



Equity and Excellence: Liberating the NHS - Consultation Response

Overview

Brent Council has serious reservations about the proposals in the White Paper in relation to GP commissioning. We agree that local government should be given an enhanced role within health service commissioning, responsibility for providing a strategic overview of commissioning in boroughs and promoting integration between health and adult social care, children's services and safeguarding. Councils should play an active role in health services and it is encouraging that public health services will be brought back under local government control. Local government already provides a number of services that have a huge impact on the health and wellbeing of the population, such as housing, leisure and sport services, planning and regeneration services. Bringing these services closer to public health and mainstream health services has the potential to improve integration, be good for patients and lead to better health outcomes for our population. We urge the government to clarify the level of resource to be allocated to local authorities to meet the proposed public health duties. We also recommend that public health budgets are not ring-fenced so as to enable councils to use the resources to greatest local effect.

We do not support proposals to give GPs responsibility for the bulk of health service commissioning. We have serious concerns about giving untested GP consortia responsibility for spending £80bn of public money at a time when considerable cuts are being made to public spending. This proposal leaves GPs and the health service open to unacceptable levels of financial risk. There is also no clear evidence that giving GPs responsibility for commissioning will lead to improved clinical outcomes.

The reorganisation of the NHS could cost up to £3bn, whilst up to £20bn is to be taken out of the NHS budget by 2014. £3bn is a huge amount of money to spend on restructuring services when there are significant cuts being made to public sector spending. The council believes that at this time the NHS and patients would be better served if more effort was put into making the current system work more efficiently than redesigning health service commissioning and at the same time trying to take £20bn out of NHS budgets.

Brent Council is also concerned about the way that GP commissioning consortia could emerge. We are not convinced it would be in patients' best interests if they develop around the organisational structures of existing primary care trusts given that the White Paper was supposed to signal the end of PCTs. This would also bring into question the need to spend £3bn on reorganising only to recreate a broadly similar structure. The letter from the Secretary of State for Health to GPs on 24th September 2010 encourages GPs to take on more commissioning responsibilities in shadow form and to work with PCTs to make this happen. Our worry is that working with PCTs based on current structures will become the default option, as GPs look for support to help them commission services.

On the other hand, we do not want GP consortia to develop across borough boundaries or to be made up of geographically distant GP practices. This will not help partnership working or integration between health and social care; it would almost certainly lead to deeper division between health and social care services. At present the government is leaving the development of consortia to GPs themselves and not providing clear guidance on issues such as the size of consortia or geographical location. We believe that the government should explicitly guide GPs into forming consortia based around local government boundaries.

We have concerns that patient choice, particularly in primary care or care provided from community settings may be compromised by the government's plans. GPs will be commissioning acute and primary care services. As more services are moved into community settings, GPs will also be directly providing a greater range of services and potentially commissioning from themselves or other practices within consortia. This may have implications for patient choice, as GPs direct patients towards services in which they have a financial interest. There need to be procedures in place to ensure patients' are aware of their rights and that GPs are open about the choices available to patients.

Despite the council's opposition to some of the White Paper proposals, we appreciate that if these changes do take place we need to make sure that health and social care services in Brent are not adversely affected and that we build positive working relationships with GPs. Brent council is committed to improving the health and wellbeing of local people and will continue to work collaboratively with health service partners.

Brent Council's substantive response to the White Paper consultation questions is set out below.

Response to *Local democratic legitimacy in health*

Each consultation document contains a number of questions relating to the policy proposals. Brent's response addresses the relevant questions in each consultation paper.

Q1. 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?

Response – Brent Council encourages and supports patient and public involvement in health and social care services and welcomes proposals for the establishment of a local HealthWatch. It is important that commissioners and providers of NHS services take account of the obligations contained in the NHS Constitution and ensure that there is a way for patients to bring matters of concern to commissioners if they are not receiving the services that they want, need or are entitled to. An effective patient and public involvement organisation should already feel empowered to seek and express the views of patients in relation to the provision of NHS services whether or not they have a formal role in ensuring that providers and commissioners take account of the NHS Constitution. The council is not convinced that this needs to be formalised. It is something that HealthWatch should be doing without legislation to require it.

