ANNEXE B

LIBERATING THE NHS: COMMISSIONING FOR PATIENTS – BRACKNELL FOREST COUNCIL'S RESPONSE TO CONSULTION QUESTIONS

Bracknell Forest Council has considered the consultation questions asked in this paper. Not all the questions are relevant for a response from the Local Authority, so these have been left blank.
The Council also wanted to make some general remarks.
The Council is concerned about the commissioning from acute providers where there may be a number of small commissioners contracting with a very large provider. There would seem to be a need for a mechanism to allow for collective commissioning to get best value for money from the provider.
Equally there will be fragmentation of funding in smaller allocations which may well not be cost effective.
The Council is concerned about the governance arrangements for consortia. This is not made explicit in the consultation paper.
The white paper is very clear that the changes proposed are to deliver greater patient choice and control. Where and how does patient choice fit in with the commissioning process as described in this consultation paper?

Bracknell Forest Council would like to make the following comments on the specific consultation questions:

Consultation Questions
Q1 - In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services? The Council would want a clearer definition of what specialist commissioning is. It would seem sensible for local consortia to have a mechanism to engage the National Commissioning Board when the weight of commissioning is too low in their area to warrant cost effective local commissioning.
Q2 - How can the NHS Commissioning Board and GP consortia best work together to ensure affective commissioning of low volume services? The analysis and use of the local Joint Strategic Needs Assessments should inform the NHS Commissioning Board of outlying demands.
Q3 - Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia? The Council would seek the views of the GPs locally on this. Children and young people are not specifically referenced in the consultation and neither are other groups like the elderly. It would be helpful to better understand how commissioning specific services for children and young people (0-19) will be catered for under these proposals. Specialist services for children and young people with disabilities or special needs or particular medical conditions are not addressed in this first consultation. How will approaches to the use of resources be standardised and prioritised if there are numerous consortia of GP commissioners? How will limited resources and particularly funding be used collaboratively when LA could be dealing

with a number of GP consortia and how will difficult decisions be reached or disputes resolved?

Q4 - 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?

There will need to be specialist advice available to the GP consortia for the more specialist commissioning. The Council is concerned about the knowledge and experience a GP led consortia would have in commissioning Learning Disability and Mental Health Services.

Q5 - How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

The Council would like to put forward the suggestion that the commissioning of GP practices as providers of service should be a Local Authority function. This would link the quality of health care in the individual practice back to the strategic plans for the wider community. As they produce the Joint Strategic Needs Assessment, local authorities are best placed to know what health services are needed locally, furthermore this would reinforce the drive for localism.

Q6 - 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?

No views

Q7 - What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

Audit type arrangements through Local HealthWatch or the Health and Wellbeing Board. Assessments of the consortia by CQC.
Is there an opportunity for patients to jointly commission with their GP? This inevitably leads on to considerations of joint funding and links with private medical insurance and those with the means to purchase higher levels of health care. How will the views of young people be represented?

Q8 - 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 support local commissioning?

No views

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

No views

Q10 - What features should be considered essential for the governance of GP consortia?

It is the view of the Council that it is important for integrated whole system working that the Local Authority is represented within the governance of the consortia. It would also seem prudent that other primary care professions were also represented.

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

There would be some difficulties if consortia populations straddled different Local Authority boundaries.

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

Wherever possible there should be co-terminosity with Local Authority boundaries. As one of the smaller unitary Local Authorities, Bracknell Forest Council would envisage a consortium which was co-terminous with its boundary as ideal. The current arrangement where NHS Berkshire East works across three Local Authority areas has not proved easy for joint working and fair allocation of resources.

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

The Council would see the consortia using the local knowledge and skills already available through the Local Authority commissioning and contracting experience and in the staff of the existing PCT who know the local needs.

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

Again, local knowledge is paramount.

Q15 - Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

Assuming the consortia are to be statutory bodies carrying statutory risks then the arrangements within Local Authorities for carrying risk could provide guidance for the consortia.

Q16 - What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition? The use of Monitor as a regulator and auditor.
Q17 - What are the key elements that you would expect to see reflected in a commissioning outcome framework? No views expressed
Q18 - Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium? Yes, but not additional payments. There should not need to be additional incentives for GP practices to work to improve the quality of outcomes for their patients.
Q19 - What arrangements will be ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health? The GP consortia should be expected to undertake equality impact assessments on their commissioning actions.
Q20 - How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight? The use of HealthWatch both locally and nationally to gain patient views.
Q21 - 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? Identify joint priorities and shared interests through the work of the Health and Wellbeing Board.
Q22 - How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient Participation Groups? Local Authorities can assist in developing community engagement. This Council has a well established process and connections with the Community. Again, this could be delivered jointly through the Health and Wellbeing Board.

Q23 - 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?

No views

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?

It would be helpful if, like the Local Authorities the GP consortia had a duty to promote joint working, integration and health improvement. The proposed 'duty to cooperate' appears passive.

Establishing a seat for the Local Authority on the consortia Governance Board would also strengthen the relationship.

Q25 - 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?

The Council would suggest looking at the model for cooperation on Children's Trusts. There needs to be strong links between the proposed Health and Well-being Board and the Children's Trust partners and partnership arrangements and sub-groups.

Q26 - How can multi-professional involvement in commissioning most effectively be promoted and sustained?

This could be achieved through the governance arrangements for the consortia. Perhaps the consortia should be viewed as multi professional (or clinically led) rather than just GP led.