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Southampton City Council and NHS Southampton Joint Consultation Response to the White Paper 'Equity and Excellence: Liberating the NHS'

This Paper sets out Southampton City Council (SCC) and NHS Southampton's joint response on behalf of themselves and stakeholders, to the consultation on the NHS White Paper 'Equity and Excellence: Liberating the NHS' and associated documents. Annexed to this paper are detailed individual responses from the Health and Well-being Board, Health Overview and Scrutiny, SCC Housing Department, which address some of the specific questions relevant to them.

We support the principles on which the White Paper is based and the vision it is aiming to achieve. However, we have some concerns about the scale, pace and potential cost of many of the changes proposed and the capacity to achieve them without a detrimental effect on patient care and outcomes. We would want to build on the positive work already achieved by the PCT.

Whilst we welcome the principle of locating commissioning closer to patients, we have concerns about how this will be achieved. We would like to see more involvement from other primary care practitioners and are concerned about the capacity of GP's to take over commissioning in such a short time scale. Joint Commissioning must continue to be supported and driven forward as locally we have progressed well on this. Sufficient governance and accountability mechanisms must be put place to monitor consortia and ensure value for money.

We are pleased to support a stronger role for local authorities, particularly in relation to public health and promotion of joined up commissioning. This will build on the excellent joint working that already exists with the NHS and other partners. However it will be important that local authorities are provided with the powers and resources required to carry out their strengthened role effectively. We are concerned about the role of the Health and Well Being Boards in relation to scrutiny and feel that this would create a conflict of interests and remove a vital element of oversight that is independent of decision makers with direct accountability to the public.

Increase in patient choice, where there is evidence that it is wanted and it improves outcomes, is welcomed. However, this needs to be closely linked with better advice and support for patients on their options and safeguards to avoid abuse of the system and protect vulnerable individuals. The new structure needs to improve the experience of the patient, joining up partners to provide seamless care.

We welcome a more outcome-focused approach to performance measurement. However, it is important that this does not lead to a general reduction in patient care and where process measures are important they are retained either on a local basis or national basis.

Finally, this is a very challenging agenda and time and effort will need to be invested to ensure that organisational cultural differences are understood and potential problems are resolved. Greater information sharing and co-operation will be needed and staff empowered to deliver change.

Our detailed comments on the White Paper are set out below.

Bob Deans
Chief Executive
NHS Southampton City

Penny Furness-Smith
Director Health and Adult Social Care
Southampton City Council

Introduction

1. NHS Southampton City and Southampton City Council (SCC) have been working closely for many years and this is a joint response from both organisations. Our response is based on a comprehensive joint consultation exercise we conducted locally to seek the views of a wide range of stakeholders and this process has included:
    - Feedback from SCC and NHS Southampton City staff
    - Consultation with PCT Trust Board
    - Discussions with SCC Senior Management Team
    - NHS Southampton City's Clinical Leadership Board which comprises GP's, nurses and clinical representation from acute and community provider organisations
    - Feedback from GPs with a meeting planned for representatives of GPs
    - Two GP Forums with representatives from across the City
    - NHS Southampton City's 'Meet The Chief Exec' event with the voluntary sector and involved 28 different organisations
    - Briefing for all elected Council Members
    - Joint Council Scrutiny Meeting of the Overview Scrutiny Management Committee and the Scrutiny Panel that focuses on health
    - Briefing for Council Political Group Leaders
    - Presentation and discussion at the LINks AGM
    - Stakeholders Workshop - including NHS (both commissioning and provider) & council services (including representation from Health and Adult Social Care, Children's Services, Housing and Legal), Voluntary Sector, and patient representatives.
    - Health and Wellbeing Partnership Board Workshop
    - Presentation at the city council's Senior Managers' Conference
    - Children and Young People's Trust
    - NHS Southampton City PCT's AGM including a 90 minute 'Big Health Questions' debate inviting questions from the public on the future of the NHS
    - NHS Southampton City's Patients Forum
    - Two Senior Manager workshop meetings with staff at NHS Southampton City
    - Monthly internal NHS Southampton City Team Briefings with all staff within the organisation including Q&A opportunities
    - Links to the public consultation being placed prominently on the homepage of NHS Southampton City's website encouraging responses from the public
    - Representation and support for South Central Strategic Health Authority's workshop held for key stakeholders in Southampton and Portsmouth

2. Our feedback is based on the following themes:
    - GP Commissioning
    - Role of the local authority
    - Choice, control and patient involvement

- Joint Commissioning
- Healthcare outcomes and the performance framework
- Cultural challenges

3. Additional information is provided from different stakeholders who have provided feedback from their perspective. This additional feedback covers other supporting consultation documents published with the Health White Paper and are attached as Appendices:

   - Appendix 1: Southampton LINk
   - Appendix 2: Southampton City Council Health Scrutiny Panel
   - Appendix 3: Southampton Health and Well Being Partnership Board
   - Appendix 4: Southampton City Council Housing

General

4. We recognize that the Health White Paper, 'Equity and Excellence: liberating the NHS' (and associated documents including 'Achieving Equity and Excellence for Children') represent a radical restructuring of the NHS that would transform how health care is commissioned, delivered and monitored. We are keen that the effective work of the Primary Care Trust in the city over a number of years is built upon rather than a complete revision and change. The PCT has had a strong leadership role in developing many creative initiatives with the Local Authority, Primary Care and other stakeholders. It is important to ensure that the experience and strong ethos of partnership working are not lost. The PCT has had a strong leadership via the Clinical Leadership Board and this could be a model to be further enhanced.

5. We welcome the opportunities presented for strengthening the role of local authorities in public health and in influencing health care commissioning. However, we are keen to work with others both locally and nationally to ensure that this scale of change is managed well so that :

   - Outcomes continue to improve
   - Outcomes for patients do not suffer in the transition period
   - Costs and disruption are kept to the minimum
   - The skills, knowledge and experience developed over many years can be drawn on and utilised in the new world.

6. There is evidence to suggest that health re-organisations have a detrimental impact on quality in the following years.[1] The safeguarding of both adults and children especially through the transitional period given the withdrawal of core functions and the potential loss of focus is also a concern. Guidance on managing the practical aspects of the transition period will be critical. PCTs, health providers, local authorities and local partners (e.g. the voluntary sector, schools) and will need to

[1] **CIVITAS: Data Briefing Re. Government Plans to Transfer Commissioning Responsibility from PCTs to GPs. 10 July 2010. Available At Http://Www.Civitas.Org.Uk/Nhs/Download/Civitas_Data_Briefing_Gpcommissioning.Pdf**

work together to retain the right level of skills mix for commissioning the range of services and outcomes that are needed to support and improve the health outcomes and experiences for citizens in our city. This must be done whist minimising job losses and redeployments and ensuring minimal service disruptions and a continued focus on and robust management of performance and finance.

