different things to different groups
3. Need to ensure some consistency nationally – so some support for some limited national prescription on arrangements to avoid confusion and maintain resilience of services
4. We don't need national prescription for partners to hold each other to account but we do need to be clear about what we mean by "localism" in this context – NHS and Local government need to agree consistent terminology
5. Some concern about "market" approach not providing safeguards on quality, governance, risk and performance provided by current arrangements
6. HWB may become a talking shop
7. Not sure how HWB will ensure patient choice – HealthWatch is consumer champion and GP are commissioning?

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

Yes but it is unclear how the HWB role(s) will be effective if it has no power over commissioning functions and it may not be able to join up scrutiny with other related issues e.g. housing and environmental matters which may impact on health service commissioning and provision and on local public health initiatives. Care will be needed to ensure HWB can work effectively with other responsible bodies e.g. local authority, GP commissioners. It is difficult to see how the role of the HWB will ensure that GP consortia are commissioning in line with HWB strategies and local needs – there is dual accountability to HWB and the NHS Commissioning Board. This needs clarification.

Q9. Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

The HWB will need to be properly resourced and will need expertise available currently to the PCT Board to fulfil its functions. If it is not properly resourced with expertise and administrative support, it will be unable to do so. Board members will need to have time and commitment to manage and maintain the strong relationships within the membership and between member organisations if the HWB is to influence as necessary to fulfil these functions.

Q10. If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

There needs to be greater clarity about how the different bodies that will exist after the proposals are implemented related to one another and there is a risk that the structural landscape will become ever more complex. There may be need to rationalise and re-allocate responsibilities in other areas. The lines of accountability for different services need to be clear e.g. children's services, housing, environmental health.

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?

Need to ensure that HWB responsibilities for services commissioned from outside the HWB area either the responsibility of the HWB in the commissioning or provider locality. Joining up across sub-region and regional areas to ensure regional and sub-regional strategic objectives are met may be necessary.

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

Membership needs to include an element of independent members to enable the HWB to draw on skills and competencies available beyond partner organisations. The HWB needs to be rooted in the community and there may need to be wider patient/consumer/community representation outside the local authority membership.

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

There needs to be clear sanctions for failure to co-operate and for local settlement of disputes between commissioners and the HWB.

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)?

Yes with two provisos:

1. HWB should have freedom to scrutinise health and health related activities to enable them to look at health issues in context of wider local public services
2. Effective scrutiny is critical and all the good work to date (particularly the strong relationships between the Health Scrutiny Committee and health commissioners/providers) need to be built upon – there is a danger that dismantling current arrangements will mean that ground gained will be lost.

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

It is not clear who ultimately has responsibility for finally deciding disputes. Local dispute resolution processes should be encouraged rather than national frameworks.

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?

There was a real concern that scrutiny of scrutiny should be avoided at all costs. The HWB should report on its activities regularly to the public and the local authority but it should not be burdened over bureaucratic scrutiny of its functions.

Q17. What actions 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?

HWB should be required to address equality and Local HealthWatch should monitor its performance on equality and patient choice.

Transfer of public health functions to local authority

The consultation document asked no specific questions about this aspect of the proposals but did ask a final question as follows.

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

Consultees were keen to support the proposals for public health which they recognised as good fit with Herefordshire's current arrangements. Need to ensure there is clarity between national and local responsibilities and resilience etc is dealt with at the right level.

The final proposals need to be rural proof. Local determination of what works best in locality and flexibility within a broad and non prescriptive framework was felt to be the best approach.

CONSULTATION 3: REGULATING HEALTHCARE PROIVDERS

The supplementary document Regulating Health Care Providers provides further information on proposals for foundation trusts and the establishment of an independent economic regulator. The overall aims and objectives of this paper are:

Aims

- To give healthcare providers more freedom to focus on improving outcomes
- To implement an accountability framework for healthcare providers which focuses on effective quality and economic regulation and moves away from control by hierarchical management.

Objectives

- Free Foundation Trusts from constraints and create the world's largest and most vibrant social enterprise sector
- Introduce of a system of independent economic regulation to sit alongside independent quality regulation.

Regulating Health Care Providers seek views on a number of specific consultation questions. On the 9th September 2010 Herefordshire Council's Overview and Scrutiny Committee held an event to engage a number of key stakeholders in this process. This paper documents the responses to the Regulating Health Care Providers consultation questions from the event.

