London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

Tuesday 14 September 2010
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Andrew Johnson (Chairman) Councillor Oliver Craig Councillor Charlie Dewhirst Councillor Gavin Donovan Councillor Marcus Ginn Councillor Steve Hamilton	Councillor Iain Coleman Councillor Stephen Cowan Councillor Rory Vaughan (Vice-Chairman)	Maria Brenton, HAFAD

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http://www.lbhf.gov.uk/Directory/Council_and_Democracy

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Date Issued: 02 September 2010

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

14 September 2010

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 11
	(a) To approve the minutes of the meeting held on 24 June 2010.	
	(b) To note that there are no outstanding actions.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	
	If a Councillor has any prejudicial or personal interest in a particular item they should declare the existence and nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.	
	At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a prejudicial interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken unless a dispensation has been obtained from the Standards Committee.	
	Where Members of the public are not allowed to be in attendance, then the Councillor with a prejudicial interest should withdraw from the meeting whilst the matter is under consideration unless the disability has been removed by the Standards Committee.	
4.	**WORK PROGRAMME AND FORWARD PLAN 2010-2011**	12 - 18
	The Committee's work programme for the current municipal year is set out as Appendix A to this report. The list of items has been drawn up in consultation with the Chairman, having regard to relevant items within the Forward Plan and actions and suggestions arising from previous meetings of the Committee.	
	The Committee is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future. Members might also like to consider whether it would be appropriate to invite residents, service users, partners or other relevant stakeholders to give evidence to the Committee in respect of any of the proposed reports.	
	Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet, including Key Decisions within the portfolio areas of the Cabinet Member for Housing and the Cabinet Member for Community	

Care, which will be open to scrutiny by this Committee.

5. THE IMPLICATIONS FOR THE COUNCIL OF THE WHITE PAPER: EQUITY AND EXCELLENCE: LIBERATING THE NHS 19 - 129

The NHS White Paper was published in July and introduces a wide ranging reform programme including replacing PCTs with GP Commissioning Consortia and enhancing the public and community voice in NHS decision making.

This report explores the potential of the reforms in enhancing the role of local authorities and in particular what they mean for Hammersmith & Fulham and include:

- The establishment of a Health & Well-being Board
- The creation of a local Health Watch, as an enhancement to the current role of the Local Involvement Network (LINk)
- The transfer of the local public health function and capacity from PCT to local government
- The impact on the integration agenda between the Council and the PCT.

6. CARERS' STRATEGY REVIEW - PROGRESS UPDATE 130 - 161

This report provides an update on the carers' strategy action plan for adult carers.

7. CONSULTATION WITH RESIDENTS ON BRINGING THE HOUSING SERVICES BACK TO THE COUNCIL 162 - 174

The H&F Homes Board has agreed to lead on consulting with residents on the Council's proposal to directly manage the housing service. The presentation outlines the background to the consultation programme.

8. THREE BOROUGHS HEALTH SCRUTINY CHAIRMEN: MEETING NOTES 175 - 183

The notes of the Joint Three Boroughs Meeting of Health Scrutiny Chairman held on 23 June 2010 are attached as Appendix A.

The notes of the meeting with Imperial College Healthcare NHS Trust held on 07 July 2010 are attached as Appendix B.

9. DATE OF NEXT MEETING

The dates of the remaining meetings scheduled for this municipal year are as follows:

Tuesday 16 November 2010
Tuesday 18 January 2011
Tuesday 15 February 2011
Tuesday 12 April 2011

Glossary: Housing

Glossary: Health and Adult Social Care

Agenda Item 1

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Thursday 24 June 2010

PRESENT

Committee members: Councillors Andrew Johnson (Chairman), Rory Vaughan (Vice-Chairman), Iain Coleman, Stephen Cowan, Charlie Dewhirst, Gavin Donovan, Marcus Ginn and Steve Hamilton

Co-opted members: Maria Brenton (HAFAD)

Other Councillors: Joe Carlebach Cabinet Member for Community Care, Lucy Ivimy, Cabinet Member for Housing and Peter Tobias, Assistant to Cabinet Member (Health)

Officers: Lyn Garner (Assistant Director, Regeneration and Housing Strategy), Nick Johnson (Chief Executive, H&F Homes), Gary Marson (Principal Committee Co-ordinator), Sue Perrin (Committee Co-ordinator), James Reilly (Director of Community Services) and Sarah Whiting (Managing Director, NHS Hammersmith & Fulham)

1. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting of the Health and Adult Social Care Scrutiny Committee held on 25 February 2010 and the meeting of the Housing Scrutiny Committee held on 31 March 2010 be confirmed and signed as accurate records of the proceedings.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Oliver Craig and Mr Geoff Alltimes and apologies for lateness from Councillor Marcus Ginn.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED THAT:

The committee's membership and terms of reference as agreed at the Annual Meeting of the Council on 26 May 2010 be noted.