GP Commissioning

7. GPs are the first point of contact with patients and are well placed to ensure a continuum of care and to drive patient choice into commissioning. The move to GP commissioning will provide opportunities to increase innovation and give patients more control over the services available. However, we feel that there are several issues that need to be considered and safeguards put in place for this to be effective. These include cost implications, inclusive primary care provision, access to specialised services, opportunities to understand the opportunities and potential benefits of working in collaboration with the local authority and other providers and local partners, particularly on services which impact on health, integrated healthcare, boundaries and size of consortia, commissioning capacity, funding for support functions, accountability and conflict of interests. Our feedback on these is detailed below.

<u>Cost Implications</u>

8. There is a risk that the transitional costs, implications for GPs and their practices and increases in local bureaucracy and potential duplication of systems (particularly in areas where the number of consortia established exceed the current number of PCTs) will offset the savings from a reduction in management costs. The introduction of greater patient choice in conjunction with a reduction in resources has the risk of raising patient expectations to unrealistic levels and creating an unachievable challenge for newly established and inexperienced consortia.

9. There are concerns about the pace of change and that the speed will distract commissioners and others from the significant QIPP (Quality, Innovation, Productivity and Prevention) agenda that the NHS is tackling currently.

<u>Inclusive Primary Care</u>

10. Whilst we support the move to locating commissioning closer to patients, the proposed model should also take account of other Primary Care professionals and the knowledge and experience they can contribute. We would like to see further consideration given to the role of dentists, pharmacists, optometrists, nursing, therapists and social workers in relation to the contribution they can bring to collaborative commissioning where integration of commissioning activity may not be achievable or desirable (particular of specialist services) and their involvement in consortia.

Specialised Services

11. It will be important that the GP consortia are required to seek expert clinical and public health advice when commissioning specialist services such as drug and alcohol dependency treatment or trans-gender issues to ensure that the issues are not marginalised. It is not clear to us why maternity services will not be commissioned on a local level and we would welcome greater clarity on this point, as in our view, they form an early and critical part of the well being journey.

12. GP consortia will need to ensure sufficient expertise in safeguarding children and vulnerable adults. GP knowledge and experience in safeguarding has been identified as an area for development by several national reports and in local Serious Case reviews.

Partnership with Local Authorities

13. We support the duty for GP consortia to work in partnership with Local Authorities in relation to commissioning and feel the duty must be a statutory requirement to ensure it happens. Without this alternative levers would need to be in place or available to be brought into use where permissive responsibilities are not enacted. However this requirement should not just be restricted to social care, early years and public health but should also recognise that other local authority services (e.g. housing, environmental health, education etc) are part of the wider determinants of health and therefore need to be considered. The balance of public health and understanding of needs assessments in the area is essential. This would help ensure that GPs consortia take commissioning decisions based on the overall needs of population in the future rather than the needs of their current set of patients. Working together with Local Authorities will also help develop skills in relation to whole system thinking which will help reduce the risk of increasing inequalities for those patients who do not engage with their local GP. The move to GP commissioning must not be a barrier to the progress that is taking place in relation to joint commissioning and pooled budgets.

Integrated Healthcare

14. Progress in moving the focus of the health service from a medical model to a more integrated model of health care could be lost with the transfer of commissioning to GP consortia. However, it is recognised that the role of the Health and Well Being Board will be instrumental in ensuring that progress continues to be made. We would also support Sir Ian Kennedy’s conclusion that a ‘Local Partnerships’ should be in place to ensure the health of children and young people in particular remains integral to health commissioning at all levels.

Commissioning capacity

15. We are concerned about the capacity, both in terms of time and skills, to undertake commissioning at an effective level. There is a need to mitigate against the potential that patient care deteriorates and GP waiting times (which are already lengthy in some areas) will increase. The support budget/role needs to be established quickly to avoid this and reporting measures need to be put in place to monitor progress.

The transition period will need to be carefully managed and timescales altered if necessary to ensure patient care, in the short and long term, does not suffer. There is also a need to ensure that Value for Money remains a key factor and that paying GP's to commission is not too expensive

GP Consortia Boundaries and Size

16. Given the benefits of close working and the potential for the consequences to be felt by either the consortia or the local authority arising from the actions of their counterpart as well as with local authorities and other public and voluntary sector bodies, we feel alignment with local authority and/or administrative boundaries could be vital. This will also align Health and Well Being Boards, which appear to be firmly located under a local authority purview.

17. Variation in the engagement, skills and enthusiasm of GPs in relation to the establishment of consortia may influence their establishment in some areas. This should not be a driver for the form and size of consortia. We would like reassurance that the NHS Commissioning Board will ensure that the establishment of consortia has been based on the needs of local populations.

18. If the size of GP consortia populations varies significantly then the range and quality of services they commission may vary across the country and local issues could be diluted. Additionally where consortia are too small there is a risk that commissioning services on a piecemeal basis will make services less efficient and cost effective.

Adequate funding for Support Functions

19. The allocation of 'support' funding by head of population in smaller consortia may raise issues of affordability in relation to the procurement of the specialist service, systems and management required that will be required to operate effectively.

Governance and Accountability

20. As sovereign bodies that will be responsible for large sums of public money, GP consortia must be required to have clear and transparent governance structures. General guidance or formal instruments will need to be in place, including specific reference to remuneration and audit committees. We would also like to see consideration of each GP consortia's governing board including an 'independent' element.

21. The new system should increase GP accountability and increase transparency through their commissioning role. However, we are concerned about how the decisions of the consortia can be challenged – on a basis that is wider than financial. There needs to be a clear accountability framework for consortia, which includes both a national and local role. The integration of health scrutiny with Health and Well Being Boards (on which GP consortia will sit) raises questions about how local scrutiny will take place and Appendices 2 and 3 provide details of the responses from the local authority Scrutiny Members.

Conflict of Interests

22. We have some concerns that there will be a conflict of interest between the GP roles of practitioner and commissioner. There could be issues between GPs business decisions and 'real' patient choice especially where a conflict or opposing view of care needs arise. Patients' rights needs to be protected and an option for arbitration available. The role of GP as both provider and commissioner also has the potential to damage the GP/Patient relationship where they need to declare that they have decided that desired treatments are not available.

