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Delegated Decisions by Leader of the Council

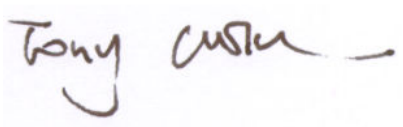
Friday, 1 October 2010 at 4.15 pm or at the rising of the Delegated Decisions by the Cabinet Member for Adult Services whichever is the later
County Hall

Items for Decision

The items for decision under individual Cabinet Members' delegated powers are listed overleaf, with indicative timings, and the related reports are attached. Decisions taken will become effective at the end of the working day on 11 October 2010 unless called in by that date for review by the appropriate Scrutiny Committee.

Copies of the reports are circulated (by e-mail) to all members of the County Council.

These proceedings are open to the public



Tony Cloke
Assistant Head of Legal & Democratic Services September 2010

Contact Officer: ***Marion Holyman***
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Note: Date of next meeting: 19 October 2010

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

Items for Decision

1. Declarations of Interest

2. Questions from County Councillors

Any county councillor may, by giving notice to the Proper Officer by 9 am on the working day before the meeting, ask a question on any matter in respect of the Cabinet Member's delegated powers.

The number of questions which may be asked by any councillor at any one meeting is limited to two (or one question with notice and a supplementary question at the meeting) and the time for questions will be limited to 30 minutes in total. As with questions at Council, any questions which remain unanswered at the end of this item will receive a written response.

Questions submitted prior to the agenda being despatched are shown below and will be the subject of a response from the appropriate Cabinet Member or such other councillor or officer as is determined by the Cabinet Member, and shall not be the subject of further debate at this meeting. Questions received after the despatch of the agenda, but before the deadline, will be shown on the Schedule of Addenda circulated at the meeting, together with any written response which is available at that time.

3. Petitions and Public Address

4. Oxfordshire County Council's response to the Consultation on 'Equity and Excellence: Liberating the NHS' (The NHS White Paper)** (Pages 1 - 16)

Forward Plan Ref: 2010/163
Contact: John Jackson, Director for Social & Community Services Tel: (01865) 323572

Report by Director for Social & Community Services (**CMDL4**).

This report gives the County Council's proposed response to 'Equity and Excellence: Liberating the NHS' (NHS White Paper) consultation questions. The White Paper has three linked documents for consultation: Commissioning for Patients, Local Democratic Legitimacy in Health**,** and Transparency in Outcomes. This report is a response to the first two consultation documents.

The NHS White Paper sets out a radical agenda of change for the NHS. The most eye catching has been the proposal to move commissioning from Primary Care Trusts (PCTs) to consortia of GPs, with PCTs and Strategic Health Authorities being abolished. It is proposed that these changes would come into force formally by 2013 but with a transition period. However, the proposals go much further than this and propose a role and responsibility for local government in strategic planning, public health and the health and well being of the population and supporting integrated and joint working with the NHS.

Responses have to be submitted by 5 October 2010.

The Leader of the Council is RECOMMENDED to consider the responses set out in paragraphs 15 to 25 and in Annex 1 of the report as the County Council's response to the NHS White Paper, together with any comments on the responses made by the Cabinet Member for Adult Services.

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Division(s): All

LEADER OF THE COUNCIL – 1 OCTOBER 2010

OXFORDSHIRE COUNTY COUNCIL'S RESPONSE TO THE CONSULTATION ON 'EQUITY AND EXCELLENCE: LIBERATING THE NHS' (THE NHS WHITE PAPER)

Report by Director for Social & Community Services

Introduction

1. This report gives the County Council's proposed response to 'Equity and Excellence: Liberating the NHS' (NHS White Paper) consultation questions. The White Paper has three linked documents for consultation: Commissioning for Patients, Local Democratic Legitimacy in Health**,** and Transparency in Outcomes. This report is a response to the first two consultation documents. The specific questions for these two documents and responses to those that are more appropriate or relevant to the County Council's concerns and experiences are given in Annex 1. The key conclusions and responses are given in the main body of the report.

2. The NHS White Paper sets out a radical agenda of change for the NHS. The most eye catching has been the proposal to move commissioning from Primary Care Trusts (PCTs) to consortia of GPs, with PCTs and Strategic Health Authorities (SHAs) being abolished. It is proposed that these changes would come into force formally by 2013 but with a transition period. However, the proposals go much further than this and propose a role and responsibility for local government in strategic planning, public health and the health and well being of the population and supporting integrated and joint working with the NHS.