Freeing Providers

The first set of questions focused on the government objective of freeing providers

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 a control operate.

The removal of the cap was generally supported by the group although concerns were raised about the

Private work should not be allowed to detract from core business

Q2. Should statutory controls on borrowing by Foundation Trusts be retained or removed in the future.

The group were not convinced that is was a good idea to remove statutory controls on borrowing. If it was implemented it was suggested that FT's were given a credit rating.

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

Staff and patient input into the constitution were considered a good thing and it was felt that the current FT model is narrow. Alternatively concerns were raised about giving FT's complete autonomy over their constitution

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

Changes should made to legislation to allow trusts to merge and de-merge more easily

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

No comments

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 as it is important to ensure that all groups in society receive an appropriate level of health care and that as health care becomes more market orientated poorer people still have influence over the health care services they receive.

Additionally processes must be in place that ensure that access to health services is not a risk if a provider fails

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

No Comments

Economic Regulation

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?

In a rural community such as Herefordshire there may be a need to have exemptions due to the lack of providers in the market place.

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

The group generally supported the principles set out but felt that model details were needed. Also a question was raised about the need for two regulators when there used to be just one. This seems at odds with the coalition government's ethos of reduce bureaucracy.

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

Organisations should be able to appeal monitors decision if they believe evidence has been missed or interpreted incorrectly.

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?

Yes as it makes monitor more accountable.

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

Commissioner need to be given greater flexibility to introduce local business rules to overcome local affordability issues.

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

If there is a specific instance of a market failure such as an externality where providers can prove the need to overcome the problem with a set of local business rules.

Q14.How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

Monitor and the commissioning board should work together. The commissioning board should focus on developing best practice pathways and tariffs and monitor should be responsible for taking these to the provider market. GP consortia should also have an input into this process

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

If the financial position of a organisation is rapidly deteriorating or putting the safety and quality of services at risk monitor should intervene

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

Smaller providers need to be given the opportunity to compete with large organisation that enjoy greater economies of scale. This would be needed if the aim is to develop providers at a locality level rather than countywide or regional

Infant industry support could be considered in rural areas to encourage new providers into the market place.

Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

Anti competitive behaviour should be legislated against but in certain circumstances consideration must be given to the market structure of individual health economies.

Could the monitoring of competition be undertaken by the OFT as well as CCP.

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?

Yes , this should be linked to local joint strategic needs assessments of local health economies.

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

A transitional funding arrangement could be implemented that moved the FT to fixed income whilst the business was reorganised or merged with other organisations.

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

No Comments

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?

The separation of needs assessment and commissioning into two separate organisations may help with this. With Public Health residing in the local authority this gives the opportunity for greater local scrutiny of health care services.

Additionally by locating the public health function in the council there may be the opportunity to do a wider capabilities assessment that shows how public services are supporting and benefiting different groups in society.

CONSULTATION 4: TRANSPARENCY IN OUTCOMES

The final consultation document, Transparency in Outcomes, proposes the establishment of an NHS Outcomes Framework that will be made up of a focussed set of national outcome goals which will give an indication of the overall performance of the NHS. These outcome goals will provide a means by which patients, the public and Parliament can hold the Secretary of State for Health to account for the overall performance of the NHS. They will also provide a mechanism by which the Secretary of State can hold the new NHS Commissioning Board to account for securing improved health outcomes for patients through the commissioning process. Beyond accountability, it is intended that the NHS Outcomes Framework will act as a catalyst for driving up quality across all NHS services.

On the 9th September 2010 Herefordshire Council's Overview and Scrutiny Committee held an event to engage a number of key stakeholders on the specific consultation issues. This section of Herefordshire's response documents the responses to the consultation questions from the event. The consultation questions can be found in *Annexe 1.*

Draft Responses
The principles underpinning the NHS Outcomes framework (NOF) are generally adequate. We consider that the move to measuring outcomes is logical and desirable.

The intention to select outcome measures that are worth measuring and not just those which could simply be measured is welcome. In particular, the balanced view across domains including patient experience is necessary and would be an improvement on the current regime.

We would like to suggest that further consideration is given to the following in order to ensure clarity and facilitate operational use of the new outcome framework:

1. That the principles and processes which will guide the development and adoption of locally developed indicators. This is because there is a risk of local health economies developing indicators which may not be comparable across the country.