Role of the local authority

A strengthened role

23. We welcome the transfer of responsibilities for health improvement and the new role in coordinating commissioning. Clearly, taking on more responsibilities for coordination and promotion requires local authorities to have the appropriate powers, resources and authority. The Government will need to give local authorities the means to take on this role effectively.

Scrutiny

24. The future of health scrutiny: Appendix 2 details the response from the Council's Overview and Scrutiny Management Committee and the Health Scrutiny Panel and Appendix 3 details the feedback from the Health and Well Being Partnership Board.

25. We feel strongly that the statutory responsibility for health scrutiny should be retained outside of the Health and Well-Being Board. Transferring scrutiny powers to the Board would create a clear conflict of interest and run counter to the principle of separation of executive and scrutiny. It would also remove a line of accountability to the local community. There are also concerns about the capacity of the Board to undertake effective scrutiny.

26. The statutory powers that health scrutiny committees currently have in relation to SHA's, PCT's and NHS Trusts will need to be altered to reflect the new structures and include GP consortia.

Public Health

27. While the proposals do not have all the details about the future relationship between local government and health, on balance, it is a positive step forward as it recognizes the central role of local government in promoting health and well-being and gives local authorities additional responsibilities and powers. Leadership and the responsibility of co-ordination of local action to improve public health and reduce health inequalities should be with the local authority.

28. We have had a jointly appointed and funded Director of Public Health for a number of years and we welcome the opportunity provided by the proposed transfer of the public health service and budget as it gives local authorities the lead in promoting health and tackling health inequalities. However, reassurance is needed on adequate funding

being made available for any additional functional or TUPE issues with the concomitant implications on local authorities' very different pay and grading structures at a time when local authorities are doing their utmost to reduce these overall.

29. We see value in retaining public health skills and expertise at local level that will ensure that the commissioning of local healthcare services achieves the most population health gain as part of whole system collaborative planning. We can see the merit in this being within the remit of the local authority, alongside leadership and responsibilities for health protection and health improvement.

Choice, control and patient involvement

Choice and control

30. A leaner approach and structures should enable a better focus on patient needs. However, patient choice is already very limited and tighter and more localised budgets may result in real choice being even harder to achieve. The proposals require a fundamental shift in national culture/thinking both in the medical profession and in terms of patient's expectations and access to information/options of choice. There is scepticism over how much patient choice there will be available as this will be hard to achieve when commissioning for an area and within constraints on budgets.

31. The Putting People First programme has shown us that some service users choose not to use their choice and wish to put the decision back in the hands of the professional. This needs to be a choice that is available.

32. Increased patient choice also has the potential to distort the principle of patients having the best service wherever they go. There are also issues regarding the best interests of patients. Patient choice may not always be the most appropriate or efficient or effective way of handling their health need or medical condition. We would like to see safeguards put in place to ensure patients are protected.

Patient Empowerment

33. Increased patient choice needs to be supported by increased advice and guidance for patients. Sign posting will be very important to inform patients of their options. There could be issues over how service users make choices, weighing up location against performance, different users have different priorities. There also needs to be support for patients if the GPs disagree with or cannot support their choice. Advocacy and accessibility of information in the right format is important, especially when it comes to personal health budgets. Everyone should have equal access to the information they require.

34. Those who are vulnerable, isolated or not outspoken may not fully understand their options and may need additional help and support to make their choice or argue their cause.

35. Particular consideration needs to be given to advocacy for the ‘voice’ of children and young people. This may not always emerge from a solely adult consideration, and it will be important to ensure the development of health promotion and health services are as child and young person ‘friendly’ as possible.

36. If communities are engaged and have a high level of awareness and understanding, they will be able to take responsibility for their own their health and lifestyle choices and make fully informed decisions about treatment.

37. Therefore, the changes need to:
    - facilitate greater understanding and awareness of the patients pathway and costs of services
    - encourage and assist voluntary sector involvement in supporting people to make decisions about their healthcare
    - Improve engagement with local communities, with wide availability of information and awareness
    - Provide education that supports increased personal responsibility

Seamless Care

38. One of the most important issues for patients is that they receive a seamless experience. Patient centred care should mean supporting them when they need it, there should be no visible seams for changing teams. There needs to be one team working with a patient across specialist areas with no need to repeat patient history. Services need to be more joined up in delivery, information sharing and communications.

39. This principle needs to apply wider than just health and social care to ensure a holistic approach to patient care at all ages is enabled including public health, housing, transport and voluntary services to achieve success. The use of pooled budgets and joint commissioning is the most effective and efficient way to achieve this.

40. Services need to be planned in a holistic way looking at wider costs and benefits. Unit costs are reduced by offering services in one place. For example, children’s blood tests currently have to be done in hospital, this necessitates time off school and can have a knock-on effect on education, there are transport issues etc. We are currently constrained by the system.

41. Foundation Trust status providers will generate the opportunity for services to be more innovative and patient focused, with more integrated delivery of community services.

42. The White Paper needs to consider more widely what measures or freedoms can be introduced to make seamless patient centred care a reality.

Communication during the transition period

43. We feel it is important to keep the patient experience positive through the period of change, making sure that statements and promises are planned and resourced to avoid the perception of lip-service being paid towards putting the patient at the centre. As the changes are worked through it will be challenging to maintain the focus on the patient, rather than the organisations undergoing change. The patient will be looking for a holistic approach with connections being made across the system to respond to their needs, something at odds with the current silo thinking. There will be a large volume of information to communicate to patients about the new structures, and in delivering effective signposting it will be essential that this is done in a timely fashion and with language that is clear and avoids jargon.

HealthWatch

44. We have several concerns about the establishment and role of HealthWatch. In order to be effective HealthWatch should be truly representative of the demography, have a broad remit and be a cornerstone to the system with clearly defined parameters, expectations and resources.

45. While the proposals to fund Local HealthWatch and for them to be accountable to local authorities gives us opportunities to consider and design holistic advice, guidance and information services, we have some concerns about in conflict of interest in relation to the complaints function. We would like to see more consideration given to a complaints service independent of local authorities who will be accountable for HealthWatch funding.

46. For HealthWatch to be successful it will need full time support from professional staff properly trained to provide this expanded service. We do not believe this service can be provided solely by volunteers but in order to be effective it will also require additional training for the volunteer members so that they have a reasonable understanding of the issues in discussion with the salaried staff.