Local HealthWatch will need to ensure the views of all patient groups are taken into account especially hard to reach or seldom heard groups. For example, the views of children and young people to be considered. Brent has an effective, vibrant and dynamic Youth Parliament which is represented at Children's Trust level and supports the work of the

Children and Families Overview and Scrutiny Committee. HealthWatch will need to connect with groups such as this to capture the full range of patient views.

Q2. 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?

Response - The proposal to give HealthWatch responsibility for the complaints advocacy service, to be commissioned by local authorities or National HealthWatch makes sense. If HealthWatch is to be the organisation that people go to with issues relating to health and social care services, then giving them a complaints advocacy role would complement their broader remit. However, it is important that people can continue to use other advocates, such as the CAB or specialist advice and support services and that their legitimacy to support patients is recognised by the NHS. The roles and responsibilities of the local HealthWatch and NHS Patient Liaison Services should also be clarified.

In developing this wider role for HealthWatch, consideration needs to be given to the existing signposting, information and advocacy services provided by Local Authorities to reduce duplication and ensure a more consistent message to consumers. In the case of Children's Services, there is already a requirement to have a Children's Information Service which provides signposting to a range of services for children and families and is only missing the advocacy component of the HealthWatch type role described in the White Paper. Integration of such services could reduce cost, duplication and deliver a consistent consumer message.

HealthWatch should support patients to exercise their right to choice when selecting which health services to use. However, it is important that health service practitioners inform patients of their right to choose providers. When GPs begin to commission services this will become especially important, to avoid scenarios where patients are automatically referred to services in which the GP has a financial interest. There needs to be checks in the system to ensure patients are being informed by practitioners of their right to choose service providers.

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

Response – Local authorities are concerned that there won't be sufficient funding to commission HealthWatch services. Funding was provided to commission Local Involvement Network Services but it is not clear whether additional resources will be provided to commission the new service. At present funding for LINKs ends in March 2011. It is not reasonable to expect local authorities to fund a new patient and public involvement service, with enhanced duties such as complaints advocacy, in an environment where local government funding is being reduced. There needs to be clarity from central government about how they intend to fund HealthWatch once the current LINK funding comes to an end. It would also be helpful for the government to clarify working arrangements for LINKs after April 2011, assuming HealthWatch won't be established by then.

In terms of the commissioning framework and guidance for HealthWatch, Brent believes that boroughs should be able to make their own arrangements to suit local needs and would not want legislation and guidance to be overly prescriptive. We would want to be able to facilitate integration with existing services providing similar services to HealthWatch and have flexibility in how these services are provided. Clarification of the roles and responsibilities of National HealthWatch would also be helpful as the consultation paper includes little detail on this.

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

Response - Brent Council believes that there are a number of things that Department of Health can do to support integrated working between health and social care and develop a whole system approach to care. Firstly, health and social care agencies need to be incentivised to work in an integrated fashion. This means designing performance indicators (assuming they continue to exist) that work to promote integration between the two systems. The way that services are funded needs to be changed so that health and social care agencies benefit from changes and improvements to the system. Operating in a financial silo, as the NHS currently does, means that there is little incentive to make improvements to services that result in savings to social care budgets. This has to change and funding needs to be allocated to localities for health and social care so that the benefits (and risks) of service changes are shared. This should lead to closer integration of services, particularly if spending plans are agreed by health and wellbeing boards.

There is also legislation in place that currently allows joint working and integration between health and social care services (Section 75 of the National Health Service Act 2006 for example). It is assumed that existing legislation will be modified to reflect GPs new role in commissioning health services.