2. That there should be some continuity with the previous performance regime to ensure that during transition there is no loss of focus on delivery of desirable outcomes.

3. That the process by which the new outcome framework will work in tandem with local performance management regime is clarified in order to enhance accountability at the frontline.

4. That it is important that the NOF links clearly to other frameworks being developed, such as the public health and social care outcome frameworks

and that the interdependence with these frameworks is managed by an accountable body with clear processes.

5. That it is important that the framework did not simply focus on the healthcare system but recognised the bearing on health outcomes that issues such as housing and employment, education and life choices had. If established in isolation the NOF would not achieve successful sustained outcomes.

6. That perhaps, as the NOF evolves that consideration could be given to the development of a unitary outcome framework encompassing health and social care issues so that the full context within which health outcomes needed to be delivered was understood and managed by accountable local bodies.

7. That once the NOF was agreed the aim should be to have a period of stability. Whilst the framework might need to be adjusted, these adjustments should be limited as far as possible.

8. That the framework considers putting in place a process by which Health Trusts would be required to provide one set of information to one body, rather than, as now, having to respond to requests from a range of organisations.

9. That the NOF seemed to focus on acute care and this could be remedied by giving sufficient weight to preventative measures and caring for people at home and in the care system in the framework (for example, preventing tobacco use in patients receiving care for cardiovascular and respiratory diseases while being treated).

10. That we broadly agree with the five outcome domains. However, it may be necessary to fill gaps by considering how a domain or sub-domain for prevention could be included.

11. That there is a need to clarify how the framework would relate to the Primary Care Quality Outcomes Framework (QoF).

12. That the framework may not encourage providers to be preventative in their approach to providing care, it appears that providing more treatment is considered good. This may create a perverse incentive to providers to undertake more treatment. Providing fewer treatment episodes could be a sign of success in improving population health and wellbeing.

13. That it is important that selected indicators take into account the condition of the patient as well as age (a patient with lung cancer would have a different life expectancy whatever the treatment). The definition of premature death needed to recognise avoidability.

14. That mental health did not appear to be covered sufficiently by the NOF and further consideration should be given to this aspect before the framework is initially rolled out.

15. That the framework did not appear take into account cost and cost-effectiveness.

ANNEX 1 – Consultation questions

CHAPTER 2: Scope, purpose and principles of an NHS Outcomes Framework

Principles

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?
2. Are there any other principles which should be considered?
3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?
4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Five domains

5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?
6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?[39]

Structure

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

[39] **Please note** that public health and prevention will be covered in a separate consultation, linking to this framework where appropriate

CHAPTER 3: What would an NHS Outcomes Framework look like?

Domain 1 - Preventing people from dying prematurely

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?
9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?
10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?
11. If not, what would be a suitable outcome indicator to address this issue?
12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

Domain 2 - Enhancing the quality of life for people with long-term conditions

13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?
14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?
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?

Domain 3 - Helping people to recover from episodes of ill health or following injury

16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?
17. What overarching outcome indicators could be developed for this domain in the longer term?
18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?
19. What might suitable outcome indicators be in these areas?

Domain 4 - Ensuring people have a positive experience of care

20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?
21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?
22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?
23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?
24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?
26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?

General Consultation Questions

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?
28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?
29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?
30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?
31. Is there any other issue you feel has been missed on which you would like to express a view?

ANNEX 2 – Stakeholder Event Flip Chart Write Up
Group work notes

Commissioning for Patients

Group 1

- Will commissioning distract GPs from their primary responsibilities for patient contact?
- Will it reduce bureaucracy?
- Tendering and procurement processes are very time-consuming (e.g. Primecare and mental health tender)
- Need to keep creativity and 'fleet-footedness'
- How can e.g. schools contribute to children's and young people's commissioning? Needs a multi-agency approach.
- How will patients/citizens views and needs be taken into account?
- How will specialised services be commissioned?
- Need more clarity on the scope of GP commissioning.
- Do we want commissioning done at the 'lowest' level?
- Confidence in capacity to manage financial risks?
- Consortia could buy in expertise
- Whatever happens, there are hard times ahead and cuts will have to be made
- One size does not fit all – e.g. rural and urban needs are very different.
- Deciding priorities will be challenging with less money in the system
- Where will the prevention agenda sit?
- QOF v. local priorities could cause tension
- Practice budget will be separate from commissioning budget
- Reducing health inequalities will be more challenging
- Herefordshire is ahead in partnership – the process could be achieved more quickly here
- Will GPs be able to commission social care? This is too often ignored or given low priority or considered too difficult or to be someone else's responsibility. In a worst case scenario this could lead to 'death by indifference' for vulnerable people