The main proposals: implications for local government

3. It is assumed that the broad principles set out in the White Paper will be implemented (since this reflects the wishes of the recently elected Coalition Government). The proposals can be grouped under five themes to summarise the proposals and the impact on and implications for the County Council:
   - The focus on patients
   - The focus on outcomes
   - The proposed commissioning arrangements
   - The role of the Local Authority
   - Joint working between health and social care

The Focus on Patients

4. The White paper emphasises the importance of putting patients and the public first. "Shared decision making will be the norm: *no decision about me without me*" (page 3). National and local HealthWatch schemes are proposed to take forward the enhanced agenda for patient and public involvement in decision

making. LINKs will become part of local HealthWatch arrangements, commissioned by the local authority, with a national HealthWatch to set standards and respond to patients' issues that have a national significance. The proposed outcomes framework specifically includes the patients' experiences, and the proposals for commissioning are based on the principle that commissioning for the NHS should take place as close as possible to the patient, which is the underlying drive for the proposals for commissioning through GPs in consortia.

The focus on outcomes

5. There is a very strong emphasis throughout all the documents that the NHS should be assessed on the basis of outcomes for patients and the public. "The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets". The three areas that the outcomes framework will cover are:
   - Effectiveness
   - Patient experience
   - Safety

6. The outcomes will be supported by quality standards developed by the National Institute of Health and Clinical Excellence (NICE) and at the end of a 5 year period there will be a comprehensive suite of 150 standards.

7. This approach is to be welcomed and a proper focus on outcomes rather than methods of delivery should drive improvements in the NHS. However, the detailed definitions and standards must be constructed so as to reflect properly the interagency and multi-disciplinary nature of much of health care.

The proposed commissioning arrangements

8. The consultation document Commissioning for Patients defines commissioning as: "understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality". This description is consistent with the approach developed by adult social care over the last 20 years. It is not to be confused with contracting.

9. Commissioning for Patients goes on to set out how commissioning should work in the future: Most commissioning decisions will now be made by consortia of GP practices supported and held to account for the outcomes they achieve by a national NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them.

10. The White Paper envisages that from a practical point of view: "It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect the views of their patients' needs and their own referral intentions." GP Consortia will be able to buy in support and decide whether they want to collaborate across consortia through say a lead commissioner. Support may be bought in from "external organisations, including local authorities, private and voluntary sector bodies".

11. Alongside this the White Paper proposes the abolition of PCTs and SHAs.

The role of the Local Authority

12. Local authorities will have significant and increased responsibility in four areas:
    - leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
    - supporting local voice, and the exercise of patient choice through commissioning local HealthWatch organisations;
    - promoting joined up commissioning of local NHS services, social care and health improvement; and
    - leading on local health improvement and prevention activity for the population.

13. The first three of these roles are already carried out to a degree in Oxfordshire and there is already the joint appointment of the Director of Public Health. One critical element will be the role of the health and wellbeing board that is being proposed which will be created by statute. The Government makes clear that this will take on the function of joining up the commissioning of local NHS services, social care and health improvement. The White Paper also gives some indication of an overall approach to adult social care, emphasising choice and control, and recognises the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including carers. It notes that barriers between health and social care funding should be broken down to encourage preventative action.

Joint working between health and social care

14. There are repeated references in the documents to the importance of joint working between health and social care. The role of the local authority will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder. It is intended that there will be coherent and coordinated local commissioning plans across the NHS, social care and public health with information and understanding about people's wants and needs systematically shaping and commissioning decisions.

Proposed response

15. The proposed responses to the consultation are given below. It is proposed that these and the detailed responses to the appropriate questions given at Annex 1 are considered as the Council's response.

16. We agree strongly agree that the proposed local authority responsibilities for joint working are supported by statutory powers which require joint working. Oxfordshire has an exemplar in lead commissioning and pooled budget arrangements for its services for people with a Learning Disability, and we are clear about the benefits in terms of service delivery and efficiency of these arrangements.

17. To make integrated and joint working a reality there must be a relaxation in the very centralised approach to service development and delivery that is taken in the NHS so that local commissioning decisions are able to be implemented in ways that make best sense locally for achieving the desired objectives. To facilitate this the lead commissioning arrangements should include the lead agency having responsibility for the procurement and contracting arrangements for all services that are arranged on behalf of the partners.