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

Response – The bureaucracy of developing pooled budgets to support joint commissioning initiatives has proven problematic in the past due to the risks for either or both organisations. Generally, both LA and NHS organisations have expressed concerns about being fixed into pooled budget arrangements which are perceived to be difficult to end or are in place for too long. Therefore, we propose that commissioning responsibilities for specific care groups could be delegated where appropriate to allow a single organisation to be responsible for the commissioning, procurement and performance management of the service. Delegation will allow increased freedom for a single organisation to progress towards integrated models of care while enabling flexibility for either organisation to review the delegated arrangements to determine whether they continue to be fit for purpose at the end of each contract period.

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

Response – Statutory powers for local government to support joint working with the NHS on health and wellbeing would be welcomed, but might not lead to deeper integration of health and social care services unless it was underpinned by a statutory responsibility for local government and GP commissioners to work in partnership. Brent Council is concerned that under the government’s proposals the onus would be on local government to use its existing skills and experience to support joint working, but in contrast to the duty for GP consortia to work with colleagues in the wider NHS and social care there would be no requirement for GP commissioning consortia to work with local government. Efforts to promote joint working could be frustrated by the unwillingness of GP commissioners to participate, no matter how much effort the local authority puts into to integration. Indeed, there are concerns in local government that the NHS does not engage sufficiently or seriously with local partnership arrangements. As highlighted in Sir Ian Kennedy’s report – “Getting it right for children and young people” (21 Sept 2010), despite the concerted effort at policy level to raise the profile

of children and young people's services, this is not matched by the results at operational level due to a culture within the NHS that results in barriers to change and improvement.

The best way to ensure clarity around the expectations for partnership working would be to introduce a mutual duty of cooperation between local authorities and GP consortia. A statutory requirement upon NHS partners to cooperate and work jointly with the Local Authority would serve to strengthen the requirement Brent Council hopes that the government reconsiders this proposal to make it a more balanced and not just rely on local government to make partnership working effective.

Q7. Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Response – Brent Council agrees with the proposal to establish a health and wellbeing board and is putting in place plans for a shadow health and wellbeing board to begin meeting before the end of 2010. The shadow board will be integrated within our Local Strategic Partnership structure and will engage GP commissioners, public health colleagues, patients group's, representatives from the local acute trust as well as elected members and council officers to work on health and social care issues in Brent.

The council believes that health and wellbeing boards will be the best way to ensure partners come together to deliver health services that people in Brent need. We agree that the boards should be considered a forum for mutual influence, giving local authorities influence over NHS commissioning and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities and social care. Without the formal role of a health and wellbeing board and GPs requirement to engage with it, Brent is concerned that opportunities for genuine integration could be missed and that health and social care commissioning becomes fragmented within boroughs.

As we have stated previously, Brent Council would like the government to ensure that GP commissioning consortia are co-terminous with borough boundaries. This is crucial to help integrate health and social care services and not lead to further divisions between the two. If boundaries are not co-terminous the council believes that any consortia with an interest within Brent, even if it covers one or two practice areas, should have a duty to work with the Brent health and wellbeing board. The council believes that there should be full representation from all GP commissioning consortia within Brent's boundaries on its health and wellbeing board.

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

Response – Brent Council has no objections to the functions proposed for the health and wellbeing boards. However, we do think that there are additional functions that could be added to their role. We would like health and wellbeing boards to be responsible for approving GP consortia commissioning plans to ensure they meet the boroughs health needs and the wider strategic plans for health and social care. If the health and wellbeing board is not satisfied that consortia's overall commissioning intentions are in line with the borough's JSNA and in the best interest of patients, the plans could be referred to the NHS Commissioning Board.

The White Paper proposes that councils will assume responsibility for public health functions. If this happens, health and wellbeing boards will need to work with GP commissioners to ensure that commissioning plans reflect the importance of public health and health promotion work. There is a risk that the separation of public health from the NHS will mean the NHS no longer sees 'health' as its responsibility, only health care, and it will focus on treating ill health, not preventing it. Brent Council believes that GPs have a critical role in promoting good health, not just treating ill health. GPs have many opportunities to offer interventions such as smoking cessation services as they see patients at times when they may be open to change – before an operation, after a health scare, when they are feeling ill, or are pregnant. Opportunities to deliver ill health prevention messages and services will only be taken if the NHS sees ill health prevention as part of its core business and this need to be reflected in the NHS outcomes framework. Working in partnership to ensure these services are delivered to the people who need them most will be crucial. The health and wellbeing board will be the best forum for local authorities to engage GPs on these issues. The government should also consider whether the Directors of Public Health should have a role within the governance of GP commissioning consortia to ensure better integration between health care and public health.