5. ELECTION OF VICE-CHAIRMAN

RESOLVED THAT:

Councillor Rory Vaughan be appointed as Vice-chairman.

6. APPOINTMENT OF CO-OPTED MEMBERS

RESOLVED THAT:

(a) Maria Brenton, Chair of HAFAD be appointed as a co-opted member for the 2010/2011 municipal year.

(b) The appointment of an additional co-opted member be considered at a future meeting.

(c) Expert witnesses be used as an alternative means of engaging with stakeholders.

7. INTRODUCTION TO SCRUTINY

Mr Marson presented an introduction to scrutiny, which included its role, principles and powers and also external scrutiny, the local arrangements and the work programme.

RESOLVED:

That the presentation be noted.

8. THE NEW GOVERNMENT'S PROPOSALS ON HEALTH AND THE LIKELY IMPACT ON HAMMERSMITH & FULHAM

Sarah Whiting presented the report, which set out the NHS priorities under the coalition government, and highlighted the following key points:

- An independent NHS Commissioning Board would be established to allocate resources and provide commissioning guidance, through regional offices, removing the need for separate strategic health authorities.

- GP consortia would commission services on behalf of their patients.

- Patients would have the right to choose their GP without restriction on location.

- The GP contract would be renegotiated and there would be incentives for the provision of improved access in disadvantaged areas.

- There would be directly elected PCT Board members, with the remainder appointed by local authorities.

Sarah Whiting outlined the three key target changes:

- Removal of primary care targets: 24/48 hour maximum wait and related patient experience.

- The 18 week referral to treatment target would be replaced with an average waiting times target.

- Four hour Accident & Emergency department target threshold down from 98% to 95%.

NHS Hammersmith and Fulham was required to cut its management costs by 16%. A funding deficit of £4-£5 billion in London had been predicted for 2016/0217.

The Healthcare for London programme, a top-down strategy for reforming services had been halted. Future and ongoing reconfiguration proposals would have to meet the following criteria:

- Support from GP commissioners

- Strengthened public and patient engagement

- Clarity on the clinical evidence base

- Consistency with current and prospective patient choice.

The PCTs were working with NHS London to construct the evidence to meet this criteria.

Ms Whiting stated that the payment system would reward excellence and be tough on poor quality, and hospitals would not be paid for treatment of patients re-admitted within 30 days of discharge.

Local authorities would play a key role in public health and addressing the wider determinants of ill-health. A focused Public Health service would be set up with 4% of NHS Budget ring fenced. The detail was not available, but it was likely that Public Health would include the Health Protection Agency, infection control and national programmes.

Ms Whiting concluded her presentation with the immediate challenges for 2010/2011:

- Reduce management costs
- Prepare GPs to lead commissioning
- Deliver key service improvement projects

In response to a question from Ms Brenton, Ms Whiting confirmed that NHS North West London had been established as an acute commissioning vehicle for the eight North West London PCTs.

Councillor Cowan queried the average waiting times target. Ms Whiting responded that it was not yet known how this target would be measured. Whilst the target included most elective surgery, it did not include specific targets such as the two week cancer wait.

Councillor Cowan then queried management costs. Ms Whiting responded that the management costs were detailed and defined in the PCT's accounts. The 16% savings was entirely focused on commissioning management costs.

Councillor Tobias stated that the GP consortia would have to be of sufficient size to challenge the large acute providers.

Councillor Carlebach suggested that, in this time of significant change, the PCT should not lose sight of health issues such as the increase in health inequalities, and added that the Hammersmith & Fulham Council/PCT integrated management was a good model.

Councillor Vaughan suggested that if hospitals were not paid for treatment of patients re-admitted within 30 days of discharge, it could result in enhanced treatment to prevent re-admission. Additionally, there should be a definition of re-admission, as a patient could be re-admitted for an entirely separate condition.