47. There needs to be consideration of the geographical scale of local HealthWatch in conjunction with establishment of GP consortia and Health and Wellbeing Boards. However, for local HealthWatch to be effective it will need to be co-terminus with one (or more) GP consortia allied as close as possible to the local authority.

48. There is serious concern about the funding arrangements during the transition period. This is pertinent given LINks funding ceases at the end of the financial year 2010/11 thus notice periods will be exercised prior to a clear picture of the new funding arrangements being in place – thus there is the potential to loose the expertise and momentum as one-service ends before the new one commences. Explicit guidance

needs to be developed to support management of the transition at a time of extreme financial constraint.

Joint Commissioning

49. We strongly support a joint commissioning approach as the crucial way forward. It is essential to enable services to move away from the current culture of 'who pays for what' approach which gets in the way of patient choice and seamless care. Ultimately, this needs to lead to pooled and integrated budgets where this is most effective for example complex health and social wellbeing conditions.

50. Joint Commissioning relies heavily on individuals making it work. The move to GP consortia and new Health and Well-Being Boards require new relationships to be developed. The joint commissioning principle needs to be strongly driven from the centre. Pooled and integrated budgets are the best way to enable the money to follow the patient's whole journey. Incentives need to be provided to drive further progress in this area including those that encourage other local partners with controllable budgets to collaborate for mutual benefit; e.g. schools in respect of the commissioning of school nursing; colleges in respect of measure to address sexual health, the police in relation to alcohol and substance misuse

Healthcare outcomes and performance framework

51. A more outcome focussed approach to measurement and monitoring success rather than the current process-centred system is welcomed. However, a more outcome-focussed approach should not mean that issues such as waiting times are dropped but instead should be focussed at a more local level to ensure that patient care does not deteriorate. There is also a notable absence in the outcomes framework in relation to children. This needs to be addressed.

52. Early considerations and decisions need to be made on how and when systems are put in place to measure the impact of the new approach on patient choice and care. There will need to be a clear direction about what we are trying to improve and measure.

53. There will need to be a sound understanding of the services that affect health outcomes and how they inter-relate. This understanding will result in a wider focus on preventative and proactive services rather than just reactive services; for example, collaborative approaches to tackling childhood obesity to offset cost associated with later remedial action. There also needs to be recognition that measuring outcomes is often a longer-term issue and very individual for each patient, particularly given increased patient choice. There needs to be a culture change for this long-term view to be valued.

54. As integration moves forward it will be essential to ensure that all organisations in the process are counting and measuring the same things in the same way. There will be major challenges in bringing

different organisations together with different IT systems, timetables and budget planning cycles and the scale of the work involved should not be underestimated.

55. As information sharing progresses there may be issues over who has responsibility for funding certain services, so it will be essential to have robust governance arrangements to resolve these issues.

56. There will be challenges in the provision of good quality personal information to the public and if the systems have not been adequately developed they will lose the confidence of the public. Ultimately, closer working and integration of data may create an opportunity for a local observatory which would be of benefit to all organisations and local people.

Cultural challenges

57. The processes outlined in the White Paper will bring together organisations with very different cultures, and significant effort will need to be invested in developing an understanding of the other organisations. GP's will need to strengthen their role with the wider public health agenda and partnership working. Local authorities will need to increase their focus on health issues. This will be particularly important as the public health function transfers to the local authority. There may be benefits in developing joint training on issues of common interest, for example between GPs and social workers. The introduction of new commissioning arrangements and the split between commissioners and providers has created information barriers in some parts of the system and this needs to be addressed. As the changes are worked through, it will be important for staff to be empowered to undertake the actions necessary to deliver change.

58. It will be essential to get the highest levels of public support for the changes ahead and this will most likely be achieved if there is transparency in the change processes.

59. There are concerns that the white paper will lead to years of unbridled change in the city for service users while providers work out and implement the process of change at a time when resources are most scarce.

60. The success of these changes will be greatly enhanced by early consideration of the training and professional development activity that will be needed in order for improved health outcomes to result. 'Intelligent' commissioning will require GPs, elected members, staff and all partners to have opportunities to learn and develop together in order that commissioning decisions remain well informed, supported and value for money.

Conclusion

61. We have consulted and discussed the White Paper widely in Southampton City. There is general support for principles and visions on which the White Paper is based and we are keen to continue the strong joint working on health and social care and related areas across the city to deliver this vision. However, there are concerns about implementation and clearly many challenges remain to be resolved and details to be clarified.

Appendix 1

Feedback from LINkS

Response by the Steering Group of Southampton LINk to the consultation on Equity and excellence: Liberating the NHS.

Southampton LINk is pleased to have the opportunity to comment. Southampton LINk has consulted on the White Paper but the response has so far been limited to a few individuals and voluntary groups. An on-line consultation with our wider membership is ongoing and will be reported by our host organisation

The steering group of Southampton LINk has considered the document **Establishing HealthWatch** in detail and responds as follows:

As a general comment, The Steering Group are concerned with the proposed reporting structure and would prefer a model that establishes local HealthWatch funded through the local authority as proposed but reporting to an independent National body, either directly or through a representative regional structure. This could well be the role of HealthWatch England. The model used for Governance could then be similar to that of a Foundation Trust.

With this general comment in mind we have responded to the specific questions in the spirit of the original proposals

Expanding the role of LINks as local HealthWatch:

Q What needs to happen for local HealthWatch to fulfil its new functions around health complaints advocacy? In particular to support people who do not have the means or capacity to make choices about their care?

The Steering Group of Southampton LINk believes that it is right in principle to expand the role of LINks to include health complaints advocacy. Currently, there is a risk that the public is confused by the various agencies involved. Link does not get involved with individual complaints and this may be seen by some currently as a weakness of LINk. Bringing all aspects of the public voice under one umbrella would help to reduce this confusion.

However, we believe this can only be achieved if Local HealthWatch is readily accessible and with additional full time support from professional staff properly trained to provide this expanded service. We do not believe this service can be provided solely by volunteers but in order to be effective it will also require additional training for the volunteer members so that they have a reasonable understanding of the issues in discussion with the salaried staff.

The ‘Board of Management’ of Local HealthWatch will require proper indemnity as will any other members undertaking this role.

As a general principle, DH should advertise the availability of the service as part of a National campaign.

Q What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

Our response to this is similar to the previous question i.e. this kind of support is best provided by professional staff rather than volunteers. Choice is important but many will not have the means or capacity to understand the options and it is an obvious extension of the LINk remit for Local HealthWatch to undertake support for disadvantaged people in this respect.

