

Stockport LINK Feedback: Liberating the NHS: Commissioning for patients - A Consultation on proposals

This is a generic LINK response collated by Stockport LINK Support and is based on individual LINK member feedback. No views from the LINK support team are included. Where there has been conflicting views the majority view has been summarised. This response will be discussed, amended and signed off at Stockport LINK Core Group for wider circulation after **September 2nd 2010**. The Stockport LINK has a current membership of over 400 people and reaches around 4,000 participants regularly.

Responsibilities

Scope of GP commissioning (Questions on page 13)

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 NHS Commissioning Board must work with the GP Consortia but must take the final decision - and preferable with local providers where possible.

Ask the public (who after all are the users of the service). In doing this, they will get answers which will be more helpful than if left to Whitehall officials. HOWEVER, a lot of time should be allocated to such consultations.

By looking at how they can commission services that meet the needs of Stockport people, by talking with the PCT before they are abolished – arrange regional conferences now. By listening to each other and by not having a pre-determined agenda.

Will need to demonstrate that they can act as an advisory body, as opposed to a controlling body, albeit that they will be responsible for setting clear guidelines and rules for monitoring every aspect of consortia performance.

How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

As above (The NHS Commissioning Board must work with...)

This will depend on the representation within the Consortia and particularly the support given to often 'Regional' and 'National' bodies for such services.

The Commissioning Board must ensure one low volume service isn't provided at the cost of another low volume service. Each case should be assessed and fair access to services should be given to everyone reducing inequalities.

Use some independent members of the public to gain and use their opinion, and the opinion of specialised user groups should be sought.

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No secrecy in the Boards – these should be open!

Reduce red tape and reduce administration.

Each consortium must be of formal construction with an elected Chair and other officials. They should agree on who should take individual leads; each lead to form a group to investigate the various possibilities and options and initially take their findings, and recommendations, to the full Board for ratification. Final decisions to go onto the NHS Commissioning Board for approval. This system should engender mutual respect and, in time, build confidence.

Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

Only people with expert knowledge of specialised services should commission these services so I feel GP consortia may not have this knowledge.

Any services commissioned should be placed with not-for-profit organisations. Therefore dental, ophthalmic and community pharmacy services.

No reason why commissioning services of any kind need to be restricted once the GP consortia feel sufficiently confident, and have proved competence to take the work forward. Build up from a slow start.

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 dentist in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

As specialists in their own field they should be allowed to refer patients, as becomes necessary, direct to the required service instead of via the GP, which is current practice. However, as finance is involved, they could have a representative within their local GP consortium to decide on a procedure for this.

Local Dentists and other family health service representatives should be involved in the Health & Wellbeing Board and so involved in the commissioning of specialist dental care.

By careful and intensive consultations which are conducted with a generous time scale to allow correct conclusion to be reached, It is imperative that independent views should be sought. The customer is the one with the most insight into performance.

By asking the quality of the service provided against the effectiveness.

Relationship between consortia and individual GP practices (Questions on page 17)

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

GP Consortia should monitor the outcomes of Primary Care providers and there should be

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minimum standards set. They must monitor the results of each practise (prescribing, referrals, screening etc...) and assess value for money.

By agreement to a set of achievable standards that each practice must reach, as a minimum. Whenever better than minimum results are produced, the relevant methods and procedures used should be identified and, following discussion and agreement, rolled out to be adopted by all in the consortia.

GPs should not be over awarded for routine services. Incentives should be consulted on and ensure they are equitable. GP salaries should be capped in line with other health care professionals.

By making time for sufficient discussion both for GPs and their local patient representative groups and between groups.

The plans set out in the consultation appear sensible (especially paragraph 3.28).

It is important that the knowledge, expertise and skills from people who may be made redundant from various PCTs are utilised.

By introducing a feedback requirement on the part of the user – perhaps something HealthWatch could undertake to ensure independence, so that people are able to feedback openly and honestly without fear of repercussions.

