

## South London CVS Partnership response to NHS white paper

The following presents a response from members of the South London CVS Partnership to the NHS white paper and associated consultations. Because of our unique position as a sub-regional partnership, this includes feedback from LINKs as well as consultation events across South London. We are very grateful to those who have contributed.

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### General

- Continual change in the NHS has not been good for patients; it distracts professionals and managers from service delivery and has huge costs in both time and money. This is too big a change to go ahead without some piloting beforehand.
- We support the notion that patients must be at the heart of the NHS. Proposals need to clarify how the GP consortia and the NHS Commissioning Board will be accountable to the public.
- Until the public health white paper is published the relationship between prevention, public health, primary and secondary care is unclear. This could lead to commissioners and providers focussing too narrowly which would have particular impact on the voluntary and community sector (VCS) which often provides aftercare support, preventative work and social support within one organisation. The new framework needs to be flexible enough to accommodate this.
- What role will the Compact have in these new arrangements?
- We are concerned that the Government envisages the VCS fulfilling several roles within health sector services – advocacy, service provision, monitoring quality - but does not say much about resources to support volunteers or voluntary and community organisations (VCS's). What additional resources are to be made available to HealthWatch, which is made up of volunteers, to take on additional complaints and advocacy functions?
- We do not wholly support the removal of targets, in many areas they have improved services and driven up standards.
- In order to enable choice people must have the right information, in an accessible format, when they need it. The information strategy must set out how this will be done and recognise that this area needs both expertise and resources, and that information needs to be developed in conjunction with those who will use it.
- Clarity is needed about the future of local care centres.
- VCO's have a history of providing innovative and effective support that makes an invaluable contribution to health and care services; this is not just in terms of service delivery but in many other ways such as through information, advocacy, and facilitating the involvement of patients and service users. In light of the impending changes, it is

essential that provision is made to ensure that the VCS can continue and increase its essential role in the health agenda.

## Putting patients and the public first

### Healthwatch: General

- Where LINKs have been effective they have been based on a VCS and a strong volunteering base and this needs supporting and resourcing to be sustainable. This includes appropriate support from paid staff. The Host staff team of the LINK is invaluable to the achievements of the LINK. Healthwatch must be adequately resourced for its tasks and its accountability needs to be clear.
- Value is attached to the 'local' element of such an organisation and there needs to be careful consideration of how geographically big a Healthwatch needs to be to be financially viable against being knowledgeable about local services and retaining a local feel that encourages people to get involved. The independence of such organisations is important and from our experience it has been helpful to have a strong connection to the VCS.
- Healthwatch should retain the power to 'Enter and View' and to monitor and uphold the NHS Constitution.
- It will be important that Healthwatch has a direct role within GP Consortia, and GP Consortia should have a duty to respond to Healthwatch in the same way that PCTs and local authorities currently have a duty to respond to LINKs. The GP consortia governing body should include Healthwatch representatives; if we are to put patients first they must be involved in the decision-making about commissioning as they are under the present arrangements.
- It is imperative that local Healthwatch are independent organisations in the way that LINKs have been, and that they are accountable to the community. We are pleased that local authorities will have a role to commission Healthwatch and ensure they are effective and don't feel that this will compromise their independence. However, if the local authority funds Healthwatch this could create a conflict of interest. Healthwatch may feel it cannot criticise local authority social care if it is reliant on that authority for funding.

### *Healthwatch England*

- We welcome the idea of national Healthwatch to bring work together at a national level but question whether it should be based within the Care Quality Commission. It should be an independent, national organisation which develops from local Healthwatch. Members should be elected by local Healthwatches.
- To be an effective community champion Healthwatch must remain focussed on local people and issues and the agenda for the work must be set by the local community not Healthwatch England or the GP Consortia.
- We would be concerned if the presence of Healthwatch England meant that national or regional bodies, commissioners and providers did not talk to local Healthwatch.
- There is currently no central resource for the information that LINKs produce nor any way for them to share good practice and other information. Healthwatch England could fill this gap.

### *The transition from LINKs to Healthwatch*

- There is concern that LINKs should be re-organised just over 2 years after they were introduced, especially because in many areas they are working well.