To make this a reality, HealthWatch will need trained members to provide this service supported by full time staff. Care will need to be taken to ensure that the service supports the individual in making their own decision and not simply taking the decision on their behalf. Persons involved in this support service will need to be carefully selected and scrutinised, including the obvious CRB checks.

It will need to be clear to potential members that they will be suitably indemnified

Embedding Patient Voice

Q What should be done to embed local HealthWatch as the local consumer voice, and HealthWatch England as the national voice for health and social care consumers?

At present there are a large number of public and patient groups all vying to represent their particular interest. Members of the public are confused about how best to make their voice heard. The value and importance of HealthWatch is that it should be able to take an overarching view without bias and thus represent the very best interest of all patients and clients.

This position needs to be widely advertised by Government Nationally and to be fully understood by all patient groups.

Legislation should be enacted to ensure that commissioners and providers are obliged to consult HealthWatch at all stages of service provision. The current opportunity for commissioners and providers to avoid consultation on the grounds that the change does not involve 'significant' change in service delivery should be reviewed; all change should be subject to the views of the public.

The proposal that HealthWatch should be included in the membership of Health and Wellbeing Board is welcomed and essential to ensure that HealthWatch is embedded as the local consumer voice.

As GPs are currently not obliged to consult, it is important that GP consortia fully understand the requirement to consult and a procedure to report non compliance needs to be established.

Similar legislation is required for HealthWatch England to operate.

Q How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

For Local HealthWatch to be effective, it is essential that it acts to co-ordinate the work of other patient and community groups. Currently, one of the difficulties facing LINks is the confusion in the mind of the public about which organisation to speak to; there is an obvious tendency for people to refer to the organisation that closely represents the issue for which they have a concern. These individual organisations have a wealth of knowledge which is invaluable to Local HealthWatch in deciding how to best represent the issue to commissioners and providers.

There should be a very clear understanding, backed by Government, that it is in the interest of patient and voluntary groups to become organisational members of Local HealthWatch. These groups should work with Local HealthWatch to ensure that the statutory authority of Local HealthWatch is available to their work. Additionally it is clear that members of a specific group can be valuable members of HealthWatch in their own right; thus groups should be encouraged to join and canvass membership of HealthWatch from their members. Officers of specific patient Groups should consider becoming part of the 'Board of Management' of Local HealthWatch.

Q How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

Local HealthWatch needs to forge strong links with the local authority to ensure that the views of the public are always considered, especially on commissioning decisions.

Local HealthWatch should be constructive and co-operative and seek membership of all relevant committees and should arrange regular meetings with the Chief Executive and Senior Officers in Council.

Local HealthWatch needs to work with Ward Councillors so that it becomes automatic for these councillors to refer all health and social care issues to Local HealthWatch; regular meetings with constituency representatives of Local HealthWatch would be ideal.

As well as the statutory responsibility to consult, Local HealthWatch representatives need to work hard to ensure that GP consortia value the critical friend relationship. Regular meetings are essential and it would be helpful if both parties identified individuals that would meet on a regular basis. Ideally, a member of Local HealthWatch should be invited to sit on the Commissioning team of the GP consortia.

Q What needs to happen for local HealthWatch to support the needs of vulnerable people –such older or very frail people? What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

Vulnerable groups such as the older or frail people and people who lack the capacity to make decisions about their care need special consideration.

For this to happen, Local HealthWatch needs staff support and funding. There is a strong need for those members of Local HealthWatch who are to work in this supportive role to be fully trained and supported. It is essential that the work is volunteer led but staff support is vital.

Where possible, members of the family need to be involved and this raises the issue of Patient Confidentiality and in some cases Power of Attorney. It is likely that there will be frequent examples where Local HealthWatch members will be prevented from providing meaningful support unless they are regarded as an extension of the health and social care support system, entitled to confidential information. In turn, this will impose severe limitations on the selection of those members able to help in this area. LINk have already encountered this problem in the release of Patients from hospital to Care; some of the un-necessary delay in hospital release is that hospitals are unable/unwilling to discuss care packages without the appropriate authority from the person holding power of attorney.

Governance

Q What governance arrangements need to be put in place to ensure that accountabilities are clear for all parties?

Arrangements are of course necessary to ensure that accountabilities are clear. We have previously stated our preference for a model that enables Local HealthWatch to operate independently of local authorities. If the model proposed in the White Paper is developed, there must be an obvious ‘firewall’ between those in Council responsible for services from those responsible for local HealthWatch. It may be prudent to ensure by legislation that there is separation by department.

It is essential that HealthWatch is totally independent with the only responsibility of the Council being the overseeing of the financial arrangements and a ‘quality function’ (if not provided by the preferred model stated earlier). Even for the latter, action against a Local HealthWatch by the Council should not be possible without reference to an independent body (This could be a role for HealthWatch England).

Local HealthWatch needs to be autonomous in respect of its work programme. Our own City Council have expressed reservations about the closeness of the Council to Local HealthWatch and has suggested that the independence of HealthWatch should be increased rather than have it commissioned via Local Authorities.

There is a co-ordinating role for HealthWatch England but this does not extend to the detail of the engagement with service providers.

Local HealthWatch needs to have much greater control over its finances than LINk.

Equally, it is clear that local HealthWatch will need a support structure. We favour a model that gives authority to Local Councils to engage and maintain staff on behalf of Local HealthWatch but with the management of that staff being the

responsibility of Local HealthWatch; the engagement of Support Organisations should not be precluded but equally should not be mandatory.

It is a serious risk that Government Nationally might limit their consultation on major issues to HealthWatch England thus bypassing the very essence of local patient involvement. As a result there needs to be a clear mechanism to enable representatives of Local HealthWatch to monitor the work of HealthWatch England.

Q How should HealthWatch England be constituted within the CQC structure?

HealthWatch England can be constituted as a division of the CQC with specific responsibilities.

To be effective they will require clear separation from the more general areas that are the responsibility of the CQC.

Q What role, if any, should HealthWatch England play in holding local authorities to account for how local HealthWatch is operated?

As previously stated our preferred model would have Local HealthWatch reporting to a body independent of local authority (HealthWatch England).

It should be up to Local HealthWatch how they operate and not to the local Council and therefore it would be inappropriate for HealthWatch England to have any say in this regard.

However, if the question was rephrased to ask if HealthWatch England should hold local councils to account for the way they **support** local HealthWatch, then the answer is they should have a role.

Certainly, it is important that local HealthWatch is fully funded, encouraged and supported by the local Council.

An annual report/questionnaire could be produced so that Local HealthWatch can provide an appraisal of their support. This could go to an independent body for scrutiny and HealthWatch England could play this role.