What arrangements will support the most effective relationship between the NHS Commissioning Boards and GP consortia in relation to monitoring and managing primary care performance?

Independent monitoring of the services provided should be carried out. And the commissions on the providers should be held to account.

By introducing performance criteria and QOF inspections.

By appointing a group of knowledgeable, committed and independent people to gather all relevant details of results and performance in every area and aspect of care within each GP consortium. Reporting back to both the consortium and NHS Commissioning Board accordingly. Monitoring is a neglected area at present and is a basic tool in business to encourage improved performance and attainment of higher standards.

There will be GPs with specialist expertise and this should not be lost. Equally there must be provision of services that has historically been left behind such as Mental health services – this has been exceptionally poor in Stockport.

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

A combination of minimising financial risk, demonstrating transparency and fairness in investment decisions and accountability to patients, the public and the Board are important. Transparency openness and honesty is paramount though.

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Promoting too much patient choice creates confusion for patients. Also too much choice will not be cost effective. By introducing a quality assurance scheme as you would in industry should prove effective.

Boards should have regionalised personnel plus representation from Patients Panels and HealthWatch.

LINK (or HealthWatch) must retain complete independence.

GP consortia should tender for services with closed tendering and best value should be used to judge who wins the contract, not necessarily the cheapest. GPs should have no financial involvement with the provider.

By putting strict instructions, not guidelines, in place as to practice and procedure. These must include insistence on robust and accurate record keeping, and copies sent to all stakeholders. Everyone concerned to declare any interests which must also be recorded and regularly checked and updated as necessary. Again, regular monitoring put in place - recorded - to ensure compliance.

Records should include full details of any tendering for services, and reasons for the final selection; always looking to achieve best value, and quality of treatment, for money. An ongoing record of regular checks of satisfaction (or otherwise) to be maintained.

The role of the NHS Commissioning Board (Questions on page 20)

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?

By gaining back from the various Health & Welfare organisation and reacting to those local needs.

Regular meetings with both parties, initially, the monthly. Regular meetings prior to the procedures being brought into being. There must be sufficient time to pre-plan and the two sides to meet and be aware of each side's position before the inevitable disagreements.

NHS Commissioning Board should monitor the GP consortia to maintain standards and they must use possible local providers.

As above - everyone should be pleased to have tight control over every aspect to ensure equity for providers; commissioners and the public. Aims and objectives must be made clear to all concerned and, as proposed, models and examples of best practice demonstrated to show that these matters can work well in both a local and national environment.

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

By keeping all systems simple.

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Contact and use local press and explain to the general public, do not work in secrecy!

A member of the NHS Commissioning Board could be appointed to attend meetings of consortia, on a reasonably regular basis and particularly in the early stages, to observe and, if appropriate, to offer advice and guidance. If carried out in a non-intrusive and empathetic manner, this would fulfil the stated commitment to support the groups whilst helping to develop best practice and consistency between the consortia.

Establishment of GP consortia

Organisational Form (Questions on page 21)

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

Accountability, especially in relation to finance and outcomes, which is spectacularly lacking in the current climate. There is no good reason why prescriptive requirements of internal governance should not be set, and they would be welcomed by, and beneficial to people who are unused to working in groups involved at this level. The basic formation of the group should be set out as a model with indications as to individual responsibilities and voting protocols etc.

That those at the top should listen to those at the bottom. Heavy local involvement. Even perhaps engage local discussion groups who could analyse/discuss/comment on decisions made by consortium.

By involving the various Health and Welfare organisations.

Forming Consortia (Questions on page 22)

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

This should be based on ease of access for patients and therefore some flexibility should be desirable and will depend on the amount of common sense shown by the various practices involved. Some flexibility is clearly required as there is no 'one size fits all' situation here and it would be useful, at least in the early stages, to see how the groups perform initially within the proposals in paragraph 4.5. If monitored properly, any concerns arising could be dealt with in a timely manner and appropriate measures taken to resolve any difficult situations

There will have to be some element of Watchdog procedures.