Group 2

- This will be a more clinically-driven approach than the current one
- Different localities will have different needs – how will this be managed and how/who will set budgets?
- How will health inequalities be addressed?
- Herefordshire is too small to be sub-divided into smaller consortia. Also its current service localities are appropriate for one commissioning organisation
- How to handle cross-border issues/patients (both in and out of Herefordshire)?
- Unregistered patients (1-2%) must not be forgotten
- The planned approach puts clinical and financial accountability together
- Population of Herefordshire is too small – challenges of rurality/range of services/economies of scale
- Top-down allocation can mask local differences
- Leaner more cost-effective services are a key aim

- Commissioning for quality in Herefordshire lacks the element of competition the government is expecting
- Herefordshire will always be 'monopolistic' because of its size
- Quality standards must be built into contracts
- Patient outcomes must be disseminated so patients and the public know what to expect
- Could ask non-Herefordshire GPs to join consortium

The above comments grouped under main themes:

Health inequalities

- Quality standards must be built into contracts
- Unregistered patients (1-2%) must not be forgotten
- Top-down allocation can mask local differences
- How will health inequalities be addressed?
- Different localities will have different needs – how will this be managed and how/who will set budgets?
- Will GPs be able to commission social care? This is too often ignored or given low priority or considered too difficult or to be someone else's responsibility. In a worst case scenario this could lead to 'death by indifference' for vulnerable people
- Reducing health inequalities will be more challenging
- QOF v. local priorities could cause tension
- Whatever happens, there are hard times ahead and cuts will have to be made
- One size does not fit all – e.g. rural and urban needs are very different.
- Deciding priorities will be challenging with less money in the system
- How can e.g. schools contribute to children's and young people's commissioning? Needs a multi-agency approach.

Patient involvement

- Patient outcomes must be disseminated so patients and the public know what to expect
- Different localities will have different needs – how will this be managed and how/who will set budgets?
- How will patients/citizens views and needs be taken into account?
- Will commissioning distract GPs from their primary responsibilities for patient contact?

Size/economies of scale

- Commissioning for quality ion Herefordshire lacks the element of competition the government is expecting
- Herefordshire will always be 'monopolistic' because of its size
- Leaner more cost-effective services are a key aim
- Population of Herefordshire is too small – challenges of rurality/range of services/economies of scale
- Need more clarity on the scope of GP commissioning
- Will it reduce bureaucracy?
- Could ask non-Herefordshire GPs to join consortium
- Herefordshire is too small to be sub-divided into smaller consortia. Also its current service localities are appropriate for one commissioning organisation

Expertise/time

- Quality standards must be built into contracts
- Commissioning for quality in Herefordshire lacks the element of competition the government is expecting
- The planned approach puts clinical and financial accountability together
- This will be a more clinically-driven approach than the current one
- How will specialised services be commissioned?
- Tendering and procurement processes are very time-consuming (e.g. Primecare and mental health tender)
- Need to keep creativity and 'fleet-footedness'
- How can e.g. schools contribute to children's and young people's commissioning? Needs a multi-agency approach

Financial considerations

- Top-down allocation can mask local differences
- Leaner more cost-effective services are a key aim
- The planned approach puts clinical and financial accountability together
- Will GPs be able to commission social care?
- Different localities will have different needs – how will this be managed and how/who will set budgets?
- Practice budget will be separate from commissioning budget
- Where will the prevention agenda sit?
- Confidence in capacity to manage financial risks?
- Consortia could buy in commissioning expertise
- Whatever happens, there are hard times ahead and cuts will have to be made
- One size does not fit all – e.g. rural and urban needs are very different.
- Deciding priorities will be challenging with less money in the system
- Tendering and procurement processes are very time-consuming (e.g. Primecare and mental health tender)

Local Democratic Legitimacy : Workshop Feedback

Summary of points raised:

HealthWatch

- Need to ensure appropriate resources (financial, officers etc) and appropriate establishment
- Must not undermine
- Build on what we already have
- Concerns about ensuring that have the skills and capacity to deliver locally (volunteers have been an issue with LINKs)
- Evolution not revolution
- Links experience has been individuals engage mostly as a result of a problem. Time and energy is required to get involved. HW must be different.