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

Response – Guidance is always helpful on such issues, but Brent does not think that detailed advice on carrying out a JSNA is needed. The council and NHS Brent have already prepared one JSNA (in 2008) and plans to refresh this document in 2011. The council also believes that rather than government set out in details how health and wellbeing board should function, it should be for members of health and wellbeing boards locally to agree terms of reference and working arrangements.

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

Response - Sir Ian Kennedy's report (Sept, 2010) sets out nine recommendations which are briefly summarised below:

1. To bring about a more holistic approach to their overall welfare, policy for health wellbeing and public services relating to children and young people should be brought under one government department. Sir Ian's suggests, but does not insist, that this might be a newly conceived Department of Public Health.
2. Government and national organisations must agree on their respective responsibilities and align services to meet them.
3. Funding for services to children and young people, including the transition to adulthood should be separately identified and allocation to the government department referred to in (1) above.
4. There should be a dedicated Local Partnership for children's health in every local authority area. The report alludes to Children's Trusts as potentially the ideal vehicles for the type of change proposed.
5. This Local Partnership should be locally accountable.
6. The Local Partnership should be able to require a Children's and Young People's Plan to be drawn up and implemented.
7. This plan must set out the agenda for children's health and healthcare.

8. This plan must integrate the children's health and healthcare agenda into the overall plan for all services provided by the Local Partnership.
9. The Local Partnership must ensure that the views of children and young people are sought and taken into account.

Recommendations 4-9 from the Kennedy report reflect current Children's Trust's arrangements. It is therefore important that the proposals set out in the White Paper do not create unnecessary layers of bureaucracy or duplication of existing mechanisms. However, it must also weigh the risk of destabilising existing structures that are effective and delivering measurable improvements in outcomes for children and young people. The White Paper's proposals for health and well being boards may well be the ideal opportunity to strengthen the requirements upon the NHS to ensure sufficient representation, engagement and interest.

It is likely that some form of local partnership focusing on outcomes for children and families will continue. In order to achieve the aim of integrating health services effectively, a strong link between health and children's/family services will be required. Children's health and well being will continue to be a key part of the children's agenda and it will be important to ensure that there are clear lines of accountability with well defined responsibilities for the health and well being board and the children's trust or equivalent partnership arrangements. There is a real and significant risk that the children's/family health agenda could be covered by both, causing duplication, or be given less focus as part of the wider health agenda without a children's board to champion children and families needs.

It is therefore clear that the interfaces between the health and wellbeing boards, the children's trust and local safeguarding children board merit further consideration. The consultation paper indicates that the health and well being board has some role/accountability over children's safeguarding in a broader sense, which appears to duplicate the role of the children's trust and the role of the director of children's services. The government should clarify roles and responsibilities in this area.

Q11. How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Response – Brent believes that individual boroughs are best placed to determine local need and establish arrangements to ensure there is joined up working between health and social care services. Brent is already working on a sub-regional procurement project in adult social care services with other west London boroughs, an excellent example of cross borough working that will deliver better services to local people. The Mayor of London does not currently have any policy powers in relation to health we would not want to see this change. Whilst we appreciate that the Mayor has a strategic overview of health inequalities in the capital Brent Council does not see a role for the Mayor or his representatives in local health and wellbeing boards unless he is given significant public health responsibilities (clarification on the services to be transferred to the Mayor would be helpful). Cross borough working arrangements between health and wellbeing boards, where this is necessary, should be agreed by the boroughs affected. We do not believe that there is a role for the Mayor in this. Our preferred option is also for boroughs and GP commissioning consortia boundaries to be co-terminous. We think that this is in the best interest of patients and reduces the need for overly complicated partnership arrangements.