- If they are to be re-organised, in the areas where they have been successful there needs to be a seamless and direct transition from LINKs to Healthwatch. Valuable time and resources should not be spent creating a new organisation, examining constitutions and developing branding when we need to concentrate on working in the interests of the community. Where LINKs have worked well the present host contract should be extended to allow a smooth transition to LINK.

#### *Complaints and Health advocacy*

- Whilst complaints advocacy is welcomed the broader advocacy role needs clarity
- If this is actually 'information and guidance' on appropriate services, the word advocacy should not be used.

#### *Concerns over general advocacy role*

- If this is proposing to offer individual advocacy to individuals who may be vulnerable or disadvantaged advocacy as generally defined there would be concerns:
  - this would be more appropriately delivered by existing advocacy and self advocacy groups who are more familiar with specific needs of particular groups of vulnerable people
  - there may be confusion between complaints advocacy relating to an incident or series of incidents and general advocacy concerning self determination over future service leading to a variable service
  - funders may withdraw funding for existing advocacy work believing that Healthwatch is carrying this work out leading to unmet need and a decrease in self determination.

#### **Heath & Wellbeing Boards**

- There is a risk that boards will be dominated by local authorities or lack strong public and patient voice -
  - The proposed membership with multiple local authority members, and those members deciding who chairs the board gives most power to local authority
  - Membership as defined has a risk of only token membership by patients through a single Healthwatch representative and no certainty of VCS representation at all.
  - There should be a requirement rather than a suggestion to have VCS representation at the board. It is recognised that as potential providers there could be a conflict of interest, but this also applies to the council as a commissioner and potential partnership provider.

#### **Improving healthcare outcomes**

- The framework should ensure that there is public and patient involvement in designing the outcomes as well as sound clinical input.
- It also needs to take account of the fact that achievement of (and therefore payment for) outcomes will also be dependent for some domains on the support that patients have from VCO's. As such outcomes need to reflect this where appropriate and VCO's should be involved in setting the framework.
- It is important that there is a strong link between the outcomes frameworks for the provision of healthcare and public health and GPs as the work of VCO's may contribute to both outcome sets.
- The outcomes should include measures to prevent a perverse incentive for GP consortia to manipulate registrations to their practices that would of themselves reduce levels of health inequality within their practice populations.

### *Outcome domain 3*

- The outcomes around helping people recover from illness/injury seem very process based such as re-admissions to hospital not qualitative about whether they have regained as much function /independence/mobility as previously. Much of this is dependent on social care rather than health interventions, particularly services provided by VCO's.

### *Outcome domain 4*

- We recognise that it is vital to have patient input and the proposals are that this should be based on patient surveys:
  - How do you survey people who lack capacity and communities which tend to participate less in surveys?
  - How will it capture information about the "patient experience" that discourages some people?
  - What are the qualities of care issues people are most interested in?
- There is clearly a role for VCS in engagement and advocacy with some communities and with those who do not respond to paper based surveys.

### *Outcome domain 5*

Although this relates to inpatient clinical safety there is a role for VCO's both in terms of advocacy for vulnerable patients suffering as a result of clinical safety issues and also in gathering data from members/clients.

## **Commissioning for patients and increasing democracy and legitimacy**

### *The operation of consortia*

- Will GP commissioning consortia have the time, expertise or interest in commissioning? If not, private firms may be bought in which would distance GPs and their patient knowledge from decisions.
- The current duty of NHS bodies to involve and consult the public should be transferred to the GP Consortia. Local stakeholders (e.g. patients and the local authority) should have a defined role to work with GPs to establish the new consortia. The Government should specify the governance arrangements for consortia and the membership must include key stakeholders including Healthwatch and the local authority. How will effective involvement of minority communities be ensured?
- Additional work will be created by the consortia not being co-terminus with local authorities or other relevant geographical boundaries. There is a danger that consortia could be too small to get services for a 'good' price from large providers or not reflecting the local population and needs if they are too large.
- Ways need to be found to ensure consortia buy small, specialist services when these are needed for patients, even though these services are likely to be more expensive and conflict with the drive to buy bigger and cheaper.
- There are concerns about equity and a potential increase in the postcode lottery because inevitably some consortia will provide better services/referrals for their patients than others. It will not be possible for all patients to move to the 'best' consortia.
- The proposals need to encourage co-operation between consortia rather than competition and avoid conflicts between GPs and consultant, between price and quality.
- It should be a requirement for all GP practices to have a patient participation group.