Health and Well-Being Board

- Must ensure that existing relationships (built over a number of years) are not broken
- Need to consider cross boundary issues and how those providing service out of the area are held to account : e.g some GP consortia will not necessarily be co-terminus. Contractual relationships with specialist hospital/ services e.g Birmingham Children's Hospital.
- Strong potential to work
- Appreciate that 'local' may mean different things to different groups
- Need to ensure some consistency and quality across England – so possible support for some limited national prescription (otherwise possibility for chaos and undermining national resilience).
- Herefordshire has strong building blocks – want to determine as much as possible as national prescription would not necessarily assist us. Don't need statutory powers to hold each other to account : nationalism vs localism debate
- In the context of the health economy, where's the check? Market doesn't always determine what is best for the community. Concerns therefore that the HWB Board could be a talking shop.
- Choice – how will this be managed? GPs will commission, but in practice it will be the patients who determine.
- Independent Chairs on other 'Boards' e.g transformational, safeguarding. Must make sure that flexibility is given to appoint an independent chair if appropriate to draw in skills/competencies. Recognise that there may be costs associated with this approach.
- Essential to have clear lines of accountability and mechanisms for resolution of issues
- Need to have clarity as to where the line is drawn in relation to wider health issues/impacts e.g housing, environment etc
- What happens if they don't agree? – where/what is the sanction?
- Roots in the community are important – need to anchor H&WB Board in the community.
- Making localism happen.
- Need clarity on who regulates the system

Public Health

- In support of the proposals in relation to public health
- Fits neatly with Herefordshire approach
- Need to ensure that national/regional issues are appropriately managed – therefore have a balance between local and national/regional
- Always been an artificial divide – new proposals are welcomed

Scrutiny

- Scrutiny should be a central part of any new structure and its good work to date must not be lost e.g building of relationships/trust/rapport
- Further detail would be welcomed on scope etc.

Other matters

- Rural proofing is very important
- How will the GP consortia be managed – either managerial GPs (not cost effective) or via a management elite

Regulating Healthcare Providers – Facilitator Marcia Pert

Session 1 (6 attendees)

Q1	• The cap should be removed.
Q2	• Not convinced as there needs to be some control on capital spend. • It was suggested that an FT could be given a credit rating.
Q3	• Staff and patient input through the constitution may be a good thing. • FT model is a bit too narrow – don't stifle employee/community enterprise interests. • The FT governance is too tight it needs opening up to change the dynamic of it.
Q4	• Merger/acquisition should be made easier – to speed up any takeover when one party may be in trouble.
Q15	• To a degree this already exists and could be incorporated into the new system. A degree of regulation is needed to prevent a monopoly. • Providers (competition) exists in urban areas. Rural areas should seek a degree of dispensation to ensure that quality ethos is maintained. There is a need to maintain the flexibility of choice. • Providing that a quality/safe/cost effective service is maintained – if this isn't happening provision can be sought from elsewhere.
General comment	• Public want one NHS providing the core priorities to high values/standards. • Affluent areas shouldn't benefit to the detriment of poor areas.

Session 2 (7 attendees)

Q1	• It was questioned on a practical level how much inward investment would come to Hereford – would a private company really build a competing hospital? • Suggested it could be linked to % of turnover to keep within some financial limits. • Needs rural proofing. • Private work shouldn't detract from the core business.
Q2	• While politically embarrassing 'Failure' may be ok in an urban area where there is easy access to alternative provision, but not so in a

	rural area where no alternative exists without travelling miles putting patients at further discomfort.
Q3	• Constant constitution and membership change would be confusing and needs to be avoided. Understood that constitutions would be monitored by Monitor.
Q6	• Currently inspections are undertaken by one regulator – is it good practise to now increase this to two separate inspection regimes.
Q11	• Fees are already in place through CQC
Q15	• Herefordshire has good partnership working – don't want anything to stop this – particularly as there isn't a wide range of competition in this area.
Q16	• The workshop group asked what does or should this look like?
Q17	• Already got the CCP.