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

On the whole in Stockport the boundary for consortia should remain that of the size of the current PCT/LA boundary area. The Stockport LINK feels that there should be only one consortia in Stockport due to the compact nature of the area.

It sometimes appears that the larger the group, the more problems arise and elicits more diverse opinions. On the other hand, a small group could easily develop into an 'old boys club' and become less effective. In reality, the number will essentially be linked to the number of practices within a particular area or, if the area covered is extensive, divided into two parts.

To make GP Consortia effective there should be minimum and maximum population size so it can provide services effectively.

Catchment areas for services differ; it is providing the best service for its population that matter.

Limits (if any) must not be too narrow.

Freedoms, controls and accountabilities

Freedoms (Questions on page 25)

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

By making and drawing down costing experience in previous organisation (PCT).

Paragraph 5.11 covers this issue adequately

GP Consortia must be able to access current advice and practice.

Set up a series of mandatory training courses to explain the basic principles and expected outcomes of the overall plan and, progressively, the finer details. This should not only build up the necessary experience to make the scheme a success, but hopefully encourage genuine interest and enthusiasm to succeed. It would be necessary to incorporate a lengthy question time and an opportunity for attendees to submit specific questions between courses for discussion at the next one.

A suitable test at the end of the training period, and close observation of attendees during each training session, should uncover particular abilities and enable identification of suitable people for specialist roles.

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

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Well informed advisors.

PCT staff who have proved their quality performance in these areas could be co-opted, initially, to provide support and shared experience of previous successes and how to avoid failures. This would engender confidence and provide a good starting point. If the PCT have themselves kept records of their own tendering system that too would be helpful, although not necessarily to be adopted.

Managing Financial Risk (Questions on page 26)

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

In general yes. The use of peripatetic accounting trouble shooters on a regular basis should minimise the risks these people should be used on a basis of their knowledge of local commissioning practices.

GP Consortia must have the right financial advice and have monthly accounts.

Most GPs should have good experience of controlling costs. It is unfortunate that NHS have not always been successful in this area, but where they have, their input would be invaluable, apparently, it is not simply a case of employing an accountant as the variables are unique to the industry, however a regular - perhaps quarterly - review of the accounts by the NHS Commissioning Board would highlight potential problems at an early stage and enable an early intervention to propose possible solutions. Lessons would be learnt and, over time, the consortia would develop their own skills and strategies.

Ensure providers are regulated and registered with CQC. Providers should report back truthfully!

Consortia should not have to pay back any under spend and should be able to commission more services perhaps from the voluntary sector to add support to say older people, mental health or learning disability.

How much resources will be allocated to research and new technologies locally? How will areas become leaders in new advancements?

Transparency and fairness in investment decisions (Questions on page 27)

What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

The answer to the previous question will go a long way in assisting. There obviously will be need to inter-consortium meetings and discussions on these matters, changed perhaps by mediators with knowledge of these situations. Again independence is of paramount importance.

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Independent scrutiny. Closed tendering should be advocates and any GP who has tendencies should not be involved in the final decision as to who wins the tender. HealthWatch be involved in the tendering process. Regular updates to HealthWatch to ensure they can inform their members and have records.

A strict protocol on voting within each consortium should ensure fairness, provided that the members represent all sections of the community and variety of practices. The voting results could be reported to a monitoring body, within the NHS Commissioning Board, with no loyalties to any group practice not only in the interests of transparency, but also to perhaps note any unusual activity and/or potential problems.

The production of a quarterly newsletter to be displayed in each general practice and, perhaps, a potted version in free local newspapers would allow patients to see good progress even if they have not personally required medical assistance in that time. This would increase confidence in the system and, hopefully, encourage people to seek treatment at an early stage to avoid lengthy, and expensive, treatment later.

Accountability to patients and the public (Questions on page 28)

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

Paragraphs 5.15 covers this well

GP should provide the best service for the patient but if this is done and saves money they should be rewarded but the budgets should not be reduced the next year.