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

Response – Brent Council broadly agrees with the suggested membership of the health and wellbeing boards.

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

Response – Brent Council believes that if GP commissioners and the local authority establish good working relationships then most disputes relating to commissioning should be resolved locally without need to refer them to the NHS Commissioning Board or the Secretary of State for Health. There is an acceptance that referral should be the very last resort and we would assume that if local arrangements are working well then there would be very few referrals as has been the case with referrals from overview and scrutiny committees to the Independent Reconfiguration Panel. If local authorities are regularly referring issues to the NHS Commissioning Board this would be a fairly obvious sign that local arrangements are not working and that relationships have broken down. It is up to councils and health service commissioners to ensure that this doesn't happen.

GP commissioners will need to commit to working with health and wellbeing boards and the government should legislate to ensure this happens. It is vital that they use the boards to test commissioning ideas at an early stage to ensure that there is agreement from all sides. Brent has already argued that if GPs become lead commissioners of health services there should be a duty on them to be members of health and wellbeing boards, and this issue gives further weight to this argument. The NHS Commissioning Board may wish to supply mediators to help GP commissioners and local authorities come to a mutually acceptable position and prevent any referral becoming necessary.

Q14. Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Response – The transfer of statutory health overview and scrutiny powers to health and wellbeing boards will mean that there is a weakening of accountability for health and social care services. One of the strengths of the overview and scrutiny function is its separation from decision making. Health and wellbeing boards are to be responsible for coordinating health and social care commissioning in the borough. They are to have executive powers. Therefore they should not be responsible for scrutinising health and social care commissioning decisions, as there is a conflict of interest and a lack of independent scrutiny. It is important that health scrutiny committees are still able to scrutinise commissioning decisions to ensure these are made in the best interest of patients.

The government should also consider how GPs will be covered by scrutiny arrangements. As independent contractors with the NHS, GPs are not currently subject to overview and scrutiny from local authorities. Will this loophole be closed so that they have to co-operate with scrutiny functions once they become health service commissioners?

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

Response – Please refer to the answer to question 13 above.

Q16. What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Response – Brent Council has reviewed its overview and scrutiny arrangements and set up a Health Partnerships Scrutiny Committee that will scrutinise the borough's effectiveness in tackling health inequalities and partnership working in health and social care. This appears to fit into government thinking on the role of overview and scrutiny in the new health service landscape. It is important that crucial areas such as health inequalities and public health continue to be scrutinised independently by elected members. We do not necessarily think that there needs to be a statutory requirement to have a health scrutiny committee as is currently the case, but that most councils will set up local arrangements to best meet their needs. Health scrutiny committees should also have the powers to scrutinise commissioning decisions, even if referral powers are transferred to health and wellbeing boards. Oversight of the boards will remain important to ensure there is independent, democratic accountability in health and social care commissioning decisions.

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

Response – The recommendations made by Sir Ian Kennedy (Sept 2010) should be considered in the context of the White Paper proposals given the significant and serious concerns highlighted in respect of the NHS, its ability to work effectively in partnership internally and with external agencies and specifically in relation to children's services.

Following on from this, if GP Consortia will not commission services provided by GPs, where does the responsibility for safeguarding lie with regard to GP provided services? This aspect requires further clarification regarding processes and commissioning levels given that Public Health Departments will be transferred to the Local Authority and GP contracts will be managed by the National NHS Commissioning Board.

The consultation paper suggests that maternity and newborn care services will be commissioned by the National NHS commissioning board as well as specialist services to ensure choice across a range of settings and services. However, it is not clear how it will be ensured that these services remain responsible to local need. Further clarity is required on why the NHS commissioning board would take the lead role for commissioning maternity services given that many aspects of maternity services need to be commissioned locally, particularly antenatal and postnatal care. Brent Council would argue that all services should be commissioned at the local level unless there are compelling financial or clinical reasons for it to be done at a regional or national level.