### *The role of the VCS*

- Commissioners, especially if private companies, may be interested in large bulk contracts (which are cheaper to administer) - cutting out potential VCS providers despite the “any willing provider” requirement.
- There is a role for the VCS in providing commissioning support – for example outreach to communities, identifying health issues in particular communities or advising on effective purchasing arrangements with voluntary and community organisations.
- There is a variable appreciation by GPs of the benefits that the VCS can bring – especially where GPs see their role purely in terms of clinical interventions.
- PCTs currently fund VCO’s to provide services that complement and support clinical work by healthcare providers. This may be less attractive to GPs because:
  - The outcome framework is based purely on medical intervention not wider social and care support which contributes to recovery/rehabilitation
  - Prevention and public health are not the responsibility of GP consortia
  - Of a lack of familiarity with services actually provided and benefits delivered.
- Guidance should encourage payment of a proportion of the consortia budget on funding VCS or a tariff structure should reflect that a proportion of payments for activity should be passed on, possibly via sub contract to principal provider, to VCS providers

### **Commissioning support**

- If GPs can buy in support from local authorities, VCO’s and private sector providers there may be a conflict of interest if these support organisations are also service providers or indeed if a consortia member GP practice wishes to provide a particular specialist service. As such:
  - consortia should not outsource the whole of their commission to any one organisation
  - if purchasing commission support, a proportion is sourced from the VCS
  - commissioning support organisations should have to consider only the best interests of their practice populations. Further accountability would be provided if such commissioning support organisations were required to include representatives from local residents and patients on their Boards.

### *Commissioning Board*

- There needs to be greater clarity about what will be commissioned locally by consortia and what will be commissioned by the NHS Commissioning Board for patients and accountability. Local Healthwatch need to be able to work with the NHS Commissioning board in relation to local services that are commissioned by it. What will the structure of the NHS Commissioning Board be - will it have regional sub boards or be a single national body? There need in any case to be strong public and patient involvement arrangements - at an appropriate level (national, regional) beyond the NHS Commissioning Board being represented on local Health & Well-Being Boards
- Why is maternity not commissioned locally? What is the rationale for GP consortia not being responsible for this?
- If dental services are commissioned by the NHS Commissioning Board, ways need to be found for local needs and local issues to influence the process.
- Particular attention should be given by the NHS Commissioning Board to mental health and learning disability services to ensure that this is being commissioned according to the best evidence available.

## Regulating healthcare providers

- The link between regulation by Monitor as economic regulator, the Care Quality Commission as quality / safety regulator and the outcomes framework is not clear in the consultations.
- There must be robust links to ensure that regulators co-operate and do so in a way that health outcomes are improved.
- Attention must be paid to ensure that the removal of the private patient cap would not mean that non-private patients would lose out. There needs to be equality of access. Any changes would need to look at impacts on Black, Asian and minority Ethnic communities, women and disabled people.
- It is unclear how regulation would work in the context of personalised budgets, where use of family members or friends to provide services may increase risk.
- Can private sector providers put patients first when they have a duty to protect their shareholders' interests?
- Some providers are able to generate a lot of money from big contracts, private patients and fundraising but some services e.g. mental health are not able to do this. The market therefore needs to be regulated otherwise healthcare will become less equal and health inequalities will widen.
- Some specialist services need to be provided at local level if we are putting patients first, but this may go against the drive for economies of scale to save money. Again this will require regulations to support local provision when this is most appropriate for patients.

### *Bureaucratic burden on small/VCS providers*

- There is a potential bureaucratic burden on small, VCS providers in registering with a quality and a separate economic regulator when they already have financial regulation requirements to the charity commission.
- Will the government take into account the VCS when setting costs for licensing?
- There needs to be the opportunity for new providers and smaller, local providers to emerge and win contracts. This will be difficult in a market dominated by large providers and the need to reduce costs, so regulations will be needed to ensure a level playing field.

## Cutting bureaucracy

- Although the proposals aim to reduce bureaucracy, management and administration costs, if there are several GP consortia within a borough, this might increase bureaucracy and transaction costs for those interacting with GP consortia. Local authorities and the new Healthwatch (formerly LINKs) previously worked at borough level and only had to work with the single borough Primary Care Trust.