High quality patient care and satisfaction together with a clear success rate in obtaining value for money.

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

The answer is YES if it can be shown that dubious or slack performances are responsible for waste/poor allocation of resources.

It is not clear whether “income” refers to the salaries of professionals on to the budget of the practice as a whole.

Surely a good outcome should be satisfying and sufficient but unfortunately this isn't always the case, Benefits on the practice should be the incentive *not* more salary for individual GPs

No! if employees of any nature are paid a fair salary/wage, then further monetary awards are unnecessary and can cause friction between people and groups. GPs are already paid high salaries and should fulfil their responsibilities within that framework. Such systems are open to abuse and manipulation and, as any such payments would be taken from the set budget, there is a danger that cheap, and less effective, treatments would be

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commissioned as a way to achieve a possible reward. Any money available to pay rewards would be better used in patient care.

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

Previous comments re peripatetic inspectors / accountants, together with regular visits from independent bodies. Even inspectors from outside the region.

Provision of Health Care should be based strictly on patients needs without giving preference to any particular group.

Good reliable monitoring by volunteering and statutory organisations.

GP Consortia should make sure all their members follow best practice with best value to give best outcomes. GPs that don't conform should be penalised financially

A recent report suggests that some doctors in affluent areas are prone to refer patients instead of treating them within the practice, either because the patient has insisted or because they do not have, or wish, to spend time with them. All consortia should include GPs from both deprived and wealthy areas, to ensure equality for all, as health inequalities stem directly from social and economic inequalities.

Recently there was a nationwide issue of invitations to persons between the ages of 35 and 70, who had not visited their doctor in the previous 12 months, to attend the surgery for a health check. This is clearly age discrimination and demonstrates an obvious inequality - this is another area to be addressed in order to improve the current situation.

Partnership

Patients and the Public (Questions on page 31)

How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

Health Watch/LINKs should be involved in the commissioning process e.g. Health & Wellbeing boards.

Strengthen and repeat local arrangements that are already in place. Build on these rather than developing new arrangement initially.

Using Health Watch which would be necessary, have to be enlarged from the present LINK organisations. They would need also professional backing.

By looking at what has worked in the past and best practice and feedback.

By setting up patient groups to include leaders of local community groups and representatives of local charities etc. in order to be informed, on a regular basis, of current options and availability. Carers and families should also be invited as many older people are unable, or unwilling, to visit their GP and these are the 'voices that are seldom heard'.

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Questionnaires and information leaflets placed in clinics; chemists; surgeries etc. The aforementioned newsletter would also be useful in disseminating information. PALS are very good but are not widely known and need to be approached in the first instance.

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?

Promote Health Watch/The LINK so that all views can be heard, enable HealthWatch to have the capacity to reach the community – the eyes and ears of the community.

Have fortnightly meeting at Health Watch Core Group/Steering Group meetings to find out what I really going on in the local community. More meeting with Practice Patient groups.

By setting up special meetings with such groups of which there are many voluntary ones. Local knowledge is fairly widespread but local charities such as Age Concern would be happy to identify many of them. By listening to their concerns and taking them on board a lot of solutions could be put in place.

The proposed Health Watch body could also provide information and help to identify relevant groups and provide them with information from the consortium.

How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient participation Groups?

Local Health Watch/LINKs has to be independent from the Consortia and the consortia should be consulted. The local Health Watch/LINKs must have a budget that allows it to be the coordinator/umbrella of all patient groups.

Developing respect.

By making people aware of Health Watch

Plenty of pre-planning meeting with OSC's and current LINK groups to cover larger issues than GP practice issues.

Put them on a more formal level with specific training; responsibilities and rules of governance etc. to give them a more formal standing, and presence, in the community. Ensure that partners share information and take them seriously. Look at their recent Annual Reports and form opinions on differing approaches and outcomes whilst questioning any anomalies which may appear.

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?