Ms Whiting responded to Councillor Donovan that children remained a key priority and that the PCT had a coherent strategy for targeting schools.

A member of the public queried the allocation of £150 million non-ring fenced money in respect of the national carers strategy. Ms Whiting responded that the allocation to carers had been increased in the current year and that local plans had been agreed in partnership with the Council.

RESOLVED:

1. That a further report be commissioned for the September meeting.

2. That the report be noted.

9. INTRODUCTION TO HOUSING SERVICES

Mr Johnson presented an introduction to the work of H&F Homes, and outlined progress against key challenges:

- The Decent Homes programme was on target for completion by December 2010.

- Transforming Services and Value for Money: the Invest to Save Programme had been successfully implemented, although there had been a £4.4 million housing subsidy loss from 2009. Investment by the Council had resulted in a full year savings of £3.6 million for 2010/2011, and a reduction of 48 posts.

- Improving Services to Leaseholders – charges have been driven down by an average of 14%.

- Increasing Resident Satisfaction was being targeted in the current year.

- H&F Homes would consult on merging back with the Council in 2012.

Ms Garner then presented the following Housing Strategy and Housing Options Challenges in 2010/2011:

- Prevention of Homelessness

- Housing Benefit Changes

- Building more affordable and modern homes

- Involving local people in Estates improvements:

    - Fulham Court: £10 million programme, with a residents steering group

    - Edward Woods: £16 million improvements to high rise blocks

- Training and employment opportunities, including West Kensington, Earls Court/Transport for London land regeneration from which significant benefits could be derived, if supported by residents.

Councillor Tobias queried the extent to which overcrowding impacted on health. Ms Garner responded that the Council recognised the distinct link, and encouraged tenants to move to larger dwellings. Initiatives included: extensions and conversions; and the provision of additional accommodation for grown up children. Councillor Ivimy added that the Council had a programme to acquire large family houses to address the acute shortage within the borough.

Ms Garner responded to Councillor Cowan that 13% of the housing stock was estimated to be overcrowded. There was no statutory definition of overcrowding, but it was deemed to be families needing more that one additional bedroom.

Ms Garner stated that under occupation was also an issue and incentives to downsize included re-decoration and investment in new property. Currently, financial incentives were not offered.

Councillor Cowan queried resident satisfaction. Mr Johnson responded that H&F homes worked with HAFTRA and with residents groups. There were tenant and resident representatives on the H&F Homes Board and Area Housing Forums. Clear priorities had been identified in respect of the Decent Homes standard, the quality of repairs and the caretaking service.

Mr Johnson stated that a satisfaction survey had been undertaken and agreed to circulate the report.

Mr Johnson responded to Councillor Cowan's query in respect of the management structure, that all posts were full time.

Councillor Cowan requested the costs for the management structure and the back office costs, and evidence that improvements and savings had been focused on back office staff, not front line services. Mr Johnson agreed to provide the information which had been reported to the H&F Homes Board.

Councillor Cowan queried how H&F Homes ensured that all complaints were registered. Mr Johnson responded that the system had been computerised over the previous year and agreed to provide the monthly complaints report, which was monitored by the Board.

Ms Garner responded to Councillor Cowan's question in respect of homelessness that there had been an increase in intermediate housing, both rented and shared ownership, split equally between income levels of £20,000, £40,000 and £60,000.

In respect of the 929 families housed in the previous year, 600 had been council lets, and there had been new dwellings from Registered Social Landlord building. Private lettings were not included in these figures.

Councillor Cowan requested information in respect of the definition of homelessness preventions. Ms Garner responded that the definition included people who were not accepted as homeless, for whom alternative accommodation was found by, for example providing a rent deposit guarantee or the provision of designated single person accommodation, rather then bed and breakfast. Additionally, some applicants did not meet the criteria for social housing.

In response to queries from Councillor Tobias and Councillor Vaughan in respect of the 52,000 repairs, Mr Johnson stated that the figure represented 52,000 repair requests. A review of the investment programme was underway, and if as anticipated the housing revenue account continued, the Council would invest this in a more ambitious lift replacement programme. The Decent Homes programme was in respect of specific standards, and individual repairs were not necessarily part of this programme.

Ms Brenton requested assurance that the accessible housing register was to be maintained. Mr Johnson confirmed that this was a formal requirement of the Audit Commission, and it was intended to ensure that this was maintained.

