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Delegated Decisions by Cabinet Member for Adult Services

Friday, 1 October 2010 at 4.00 pm
County Hall

Supplementary

4. Oxfordshire County Council's response to the Consultation on 'Equity and Excellence: Liberating the NHS' (The NHS White Paper) (Pages 1 - 14)

Supplementary report of the Director for Social & Community Services and Director for Children, Young People & Families (CMDAS4 – supplementary)

The Cabinet Member for Adult Services is RECOMMENDED to consider the additional responses set out in the report and in Annex 1 to be included in the County Council's response to the NHS White Paper.

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Division(s): N/A

CABINET MEMBER FOR ADULT SERVICES - 1 OCTOBER 2010

SUPPLEMENTARY REPORT - OXFORDSHIRE COUNTY COUNCIL RESPONSE TO THE CONSULTATION ON 'EQUITY AND EXCELLENCE: LIBERATING THE NHS' (THE NHS WHITE PAPER).

Report by Director for Social & Community Services and Director for Children, Young People & Families

Introduction

1. This supplementary report covers the Consultation key issues in relation to Children and Young People's Services and 'Achieving Equity and Excellence for Children' following discussion at the Children's Service Scrutiny Committee on 28 September. The needs of children and young people should be considered throughout the proposed changes under the NHS White Paper. The Department of Health (DoH) has subsequently issued two reports. The points made in this supplementary report are in addition to those set out in the main report. Annex 1 has been added to, and this updated version is attached to this report with additions highlighted in bold.

Health and Well Being Partnership Boards

2. Children's services must have a clear and high level presence on the proposed Health and Well Being Boards, which should be statutory. This presence should be at Lead Member/Director of Children's Services level. The changes to the arrangements for Children's Trusts will mean that many of the partnership and joint arrangements with the NHS and the oversight of these should be seen as being part of the Health and Well Being Boards' responsibilities.

HealthWatch

3. The previous arrangements for LINKs did not provide for their comprehensive involvement in children's services. Establishing new arrangements with national and local HealthWatch organisations gives a good opportunity for this omission to be rectified, Local Authorities (Children's Services) have existing consultation statutory duties and this would be a good opportunity to maximise the wealth of experience across the two organisations. We think that HealthWatch at a national and local level should include children's services within its remit and that any guidance given to local authorities for the commissioning of local HealthWatch arrangements should make this clear.

RECOMMENDATION

4. **The Cabinet Member for Adult Services is RECOMMENDED to consider the additional responses set out above and in Annex 1 to be included in the County Council's response to the NHS White Paper.**

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Background papers: Nil

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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. **The board could also consider the potential role of schools in commissioning services as well as their provider role.**
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	The understanding of and experience in commissioning amongst GPs is

	capacity and capability in commissioning?	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	This could be part of the approach set out in 18 above. The outcomes framework should include indicators that cover avoidable health

	inequalities in health?	inequalities
20.	How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?	The underlying principle of involving patients and the HealthWatch (locally and nationally) is fully 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?	**National HealthWatch should as part of their role of setting standards ensure that local HealthWatch organisations evaluate local systems of engagement. This would be included in any guidance issued to local authorities as the commissioners of local HealthWatch arrangements. Children's Services already have very effective arrangements for involving children, young people, parents and carers in service review and design. We would support more integration of these functions across LA and NHS.**

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, **children's therapy services, speech and language**. The services are commissioned against a clear outcomes framework rather than the form of provision. **The JSNA was used extensively to support the development and delivery of the CYPP and has promoted 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	Yes they should. The joint working on health and well being must be supported and underpinned by

	by statutory powers?	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?	**The Children's Trust in Oxfordshire has led strong strategic oversight of how children and young people's needs are met thorough integrated and individual agency delivery. It has led to strong and effective working relationships between all statutory partners, NHS services and the PCT. We believe that the Health and Well Being Boards should clearly include children's services in their scope and remit. This would give a clear, and we hope statutory basis to the continuation of partnership and joint working in children's services. Children's Trusts (or constituent statutory partners) should be key advisors/members of Health and Well Being Boards. We see the Lead Member/Director of Children's Services being a member of the Health and Well Being Board.**
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?	

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