Finally, with regard to Public Health, the definition of public health will need to be redefined in line with its new broader remit. For example, in the context of children's services, public health service could be defined as those provided by health visitors, community midwives and school nurses. Therefore an underlying assumption could be that such roles come under the auspices of local government to better support delivery of integrated services that promote health and well being, provide early intervention and preventative support.

Response to *Commissioning for patients*

Q9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

Response - The Commissioning Board should ensure that local commissioning is undertaken with due regard to public health and preventative medicine and with the active involvement of Directors of Public Health and health and wellbeing boards.

Q11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

Response – Brent is firmly of the view that local people would be best served if their GP practice was part of a consortium with firm links to the borough and that preferably consortia boundaries in Brent matched the borough's boundaries. Indeed, we would like the government to ensure consortia boundaries match borough boundaries. We do not think that practices will be well served in terms of quality and support if they are part of a consortium that is primarily based in another borough or geographically distant to Brent. It is also not good for patients. If practices are based away from their consortium but a patient is referred for specialist treatment provided by another practice in that consortium they may face a long journey to receive that service. This isn't going to be in patients' best interests. If GP consortia and Health Watch boundaries do not make sense to local people how can they be expected to engage with them? Equally, if the boundaries of a consortium straddle more than one local authority area this could lead to a greater dislocation of public health and social care provision, again with the greatest impact being felt by patients.

Q12. Should there be a minimum and/or maximum population size for GP consortia?

Response – It is crucial that GP commissioning consortia are sustainable and have the capability and capacity to become effective commissioners and manage the financial risks that will come with the responsibility for spending NHS budgets. Brent believes that consortia will need to be commissioning health services for at least 100,000 patients, but it is more important that consortia are robust organisations able to deliver and commission excellent health services than it is to be overly prescriptive on the population size they need to serve.

Q13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?

Response – Brent Council believes that there is a role for local government in supporting GP commissioning consortia and we are pleased that this option is mentioned explicitly in the White Paper. Local authorities are already experienced commissioning organisations and many will have the skills and capacity to support GPs in their commissioning work. For example, councils are able to provide skills such as demographic analysis, contract negotiation, performance monitoring and financial management. The key issue for Brent is that GPs themselves are able to choose the support they want to develop their own capacity and capability and are not forced into replicating existing systems by current NHS organisations, which is what we feel will happen as the proposals currently stand. GPs should be able to engage local government, PCTs, the private sector or the third sector in their own time to consider the support they need. The government should ensure that attempts to replicate existing structures of support through reformed PCTs does not become

the default position for consortia. The whole purpose of the White Paper was to radically change the way that health services are commissioned, not to replicate the existing system.

That said we are also cautious about private sector involvement in health service commissioning. We do not think that profit should be the driving force in health service provision, but why else would private sector firms be looking to support GP consortia? Our worry is that patients will receive inappropriate services if the private sector supports consortia, as GPs are encouraged to seek low cost solutions to save commissioning budgets, when this might not be in the best interest of patients.

Q14. What support will GP consortia need to access and evaluate external providers of commissioning support?

Response – It is a concern to Brent Council that support for GPs to evaluate external providers of commissioning support may come from existing PCTs. Not only is there a potential conflict of interest as PCTs reform themselves as social enterprises to provide this support, the transition period could also be difficult as the NHS makes the management savings required of it, whilst supporting GPs. At the very least, GPs should receive advice and guidance on evaluating commissioning support from organisations that are not bidding to provide that support to eliminate the potential for conflicts of interest. Strategic Health Authorities or the NHS Commissioning Board may be best placed to provide support to GPs.

Q17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

Response – Brent Council believes that a commissioning outcomes framework should not just reflect health services commissioned by GPs, but needs to be used to help integrate health and social care services to deliver a whole system approach to care. Any framework which enhances the silos that separate health and social care will be detrimental to the overall care of people in Brent. The reorganisation of health service commissioning presents the department with an opportunity to enhance the link between health and social care by making this explicit in the outcomes framework. This includes factors such as shared objectives and targets that health and social care will be expected to deliver together. We would also expect to see key public health indicators including smoking and obesity prevalence to help focus GPs on preventing ill health.