Ms Garner confirmed to Councillor Ginn that, in respect of homelessness the Council worked with charities, for example the YMCA and with supported housing charities.

Mr Johnson confirmed to Councillor Cowan that the provision of supervision and support of the two Assistant Directors had transferred to him to enable James Reilly to focus on the integration of the Council and the PCT.

Councillor Cowan requested information in respect of the West Kensington re-development. Mr Johnson responded that consultation would provide the opportunity for the community to look at the proposals in greater depth. The re-development of the Gibbs Green Estate would provide a new home for every tenant and leaseholder, and the acceptability of the proposals was being discussed with residents. Councillor Ivimy stated that the information given to tenants could be shared but detailed information was not currently available.

A member of the public queried the cost effectiveness of the work currently being carried out in West Kensington. Mr Johnson responded that new kitchens, windows and other work was being undertaken in respect of the Decent Homes Programmes. The cost was in the region of £4 million, and would be cost effective because the re-development of the estate was a 15/20 year programme.

RESOLVED:

That the report be noted.

ACTION:

That the following information be provided:

(a) Report on satisfaction survey.

(b) Board reports on management and back office costs and improvements and cost reductions.

(c) Board report on complaints.

(d) Analysis of the homelessness preventions.

(e) Re-development of the Gibbs Green Estate.

ACTION: Chief Executive, H&F Homes/AD Regeneration and Housing Strategy

10. HAMMERSMITH & FULHAM LINK: UPDATE REPORT

RESOLVED THAT:

The Hammersmith and Fulham Local Involvement Network (H&F LINk) update report be noted.

11. SCRUTINY DEVELOPMENT AREA: HEALTH INEQUALITIES

The committee received a report in respect of the successful bid by seven of the North West London Health Scrutiny Committees to become one of nine Scrutiny Development Areas across the country as part of the Centre for Public Scrutiny's Reducing Health Inequalities programme.

RESOLVED THAT:

(a) The committee recommends to the Overview and Scrutiny Board that a Task Group be established in respect of the Scrutiny Development Area: Health Inequalities project.

(b) The committee recommends that membership of the committee includes Councillors Tobias, Vaughan and Cowan.

12. INTRODUCTION TO AND CHALLENGES IN ADULT SOCIAL CARE

Mr Reilly informed of the change in his role, whereby, in addition to responsibility for adult social care, he was a PCT director with responsibility for a portfolio of services.

Mr Reilly then presented the key issues in community services, which included the following key national policy issues and community service local priorities:

National Policy Issues

- Sustainable funding, balancing state and individual contribution – National Commission
- Integration – joined up access, assessment and service provision with health and supported housing
- Personalisation – extending choice and control through individual budgets
- Prevention – recovery and rehabilitation.

Community Services Local Priorities

- Strengthen Safeguarding of Vulnerable People
- Extend Personalised Budgets to 36% of users by April 2010
- Extend re-ablement services to all assessments for home care

- Complete contract renewals in Adult Social Care, Supported Housing and voluntary sector

- Progress integration with local health services – prevention and service re-design

- Identify and deliver efficiency savings

- Quality Assurance and improved support services

Councillor Dewhirst queried the prevalence of people with mental health needs. Mr Reilly responded that this could be attributed to Hammersmith and Fulham being an inner London borough, with areas of high deprivation, a high percentage of older and single people and alcohol and drugs abuse.

In response to queries from Councillor Vaughan, Mr Reilly stated that the PCT in conjunction with the West London Mental Health Trust, would consult on services based around St. Vincent's Day Hospital. Other initiatives included: the provision of memory clinics; updating of GP registers to capture all dementia sufferers, deemed to be around 1,000 people and the provision of specialist nurse support services.

Mr Reilly stated that personalised budgets was a three year programme ending in March 2012. There was no formal target beyond 36% of all users by April 2011. However, the Council was aiming to achieve 50% in 2011. Personalised budgets were being offered to all new entrants.

Mr Reilly responded in respect of conflict in his integrated role between the Council and PCT in respect of delayed discharges from hospital into social care that it was unlikely but possible, and that there was a particular issue in respect of mental health services where discharges were dependent on people being offered continuing care.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the committee extended the meeting by 15 minutes.