Independence and Accountability

Q What needs to happen for local HealthWatch to be an independent consumer champion for health and social care?

Local HealthWatch will build on the already successful LINk. It would be a mistake for the past to be forgotten, LINk disbanded and a new organisation called Local HealthWatch to be established. Everything possible needs to be done to ensure a seamless transition from LINk to local HealthWatch, albeit with an expanded role.

National publicity should be organised to emphasise the success of LINk and therefore the increase in its remit.

Although Local Authority is the channel for funding and support, Local HealthWatch must be established clearly independent of local authority influence (preferably reporting to HealthWatch England). Under the model proposed in the White Paper, local authorities will need to satisfy themselves that Local HealthWatch is operating effectively but this must not be left to the local authority view alone and an independent audit of local HealthWatch should be conducted before any sanctions are applied against it.

Q What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

Our preferred option is that Local HealthWatch operates independently of the local authority, probably reporting directly to HealthWatch England.

However if this does not happen, as stated in reply to the previous question local authorities will need to satisfy themselves that Local HealthWatch is operating effectively and this could be done through the proposed Health and Wellbeing Board. Local HealthWatch could be expected to report its activities regularly and be open to question from other members of the Board.

An annual report along the lines of that required from LINk should be expected and this could go to HealthWatch England as well as other interested parties.

Serious concerns should be subject to a review process with sanctions available through the CQC.

Q What needs to happen to ensure transparency over how HealthWatch funding is spent by local HealthWatch and by local authorities?

Transparency of funding is critical to the public perception of Local HealthWatch.

Part of the problem with the funding of LINk could be avoided in future if the DoH funding for Local HealthWatch was ring fenced.

Local Councils should be required to publicise the amount of money received for local HealthWatch with a detailed breakdown of its allocation.

Local HealthWatch should appoint its own treasurer who will be expected to produce detailed accounts of its expenditure.

The local authority auditors could provide an annual audit and both audited accounts should be published with the annual report.

Q How will local HealthWatch cover both health and social care services?

Currently, LINk covers both Health and Social Care and although this is challenging it is essential as problems may well arise at the interface and much closer working to provide an integrated service is needed.

Local HealthWatch needs to be involved at all stages in this closer integration. There is no doubt that more volunteers and support staff are needed to undertake both functions.

There is some concern that the name HealthWatch itself gives a misleading impression that Social Care is not included. This needs to be carefully addressed.

Q What role should local HealthWatch play in seeking patients' views on whether local providers and commissioners are taking account of the NHS Constitution?

For Local HealthWatch to be fully effective it is essential that it engages directly with the public.

We support the view that NHS Trust members should be encouraged to become members of Local HealthWatch. It is these people that are most likely to have direct experience of Commissioners and Providers and whether they have complied with spirit of the NHS Constitution.

An annual survey would be a very effective tool for this purpose.

National/Local Balance

Q What needs to happen to ensure an effective balance is achieved between HealthWatch England and local HealthWatch?

We propose that HealthWatch England is at least in part constituted from representatives of Local HealthWatch through a representative cascade structure. If this were to happen many concerns would be reduced.

If HealthWatch England does not include representatives of Local HealthWatch, the Government must resist the temptation to seek only the views of HealthWatch England; they may not be truly representative of the public and patient views and therefore the view of Local HealthWatch may not be coincident with that of HealthWatch England.

It is clear that Government will not be able to consult with all local HealthWatch bodies and so simple manageable representative structure is required to ensure a proper reflection of local views.

Q What role should HealthWatch England play in achieving this balance?

Under the model we would prefer, HealthWatch England has an obvious role in supporting the development of a representative structure and the subsequent reporting of Local HealthWatch.

Relationships

Q HealthWatch England will need to develop working arrangements with the NHS Commissioning Board, Monitor, Department of Health and CQC. What principles should underpin these relationships?

The Principles needed to underpin the relationship between HealthWatch England and the DoH, the Commissioning Board, monitor and the CQC is that it should at all times reflect a position that it believes is in the long term interest of the public

and patients. This may not always be in line with the patient and public initial view.

To ensure that its views are truly reflective it must be in constant touch with representatives from local HealthWatch, listening and taking account of local opinion.

Q What needs to happen to build relationships between local HealthWatchand other local partners, such as local authorities or GP Commissioning Consortia?

Building of relationships between Local HealthWatch and local authorities, GP consortia etc, will require a determined effort on all parties.

In most cases LINk has already established sound relationships with some in local authority and this will need to be expanded on to cover other interested parties in the new relationship.

GP consortia are an unknown at this point and potentially are a greater challenge. Government can help in making it clear to the proposed GP consortia that they have an equal responsibility to develop the relationship.

It is entirely possible that a GP consortia could be developed that is not co-terminus with a local authority. However for local HealthWatch to be effective it will need to be co-terminus with one (or more) GP consortia allied as close as possible to the local authority.

Work on the relationship should start as soon as possible and GP consortia should be encouraged to contact LINk in the first instance to begin the dialogue.

Transition

Q What do we need to take into account for the transition of LINks into local HealthWatch?

For the transition of LINk to Local HealthWatch it is important to achieve this with minimum disruption.

Clearly, if all the proposals are incorporated, it will require a significant increase in support and training of volunteers to undertake the expanded role.

The greatest need is to remove uncertainty at the earliest possible moment. At present there are uncertainties about the role, the need for, and function of, a support organisation, Finance beyond March 2011, etc.

With the expansion of the role it is becoming increasingly likely that the management of the local HealthWatch will need strengthening with members with additional experience and skill being recruited. Within LINK, gaining volunteers to become members of the management group has not been easy; it is likely to be even harder for Local HealthWatch. It may be worth considering a payment system similar to that currently used to attract Non Executive Directors to the Health Trust Boards.

Q What support will LINks need during this period?

To transform LINk to Local HealthWatch will require funding during the transition period, concerted effort to ensure the public are aware of the transition, support with volunteer recruitment especially to the management committee, training in the additional areas of responsibility and support from the local authority in developing realistic support structures for Local HealthWatch.

Q What additional skills will staff and volunteers require to deliver the expanded functions, and how can they be developed?

Both staff and volunteers will need a much better understanding of the patient experience and complaints functions of the commissioners and providers. This would be achieved most easily if the existing teams, employed by the Trusts, were contracted by the local authorities to provide the training. It may be that some of the staff currently employed by the Trusts in the Patient experience teams would be re-deployed to the support function of Local HealthWatch.