18. The proposed arrangements for Public Health are welcomed as are the responsibilities for leading on the county's health and well being; tackling health inequalities is an important priority for all of local government.

19. Oxfordshire already has a Health and Well Being Partnership Board, and the proposed statutory basis for these boards is welcomed. It is clear that the boards proposed by the White Paper will carry significant formal responsibilities; they will and must not be expanded versions of the current arrangements.

20. Health and Well Boards under the new arrangements should be broad in their scope and strategic in their focus. Their role is critical to how the White Paper's objectives are to be achieved. They should therefore not be drawn into operational matters or specific service redesign issues. For these reasons they should not take on the scrutiny functions vested in the Health Overview and Scrutiny Committee (HOSC). We strongly believe that the HOSC arrangements should remain and, furthermore, they should take on responsibility for the scrutiny of the Health and Well Being Boards.

21. The Joint Strategic Health Assessment (JSNA) is already significant in supporting and driving local strategic planning and service development. Moving the leadership of this to the local authority with the Director of Public Health is a positive step that reinforces the potential of the JSNA to be used to give as comprehensive a view of local needs and priorities as possible. The inclusion of HealthWatch in the Health and Well Being Board arrangements will encourage the JSNA processes to include systematic qualitative reviews of the experiences of patients and service users as they use health and social care services.

22. We will work hard and constructively with local GPs and the emerging consortia to ensure that local commissioning is carried out effectively and on a joint a basis as possible. We believe that the experiences and skills in local authorities, and particularly in social care, can make a significant contribution to how the NHS can deliver local services that keep and maintain people in their own homes as far as possible. GP consortia should, as they develop, be encouraged and supported to engage with their local authority partners to establish effective and skilled support for commissioning and contracting across all of their commissioning responsibilities.

23. We do think that consideration of the use of lead commissioning; pooled budget and other joint arrangements should be on a statutory basis for all appropriate services. These would be at least services that are commissioned on a consortia basis and, where there are number of consortia working within one local authority area, or an aggregated basis.

24. The outcomes framework is welcomed and we think that it is important that the performance management of this does focus on outcomes and that payments to GPs should reflect their performance against outcomes and simply activity levels.

25. The emphasis on choice and control by people who use the NHS (and social care services for that matter) is strongly supported and the HealthWatch arrangements have considerable potential. However, for this to be fulfilled there must be confidence in local authorities that the funding for commissioning local HealthWatch is sufficient, secure and ring fenced. We would expect local authorities to be consulted on and involved in these developments.

26. **Financial and Staff Implications**

There are no financial or staffing implications arising directly from this report.

RECOMMENDATION

27. **The Leader of the Council is RECOMMENDED to consider the responses set out in paragraphs 15 to 25 and in Annex 1 as the County Council's response to the NHS White Paper, together with any comments on the responses made by the Cabinet Member for Adult Services.**

JOHN JACKSON
Director for Social & Community Services

Background papers: Nil

Contact Officer: Nick Welch; Head of Major Programmes
Tel: (01865) 323569

September 2010

ANNEX 1

NHS White paper
Commissioning

Commissioning for Patients		
	Question	**Response**
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?	
2.	How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?	The arrangements between the NHS Commissioning Board and GP consortia must have regard to the commissioning of social care for these services as they include some conditions that give rise to considerable and at times life long needs for social care and support.
3.	Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by 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?	Tier 4 CAMHS could be effectively commissioned by GP Consortia. There is already a strong interface with this local authority's specialist commissioning.
5.	How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?	It is suggested that this will be through, or will have as a significant element, a careful and well-considered engagement and communications strategy, and a clear willingness for consortia to consider and reflect particular high priority needs in GPs' practice populations. A significant element of primary care at a practice level is the effective engagement with other statutory and voluntary services for all use groups but in particular those working with vulnerable older people and children

		and with all preventative and health promotion activities.
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?	
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?	It will be important for there to be a clear understanding and promotion of the roles of the local authority, HealthWatch and the NHS Commissioning Board across all practitioners in primary care and in Consortia. The provision of relevant and timely aggregated data on needs, performance and costs should be widely available and considered as part of the oversight and accountability arrangements with the Health and Well Being Board. This should include transparency around 'make or buy' decisions.
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?	The NHS has taken a very prescriptive route in its development of and support for commissioning in PCTs. This is not, in our view, an appropriate approach as it can inhibit efficient and cost effective local solutions. The NHS model contract, with its emphasis on a 4 year maximum contract term give a framework that makes it very difficult to have viable arrangements on a joint basis for service developments and arrangements with the independent sectors that have the potential for significant efficiencies and savings; the 4 year contract term makes this commercially problematic, but these developments are not possible without the independent sectors' involvement and investment. The tariff arrangements a re complex are also prescriptive and complex. It has to be asked if they have led to high quality outcomes or a better use of resources than a less prescribed approach would give. The NHS Commissioning Board