Councillor Coleman queried the letter to all carers in respect of the Carers' Centre. Mr Reilly responded that the Carers' Centre did not meet required standards and the contract would not be renewed at the end of July 2010. Interim arrangements would be put in place to ensure that support was safeguarded.

Mr Reilly stated that there would be no reduction in the carers' budget in the current financial year, but he was unable to comment on future years.

Mr Reilly then responded to Councillor Cowan that every element would be resourced to the level in the contract. The Carers' Centre would not be re-provided in Hammersmith Road, and carers would be able to access support groups and activities in various locations across the borough rather than just one building.

Mr Reilly stated that the lease on the Carers' Centre would end in August, and the building would be subject to normal Council procedures in respect of alternate use or disposal.

Councillor Cowan queried whether the PCT budget of £85 million had previously been two separate budgets. Mr Reilly responded that the money represented health budgets for community health, mental health, offender health and other community health service funds for a range of services including community services and mental health services. Council budgets for Adult Social Care and Supported Housing were £104 million, including a small number of joint funds. The PCT budget in Mr Reilly's area was £75 million.

Mr Reilly stated that NHS efficiency targets were excluded from Council efficiency targets, which were subject to the medium term financial strategy process. The Council would not be cutting vital services, but prioritising and re-designing services to provide services at a lower cost, for example people being treated at home. However, there were serious risks, such as raising the eligibility criteria.

Mr Reilly stated that where mental health patients were treated out of area, the costs transferred with them when they returned to their home borough.

13. WORK PROGRAMME AND FORWARD PLAN 2010-2011

RESOLVED THAT:

(a) The work programme be agreed.

(b) The following items be added to the work programme:

- Health White Paper
- Overcrowding
- Regeneration projects
- Voluntary sector – working in partnership
- Housing benefits

14. DATES OF NEXT MEETINGS

14 September 2010
16 November 2010
18 January 2011
15 February 2011
12 April 2011

Meeting started: 7.02 pm
Meeting ended: 10.15 pm

Chairman .....

Contact officer: Sue Perrin
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London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
14 September 2010	Work Programme and Forward Plan 2010-2011	All Wards

SYNOPSIS

The draft work programme has been drawn up, in consultation with the Chairman, from items in the Forward Plan and from action arising from previous meetings of the Housing, Health and Adult Social Care Select Committee and its predecessor committees.

The committee is requested to consider the items within the proposed work programme set out at Appendix A to this report and suggest any amendments or additional topics to be included in the future.

Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet, including Key Decisions within the portfolio areas of the Cabinet Member for Community Care and the Cabinet Member for Housing, which will be open for scrutiny by this committee.

CONTRIBUTORS

Finance and Corporate Services

RECOMMENDATION(S):

That the committee considers and agrees its proposed work programme, subject to update at subsequent meetings of the committee.

NEXT STEPS

CONTACT

Sue Perrin
020 8753 2094

LOCAL GOVERNMENT ACT 2000

LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Forward Plan, September – December 2010	Sue Perrin/Extension 2094	Hammersmith Town Hall

APPENDIX A

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE, WORK PROGRAMME 2010/2011

June 2010
The New Government's Proposals on Health and the Likely Impact on Hammersmith & Fulham
Introduction to Housing Services
Introduction to and Challenges in Adult Social Care
September 2010
The Implications for the Council of the White Paper: Equity and Excellence; Liberating the NHS
Carers' Strategy Review: Progress Report
Residents Consultation on Housing
November 2010
Housing Benefit Changes
Other Items
Commissioning of Learning Disabilities Services to include: Employment and Day Opportunities
CSD Business Plan and HFH Delivery Plan
Estate Regeneration
GP Surgeries • Access • Incentives for GPs to move into the north of the borough • Patient Experience: Monitoring Poly-systems: Update report, to include: • Polyclinics opened/planned and services offered • Evaluation in terms of patient experience, access to services, clinical effectiveness and value for money
H&F LINk: quarterly updates
Home Care and Housing Related Support: Update

Housing Allocations Scheme: Post Implementation Review
Housing Initiatives: Progress Report (to include Overcrowding)
Leaseholder Services
Local Development Framework
Maternity Services, to include: Quality and continuity of care for mothers and babies
NHS Hammersmith and Fulham Mental Health Services: Update Report to include Employment and Day Opportunities
Nuisance and Dangerous Dogs
Offender Health Care
Older People's Strategy
Personal Health Budgets
Regeneration Projects
Voluntary Sector – Working in Partnership

Briefing Reports
Safeguarding Adults: Annual Report

Appendix B

FORWARD PLAN OF KEY DECISIONS

Proposed to be made in the period September 2010 to December 2010

The following is a list of Key Decisions, as far as is known at this stage, which the Authority proposes to take in the period from September 2010 to December 2010.