Similarly, there is currently very limited knowledge of Choice and its implications for the patient.

If HealthWatch is to support vulnerable people in this respect, they will need training to do so and potential obstacles such as patient confidentiality and power of attorney will need to be addressed.

Q What are the organisational and resource implications of expanding LINks' functions?

Until the exact role and extent of the role is determined it is not easy to comment definitively on the organisational and resource implications. However it is possible to make some generalised remarks.

Organisationally, HealthWatch will need to be established as a representative body otherwise there will be issues of insurance and indemnity as there is now with LINk. This can still be established whilst maintaining the overriding principle of universal access.

Perhaps a constitution where there are defined representatives would be possible. A mix of nomination and election is also a real possibility.

It is essential that a realistic funding formula is developed for Local HealthWatch.

In our case, Southampton is home to a major teaching and Regional Centre of Excellence for many specialities; we also host a community provider function (now applying to become a FT) that services much of Southern Hampshire. The Mental Health trust for Hampshire, although technically just outside the city boundary has a major hospital provision within the City boundary. Under the LINk formula, based roughly on population, we received a fraction of the funding of the county LINk. This needs to be addressed more carefully for Local HealthWatch.

There is real concern that the advocacy and choice functions are not deliverable by volunteers; this implies a salaried professional staff to support the volunteers in these matters.

Appendix 2

SOUTHAMPTON CITY COUNCIL PANEL B/OSMC RESPONSE TO THE GOVERNMENT HEALTH WHITE PAPER 2010 - "EQUITY AND EXCELLENCE: LIBERATING THE NHS"

- **HealthWatch**: The Panel is concerned about the lack of certainty regarding funding for LINks for the period between the end of the current allocation in April 2011 and the establishment of HealthWatch in 2012. In order for the LINks to deliver the new responsibilities as HealthWatch, there will need to be a shift in the type and level of skills and support provided by the organisation. Funding for the new organisation will need to reflect both the responsibilities assigned to them and the level of personnel required to deliver the role effectively. Additionally the ring fencing of this funding would be welcomed. Given the increasing role of Local Authorities in providing and commissioning health services (not least with the transfer of the Public Health function to Local Authorities), the Panel would argue that it would be more advantageous to increase the independence of HealthWatch rather than have them commissioned via Local Authorities.

- **The NHS Commissioning Board**: This will have a mammoth task in monitoring, on a national basis, the commissioning activities of the 500 plus GP consortia. The Scrutiny Panel are concerned that outposts of the Board should cover the correct geographic areas. The current CQC groupings are sensible and the Scrutiny Panel would like to see the Board established along the same boundaries.

- **Health and Well-Being Boards** (HWBB) will replace the Health Overview and Scrutiny Committees. The Scrutiny Panel are keen to ensure that there is the correct level of democratic accountability for the HWBBs and that councillor representation is sufficient. Additionally, there is no mechanism for scrutinising the decisions of the HWBB and those relating to health improvement activity. The Scrutiny Panel would be keen to see a scrutiny role retained outside of the HWBB.

- **Performance:** The Scrutiny Panel is pleased to support the move to an increased focus on outcome based performance measures and is keen to see the social care model in due course. This will have a positive impact on the service as reporting on the current set of process targets is a significant task and does not necessarily represent successful outcomes for patients. However, there needs to be an acceptance that there are some basic process measures which have a direct impact on outcomes and it is important that where this is the case, these measures are not lost.

- **GP Commissioning.** The panel has some concerns about the capacity and skills of GPs in Southampton to take responsibility for commissioning and spending around £400m in such a short time scale. We are concerned that this will distract from their clinical responsibilities. It may be more cost effective for consortia recruit others to support them in this function. GP’s training was focused on clinical practice but the PCT have staff, who will be made redundant, who are trained commissioners. These skills should not be lost. We look forward to receiving more information on the detail of how consortia will be established – particularly in Southampton.

- **Integrated Commissioning** Finally, there is some concern that progress in moving the focus of the health service from a medical model to a more integrated model of health care could be lost with the transfer of commissioning to GP consortia. However, it is recognised that the role of the HWBB will be instrumental in ensuring that progress continues to be made.

Appendix 3

Feedback from the Health and Well Being Partnership Board

Liberating the NHS - Legitimising Local Democracy
Response to questions relating to
Health & Wellbeing Boards

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 proposal to establish statutory Health and Wellbeing Boards is welcomed. It will provide a focus for partner organisations to improve the health and wellbeing of people living in the local authority area. The recent experience of partnership working outcomes has been that it is those partnerships established on a statutory footing that have been able to achieve more than non-statutory ad hoc partnerships. There will need to be a requirement for partners to commit resources to joint working, as simply committing to just participating in meetings will not deliver the required health improvements.

Do you agree that the proposed health and wellbeing board should have the main functions described:

1. *Assess needs of local population and lead the JSNA;*
2. *Promote integration and partnership, including through promoting joint commissioning plans across the NHS, social care and public health;*
3. *Support joint commissioning and pooled budget arrangements;*
4. *Undertake scrutiny role in relation to major service redesign.*

Whilst the functions listed are generally appropriate it is suggested that function 2 as listed should also refer to the need to incorporate all local authority commissioning plans, projects and strategies that will lead to improved health outcomes. For example the Health and Wellbeing Board may wish to assess the contribution of strategies such as the Local Transport Plan to accessing health facilities and the Local Development Plan in securing a safe environment and access to recreational facilities.

In respect of function 4 above it is would be beneficial if the Health and Wellbeing Board was seen as both challenging partners in major service redesign, and championing innovation and best practice.

Is there a need for further support to the proposed health and wellbeing boards in carrying out these functions, for example information on best practice in undertaking JSNAs?

This will depend in part on how the development of Health and Wellbeing Boards affects the partnership landscape in a local authority area. In a time of financial constraint it is unlikely that substantial additional resources can be justified. What will be required is the willingness of partner organisations to commit reasonable resources to the boards, and to seek to identify lean and non-bureaucratic processes so that the resources which are available are seen to be adding value to the process.

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 has been a degree of conflict in a number of authorities with health partnerships over where the lead for issues relating to children's health should rest. For example, teenage pregnancy strategies may have been led through Children's Trusts, and this may have lessened the potential input from health providers and commissioners. If the children's trust become non-statutory bodies it would provide an opportunity for Health and Wellbeing

Boards to focus on health issues at all stages of life without the imposition of arbitrary age barriers.

How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas (e.g. Greater Manchester/London)?