		should therefore engage with Consortia and their commissioning partners in the development of commissioning and contracting frameworks and tariffs that are a better able to support a wide range of provider initiatives and developments.
9.	Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?	The NHS Commissioning Board should, as part of it responsibilities in supporting effective commissioning, ensure that it promotes and supports local partnership working at a number of levels: practice, consortia, and upper tier local authority level. There is a link with the questions in democratic accountability, the use of partnership arrangements and the statutory responsibilities in the new arrangements. The considerations in the answer above are also relevant. The NHS Commissioning Board could usefully consider its 'tight-loose' continuum, looking at how it can free up local decision making and discretion as far as possible.
10.	What features should be considered essential for the governance of GP consortia?	GP Consortia should have on the governance bodies' representatives of local authorities to ensure that they are able to discharge effectively their responsibilities in joint commissioning and safeguarding.
11.	How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?	
12.	Should there be a minimum and/or maximum population size for GP consortia?	The absolute size may be less important than the levels of commissioning that they are responsible for. There should be clear financial risk management around consortia size.
13.	How can GP consortia best be supported in developing their own capacity and capability in commissioning?	The understanding of and experience in commissioning amongst GPs is low, for very understandable reasons. The experience that they may have had of PCT commissioning may not have equipped them sufficiently with

		knowledge and understanding of the significance and potential that commissioning has. Any support should include a comprehensive induction or training programme for GPs, which should have a different approach to World Class Commissioning. It should be more immediately applicable to local commissioning. for example, the ,model put forward by the Commissioning Development Programme, although prepared around Children's Services, is a clear training and development programme that is relevant across all service areas and could be seen as a generic model.
14.	What support will GP consortia need to access and evaluate external providers of commissioning support?	
15.	Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?	
16.	What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?	
17.	What are the key elements that you would expect to see reflected in a commissioning outcomes framework?	The measures and indicators developed to support the performance management of the outcomes framework should reflect and support the drive towards integrated and joint work working across social care and the NHS.
18.	Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?	Yes, this would be a positive approach to incentivising a broader approach to commissioning and the delivery of services through primary care.
19.	What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?	This could be part of the approach set out in 18 above. The outcomes framework should include indicators that cover avoidable health inequalities
20.	How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning	The underlying principle of involving patients and the HealthWatch (locally and nationally) is fully

	decisions that are built on patient insight?	supported. Involvement in the development of specifications and the selection of providers would make a significant contribution to this..
21.	How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?	Guidance and advice should be given to consortia on engagement with user groups and user advocates, and voluntary organisations of and for service users. Local authorities have extensive contacts with these groups and experience in working and learning from them. Local authorities should be involved in supporting and informing consortia in their engagement with local groups and organisations. The local authorities (proposed) lead on the preparation of JSNAs should be used to ensure that there is a comprehensive and thorough approach to seeking and using local views and experiences of health and social care, which should be a basis for local commissioning decisions. The positive experiences in the integration of some JSNAs into the work of LSPs' and Children's Trusts should be drawn on.
22.	How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?	
23.	What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?	
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?	Local Authorities, and in particular those with social service responsibilities, should required to engage with the GP Consortia as they develop. There should be an expectation and a requirement that these local authorities are involved by the PCT and as necessary by the SHA in the discharge of their responsibilities for the development and implementation of GP

		Consortia.
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?	Oxfordshire County Council and Oxfordshire NHS has established a fully integrated lead commissioning and pooled budget arrangements for services for people with a learning disability. The services are commissioned against a clear outcomes framework rather than the form of provision. The CYPP and J|SNA also give good examples of joint working. We would suggest that good practice around outcome based commissioning and the linking of lead commissioning with pooled budgets should be identified and taken forward.
25.	How can multi-professional involvement in commissioning most effectively be promoted and sustained?	The interrelationship and interdependence between the delivery of effective health care and social care should be clearly set out as one of the main platforms for taking the reforms forward and the forthcoming white paper on social care should discuss and develop this theme further. The outcomes framework should be used to reinforce joint working.