Transparency in Outcomes – a framework for the NHS

Scope, purpose and principles of an NHS outcomes Framework

Principles

- That the principles underpinning the NHS Outcomes framework (NOF) were adequate.
- The move to measuring outcomes was logical.
- The outcome measures needed to be specific and measurable to ensure proper comparisons could be made with other areas. However, the outcomes must be worth measuring and not selected simply because they could be measured.
- There needed to be provision for locally decided measures.
- A reduction in the target culture could free up resource and benefit patients.
- That there should be some continuity with the previous performance regime, keeping what did work (eg measuring mortality rates and avoidable harm) and adding in the patient experience.
- Consideration needed to be given to how the framework would actually help people to deliver effective care.
- It would be necessary to ensure the framework worked effectively to achieve change.
- That it was important that the NOF linked clearly to other frameworks being developed, such as the public health framework and was interdependent with them.
- It was important that the framework did not simply focus on the healthcare system but recognised the bearing on health outcomes that issues such as housing and employment, education and life choices had. If established in isolation the NOF would not achieve successful sustained outcomes.
- There needed to be a unitary outcome framework encompassing health and social care issues so that the full context within which health outcomes needed to be delivered was understood.
- That the NOF framework needed to be flexible.
- That once the NOF was agreed the aim should be to have a period of stability. Whilst the framework might need to be adjusted, these adjustments should be limited as far as possible.
- That Health Trusts should be asked to provide one set of information to one body, rather than, as now, having to respond to requests from a range of organisations.

- That it was important that indicators related to local need. There should be some national targets for key health issues. Regional targets were not helpful as they were often not relevant to Herefordshire.
- That a number of the indicators focused on process not outcomes.
- Greater clarity was needed around the process for monitoring performance against the NOF.
- There needed to be a focus on what patients wanted to get out of their healthcare experience, striking a balance between quality of life issues and clinical outcomes. The emphasis seemed to be on keeping people alive not about quality of life. Different patients wanted different things. Patients' wishes had not been listened to – eg end of life care. Patients wanted to be involved in deciding on their care.
- The NOF seemed to focus on acute care. It did not give sufficient weight to preventative measures and caring for people at home.

Five Domains

- There was broad agreement with the five outcome domains. However, it was thought that there were gaps. For example the differences in affluent and deprived areas were not measured.
- It was suggested prevention should be a domain.
- There needed to be clarity as to how the framework related to Primary Care.
- The framework did not encourage providers to be preventative. There was a perverse incentive to providers to undertake more treatment. Doing less could be a sign of success.
- It was important that the indicator took account of the condition of the patient as well as age (a patient with lung cancer would have a different life expectancy whatever the treatment). The definition of premature death needed to recognise avoidability.
- There was a need to avoid targets distorting care. If the definition of premature death referred to deaths under age 75 this could lead to a situation where treatment of those over age 75 was not given the appropriate weight.
- The treatment of those over age 75 was important in the Herefordshire context and not addressed well in consultation paper. The message was negative rather than promoting health.
- There should be target for protecting those over age 75 from avoidable harm.
- The document was paternalistic. The outcomes needed to promote health and self-help. This reinforced the need for a unitary framework taking account of health and social care outcomes.

- There was too much focus on secondary care. The Framework focused too much on traditional approaches.
- The focus was on what the health service could deliver. There needed to more emphasis on working in partnership.
- There were concerns that if there was less incidence in Herefordshire of one of the things being measured resources would be transferred away, although there might be needs in Herefordshire not being measured centrally for which those resources were needed.
- Mental health did not appear to be covered by the NOF.
- The framework did not take account of cost effectiveness.
- Herefordshire needed fairer funding, with proper recognition of the financial pressures created by rurality.
- There needed to be a wider assessment of outcomes, measuring them over the long term. This was when the link to other frameworks such as heath and social care and the bearing factors such as housing and employment had on health was important.

General

- There was some concern that the changes proposed in the White Paper and their extent could potentially have a negative impact on the health service.
- Whilst the PCT had invited some GP involvement in commissioning, GPs had felt peripheral. GPs would, however, need help in taking on the commissioning role. There was concern about the pressure on the NHS to reduce management costs, a view being expressed that Herefordshire PCT had already pared down its management.
- It was important that the framework did not lead to any reduction in the partnership working developed in Herefordshire.