Q18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

Response - There are a number of ways in which GPs can be incentivised, but Brent would want to see incentives that are consistent with reducing ill health and improving health inequalities in the borough. We would not support proposals that would lead to GPs retaining commissioning budgets if they are not fully spent. This could encourage under referring to the acute sector even when patients require specialist treatment and might work against broader borough objectives. Brent believes that in order to foster joint working and closer integration between primary care, social care and public health, GPs need to be incentivised in a way that compliments the borough's aims for social care and public health. This includes broad objectives like increasing life expectancy and reductions in morbidity, which should be reflected in consortia commissioning. Linking GP incentives to underspending in their budgets may not be in patients' best interests. The government should involve public health and social care professionals in discussions with GPs about the most appropriate way to

incentivise and reward GPs. The rewards system for GPs and the proposed health framework also needs to compliment the wider adult social care and wellbeing framework.

Q19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Response – Brent Council has already argued that through the development of health and wellbeing boards, GP commissioners and the council should be working in partnership to develop a whole system approach to health and social care service provision. This can be further strengthened through the implementation of GP incentives that complement the broader aims of social care and public health. In Brent reducing health inequalities is a priority for both the council and PCT. Effective partnership working between GPs and the council will be crucial if progress in any progress is to be made in this area of work. Therefore, our argument that there should be a mutual duty of cooperation between local authorities and GP consortia would be of benefit to help reduce health inequalities – this isn't something that can be achieved by local government or the NHS alone.

Q24. 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?

Response – Since the White Paper was published Brent Council has been proactive and engaged groups of GPs to discuss the issues connected to GP commissioning, to see what help and support GPs will need and also to consider how the council and GPs will work together from now on. Although the council has reservations about GP commissioning building these informal relationships is an important first step that needs to be taken in preparation for more formal partnerships that are likely to follow once the Health Bill has passed through parliament.

As we have already stated, in preparation for the creation of health and wellbeing boards, Brent is going to put in place shadow arrangements and we would expect GPs to participate in these. Although there will be no requirement for them to do so, it would indicate a willingness to work in partnership with the local authority in the longer term. The sooner that local government and GPs can begin discussing issues relating to health and social care, the more likely that objectives such as integrated working becomes a reality. It will also help us better understand our respective needs and ambitions for health and social care. We hope that the Department of Health will encourage GPs to begin working with local government as soon as possible, including participation in shadow arrangements in the lead up to the abolition of PCTs.

Joint working and integrated commissioning is to become increasingly important as the amount of funding available for health and social care reduces. Services for vulnerable groups are particularly important as they may not be the first priority for GP commissioning consortia. Brent Council believes that local government could take a lead role in commissioning services where it has considerable experience and a proven track record in commissioning, such as mental health, health and wellbeing of homeless people, services for children and young people and services for people with learning disabilities. In some areas, local authorities may wish to delegate commissioning responsibilities to GP commissioning consortia if they have the capacity and expertise to do so. Equally, they may wish to delegate commissioning to sub-regional or supra-regional commissioning groups. In either case this should be for local decision.

Perhaps the greatest challenge to the new NHS will be how to put prevention at the heart of the NHS. The new structures for health and social care will place responsibility for health care and ill health prevention into separate organisations with different outcome frameworks. There could also be different geographical boundaries between organisations that will have to work together. Failing to engage primary care effectively in preventative medicine will impose burdens to the public in terms of ill-health, to GP consortia in terms of a heavier work load and the NHS as a whole in terms of unnecessarily high costs. Ensuring that the two new services (public health and health care) work together effectively must be of the highest priority. As we have already said, proposals for the NHS Outcomes Framework should be reviewed to include specific public health indicators, especially for smoking and obesity which have a huge impact on peoples' health and cost to the NHS.