ANNEX 1

NHS White Paper: Consultation questions and responses
Local Democratic Legitimacy in Health

Local Democratic Legitimacy in Health		
	Question	**Response**
1.	Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?	Local HealthWatch should have a formal role on in seeking patients' views on local providers and commissioners taking account of those sections of the NHS Constitution that cover the rights and responsibilities of patients, but it should not have a role in relation to the sections dealing with NHS staff.
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?	Local HealthWatch should be able to work with local organisations that people are more likely to be able to access and which will be able to understand and reflect local concerns more clearly than organisations that are more remote.
3.	What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?	It is probable that across England there will be a range of approaches that are taken towards advocacy and the support of people who wish to complain. These local initiatives should be supported but within a framework established by the Government setting out core principles and standards that cover the role and responsibilities of the local authority, the local HealthWatch` and the organisations commissioned to provide the services.
4.	What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?	The outcomes framework and the guidance for and requirements placed on GP consortia will be important in encouraging and supporting integrated working. Local government and the commissioning of social care should also be held accountable against outcomes criteria. There are at present differences in how the NHS and local authorities manage their procurement processes, the rules they apply and the contract models that they apply. This can lead

		to drawn out and sometimes complex arrangements being made to accommodate different approaches and to reconcile the risks analyse of each authority. All the approaches are nonetheless compliant with EU and UK law and requirements. Integrated working would be supported by it being made clear that the lead authority in lead commissioning arrangements uses its procurement and tendering approaches and carries any risks that arise from the application of procurement procedures.
5.	What further freedoms and flexibilities would support and incentivise integrated working?	There are at present some significant differences between the NHS and local government, and particularly in social services and social care, over approaches to procurement and contracting. As an example, the standard NHS contract is limited to 4 year maximum term. While this is reasonable and justifiable for many services, for those with higher set up costs, which may well be the case where new providers come into a market or innovative services are being developed, a 4 year limit is very likely to lead to higher annual costs as providers are driven to recoup development costs more quickly. Lead commissioning needs to be able to take the best practice from across the NHS and local government to achieve the best services for the patient or service user and best value for the tax payer, and not be restricted by today's models. Both local government and the NHS should be supported in the development of commissioning against a common set of outcomes.
6.	Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?	Yes they should. The joint working on health and well being must be supported and underpinned by statutory powers. We would also suggest that to drive and support integration and joint working there should be a requirement to establish joint or lead commissioning and

		pooled budgets for relevant activities including adults with learning disabilities, mental health problems and long term conditions.
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?	The move to local accountability for the delivery of health care and the emphasis being placed on joint and integrated working, both of which are supported, should be overseen by a properly established board to ensure good governance for strategic decision making. We would agree that health and well being boards should be a statutory requirement.
8.	Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?	We agree that the functions of health and wellbeing boards are covered by paragraph 30, except for the scrutiny function We do not agree that the health and well being board should carry the scrutiny responsibilities currently vested in overview and scrutiny committees.
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?	It is unlikely that good practice in the development and use of JSNAs has been fully explored and disseminated. A good and comprehensive JSNA can have a considerable impact on the development of relevant and effective local services and support on this would be constructive. The formal requirements for the submission of service plans and strategies, for example a Children's Plan, should be reviewed in the light of the opportunities given by the JSNA and the changes that could be achieved by moving to a stronger outcomes framework for the NHS and social services. Support and training for the chairs and others who serve on the boards in good practice in joint working may also be beneficial.
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?	
12.	Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?	We agree with the proposed membership. A health and well being board necessarily covers a wide range of interests and this is in many respects the whole point of having them. However, for them to be effective in arriving at a proper understanding of local interests and pacing then in the context of the outcomes for the NHS it is important that the boards operate at a strategic level, and do not get dragged into detail and operational issues.
13.	What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?	
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)?	No, we do not agree with this. This proposal is very likely to lead to confusion. Who for example would scrutinise the performance of partnerships? The Health and Wellbeing Board which would have the role of co-ordinating those very partnerships and so could not be described as independent. We strongly suggest that the statutory powers that the HOSCs currently have remain with them and that they continue with their scrutiny role.
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?	We strongly suggest that the cuurent arrangements remain: the HOSC should remain and the scrutiny of the health and well being board be given to them.

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?	