It is considered important that there should be the ability to establish a Health and Wellbeing Board covering the area of a local authority where the local authority and its partners deem this is the most appropriate mechanism for contributing to health and wellbeing outcomes. Cross boundary boards should not be imposed. That said, there will be occasions when two or more boards may decide it is appropriate to work together on an issue, and then they should be the power to determine appropriate mechanisms locally to deal with these matters.

Do you agree with our proposals for membership requirements?

- *Leader*
- *Social care*
- *NHS commissioners*
- *Local government*
- *Patient champions*
- *HealthWatch*
- *Director of Public Health*
- *GP consortia representative*
- *NHS commissioning board representative*
- *Voluntary sector representative*
- *Other relevant public sector officials*
- *Providers*

The above list largely reflects the individuals most likely to have key contributions to make to Health and Wellbeing Boards. However, membership should ultimately be determined by the functions agreed for boards. In the light of the existing diverse range of solutions developed there should be provision to allow any organisations with key contributions to make to be fully participating members of the board.

The large range of membership proposed brings it own challenge. The Board will have to focus on strategy rather than delivery. It is likely that sets of governance arrangements will need to be developed in each area to ensure there are mechanisms to co-ordinate, deliver and monitor the high level outcomes set by the Health and Wellbeing Board.

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

No specific needs have been identified. There has been a positive experience of partnership working in Southampton, and although there have been problems between partners on some difficult issues (e.g. continuing healthcare costs) there has always been a mature and rational attempt by elected members and senior officers to resolve the matter. If a legal duty is not being fulfilled then this could be picked up by the appropriate regulatory body.

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)?

No, this should be disaggregated. The principle established under the Local Government Act 2000 was that no executive member should be able to participate in overview and scrutiny committees, and proposal for the leader of the council, (and probably at least one other cabinet member with responsibility for health and social and children) would undermine this

principle.

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

The experience of the HOSC in Southampton has been that mature debate and a positive approach to difficult issues has overcome difficulties. The provisions for arbitration under the Health and Social Care Act 2001 should be continued.

What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing boards functions? To what extent should this be prescribed?

There are 3 elements that could be used: the HOSC, external regulators, and local communities. This Partnership would support the concept of the Health and Wellbeing Board being required to put itself in front of local communities on an annual basis to account for it actions and progress in improving health. Transparency to local communities has not been adequately reflected in the White Paper.

Appendix 4

Feedback from Southampton City Council Housing Services

(public and private)

Response to consultation paper *'Local Democratic Legitimacy in Health'*

We welcome moves to put Public Health and prevention at the heart of the new NHS. Housing is a critical element of this, poor housing lead to poor health. Improving housing standards will impact positively on health outcomes. An example would be where a lady in her late seventies fell as she moved from her bedroom to her bathroom as her hand slipped on the doorframe. Her hip was broken. The handrail that was subsequently fitted cost a few pounds to install against the cost of the three day hospital stay and five week intensive care and support package that followed costing thousands.

Responses to Questions

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

   We agree. Patient choice is positive and giving 'people a voice' is very important but can expectations of service users meet the ability for GP's to commission effective services?

   Experience of LINk locally shows it seems to do well at collecting a good cross section of views, they would be well placed if they were to become the new HealthWatch and good that they would represent public views on the new Health and Wellbeing board.

2. *Should local HealthWatch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?*

   Expanding the role to be more like Citizen Advice Bureau on health and social care sounds like a good idea but we would have concerns about the role of supporting individuals to choose a GP practice being at odds with offering impartial advice, dealing with complaints etc

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

   It is important to pool the information all services have about the community and their needs

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

   We would consider it important to include a requirement to include an assessment of an individual's current housing; this would then be used to

identify their needs and access to appropriate services and support. This may encourage people to think earlier about their housing options/suitability.

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

   Provide financial incentives to support development of best practice and seeking news ways of working. There may be a need to provide guidance on information sharing and the perceived restrictions around data protection and data sharing whilst maintaining the safeguarding agenda.

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

   To protect the work as a priority within many local authorities' statutory powers would be needed.

7. *Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?*

   We would consider it important to create a Board with the minimal prescription of membership. This would allow local authorities to form a board that will have the skills and knowledge to work effectively to meet local need.

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

   We agree.

9. *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?*

   Guidance provides good supporting information for local authorities' who will have varying levels of experience and success in this way of working.

10. *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?*

11. *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?*

    There are many local authorities already looking at the shared service agenda and working across multiple authority areas.

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

The membership should include someone who can represent the local authorities' strategic housing role and this should be directed under membership of the board to ensure the integration with Social Care and Health.

Health and wellbeing boards should be lightly represented by elected members for example Cabinet Member (or equivalent) or maybe the Council Leader or elected Mayor should also be a member. The board would be more effective with a wider range of services being represented, e.g. voluntary sector, etc. Elected members need to have an understanding of the work and priorities, but there will be a delicate balance between the roles proposed of the board and any political aspirations.

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

    Guidance being available, sharing information and best practise

14. *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)?*

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

16. *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?*

    Minimal prescription to ensure it takes place but allow for the boards functions to follow the same style of scrutiny that already exists within the governance of the local authority.

17. *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?*

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

    - There is not a great deal in the document about how clinicians will feed into this process other than at GP level. Again on a strategic higher level services may need to be influenced by the services GP's commission and are GP's expert in so many fields to be able to commission effectively? For example when considering services such as Mental Health or other issues such as drug and alcohol dependency.
    - If an area has for example a high percentage of elderly population is there a risk that services will meet a minority only – a more costly client group which will see resources directed at that?
    - Devolving of budgets to GP's and consortia could have implications for effective service commissioning – could see an increase in 'postcode lottery' issues if people are in more deprived areas may see GP's pressured into commissioning suitable services to meet diverse needs.

- Will commissioning services piecemeal across areas make services less efficient and cost effective?
- NHS commissioners and local authorities should be made to work together – not given a choice. Services will become fragmented if allowed to make local arrangements. Need to feed into an overall strategic plan to be able to react and provide long term health care and planning for future i.e. obesity, smoking cessation and other health related issues that affect people's housing and social needs.
- The assessment of need would need to include the role of local Strategic Housing / Neighbourhoods intelligence if commissioned services are to truly be targeted around people, families, lifestyles and the effects of where they live and their ability to access services.
- Need more emphasis on prevention, rehab and re-ablement including things like wider staff joint training and working with other LA's
- Generally not enough credence given throughout the paper to housing and the affect on an individual's health and wellbeing and therefore the importance of Housing professionals within any new integrated working