There should be no decisions made behind closed doors that affect patients and staff. Real consultation has to be done, not Box Ticking consultation.

Perhaps a sub-group of LINK/Health Watch be developed with special expertise.

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I'm in favour of opportunity. Equality of outcome for patients is paramount; equality of outcomes for staff would reward the incompetent as well as the competent. Paragraph 6.3 covers this.

Treat everyone equally regardless of status; address; lifestyle etc. Take time to listen to those who will speak up and encourage those who do not. Older people are often in awe of what they perceive as authority and wary of dismissal. As some people will not question a doctor, it should be mandatory to offer the best treatment and choice of hospital so that they feel involved in any decisions. All staff should be given full relevant information concerning any changes in their situation and offered solutions to any potential problems.

Annual staff reports, based on regular observation and discussion with them, would be sufficient to show that they are being motivated and supported to achieve good results and therefore to move onward and upward. Recognise skills and reward them and also recognise areas which can be improved and arrange further training where this would resolve the problem.

Local Government and Public Health (Questions on page 32 & 33)

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?

By giving time to meet with the relevant organisations. Also by not having a pre-agenda

Personal contact with the various parties and pre-planning with plenty of time for consultation. No excuses for not doing this. There are too many egos in local government and medical personnel. Go for it with good will.

GP to work with social care professionals and be involved with the local LINKs. Pool budgets to produce best outcomes must meet at least 6 times a year.

By keeping in touch with ongoing events within the Borough and arranging regular meetings with the LA to keep abreast of, and discuss, existing situations and (potential) problems, and proposals for solutions. Ensure that the best qualified local authority staff are involved - those who are best placed to take this project forward successfully - not just the most high profile people in post.

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 transitional to the new arrangements?

By looking at current Best Practice throughout the country.

Paragraphs 6.8 covers this. Speaking to the various people concerned before committing. Consultation, consultation, consultation.

GP must work with care trusts etc and improve outcomes. GP must take advice from care

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trusts, children's trusts. They must be involved in the decision making.

By bringing together, and meeting with, the bodies that have consistently demonstrated good results, in every relevant area, and issue guidelines as aids to advice and information. This should highlight current practices which will need to be preserved and built upon.

Other Health and Care Professionals (Questions on page 33)

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

By training off the job and by experience gathered and realising potential.

Strong, sensible leadership. Sift out the weak administrators and the rest will happen, Engage people who have not spent a lifetime in the NHS and mix them with the knowledgeable.

Health and WellBeing board must be formed, this involves GP consortia and all other Health and care Professionals including local authorities and the public to be involved on this board. Including LINKs/Health Watch

Commitment to best principles and building on current successful practices. All to be like minded and determined to succeed and unafraid of discarding long standing practices which have been unsuccessful. Sustainability will flow from recognition of success.

Other Comments

Do you have any other comments on this consultation? Please let us know here.

These are major changes which in general are good but should not be forced, though patient outcomes should be given preference. The decision should be open to public scrutiny.

With the LINK organisation becoming more heavily involved it is apparent the Health Watch will be inundated with extra duties/work. There should be expansions in the employed managers especially in the role of research assistants. Whether this could be achieved by utilising students from local colleges, universities or like establishments remains to be seen but it is worth investigating. The funding for Health Watch should be improved! That is over and above what is received at present.

This also should be carefully supervised, in certain large cities this has been a waste of funds, particularly in advertising the presence of LINK in these cities then for organisations to be unable to manage demand.

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I would also suggest that the volunteer service should receive more encouragement to grow as I see problems if the geographical boundaries are further stretched.

There is a large role for OSC's in this and a lot more should be done to encourage the future Health Watch.

Assuming that implementation does not precede analysis of the consultation results, and notice taken of feasible and sensible comments/suggestions, there should not be too many problems.

An important feature is that nothing should be left open to interpretation. Guidelines are good where appropriate but rules, particularly in relation to finance, governance and forms of reporting, should definitely be put in place.