KEY DECISIONS are those which are likely to result in one or more of the following:

- **Any expenditure or savings which are significant, regarding the Council's budget for the service function to which the decision relates in excess of £100,000;**
- **Anything affecting communities living or working in an area comprising of two or more wards in the borough;**
- **Anything significantly affecting communities within one ward (where practicable);**
- **Anything affecting the budget and policy framework set by the Council.**

The Forward Plan will be updated and published on the Council's website on a monthly basis. (New entries are highlighted in yellow).

NB: Key Decisions will generally be taken by the Executive at the Cabinet. The items on this Forward Plan are listed according to the date of the relevant decision-making meeting.

If you have any queries on this Forward Plan, please contact
***Katia Richardson** on 020 8753 2368 or by e-mail to katia.richardson@lbhf.gov.uk*

Consultation

Each report carries a brief summary explaining its purpose, shows when the decision is expected to be made, background documents used to prepare the report, and the member of the executive responsible. Every effort has been made to identify target groups for consultation in each case. Any person/organisation not listed who would like to be consulted, or who would like more information on the proposed decision, is encouraged to get in touch with the relevant Councillor and contact details are provided at the end of this document.

Reports

Reports will be available on the Council's website (www.lbhf.org.uk) a minimum of 5 working days before the relevant meeting.

Decisions

All decisions taken by Cabinet may be implemented 5 working days after the relevant Cabinet meeting, unless called in by Councillors.

Making your Views Heard

You can comment on any of the items in this Forward Plan by contacting the officer shown in column 6. You can also submit a deputation to the Cabinet. Full details of how to do this (and the date by which a deputation must be submitted) are on the front sheet of each Cabinet agenda.

LONDON BOROUGH OF HAMMERSMITH & FULHAM: CABINET 2009/10

Leader:	**Councillor Stephen Greenhalgh**
Deputy Leader (+Environment and Asset Management):	**Councillor Nicholas Botterill**
Cabinet Member for Children's Services:	**Councillor Helen Binmore**
Cabinet Member for Community Care:	**Councillor Joe Carlebach**
Cabinet Member for Community Engagement:	**Councillor Harry Phibbs**
Cabinet Member for Housing:	**Councillor Lucy Ivimy**
Cabinet Member for Residents Services:	**Councillor Greg Smith**
Cabinet Member for Strategy:	**Councillor Mark Loveday**

Forward Plan No 100 (published 13 August 2010)

LIST OF KEY DECISIONS PROPOSED SEPTEMBER 2010 TO DECEMBER 2010

Where the title bears the suffix (Exempt), the report for this proposed decision is likely to be exempt and full details cannot be published.

New entries are highlighted in yellow.

* All these decisions may be called in by Councillors; If a decision is called in, it will not be capable of implementation until a final decision is made.

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
Cabinet	14 Oct 2010 Reason: Expenditure more than £100,000	**Hostel improvement works** Seeking to reinvest capital receipts from the hostel disposal programme to invest in the hostel stock in order to bring them up to a decent standard and to provide an additional 3 disabled units.	Cabinet Member for Housing Ward(s): Askew; College Park and Old Oak; Fulham Broadway; North End; Wormholt and White City;
Cabinet	14 Oct 2010 Reason: Expenditure more than £100,000	**Regeneration of 248 Hammersmith grove - Compulsory Purchase Order Powers** This report proposes the Council agrees that offers may, if necessary, apply for Compulsory Purchase Order powers on resident leaseholders at 248 Hammersmith Grove in order to facilitate the disposal of the Council's headlease to NHHG.	Cabinet Member for Housing Ward(s): Hammersmith Broadway;
Cabinet	14 Oct 2010 Reason: Significant in 1 ward	**Fulham Court Estate Improvement Strategy: Phase Physical improvements** The Integrated Children's & Community Centre is one element of phase 1 of the physical improvements programme. Tender Acceptance: This report seeks to accept a tender and award a contract to build the integrated Children's & Community Centre, subject to Planning consent.	Cabinet Member for Housing, Cabinet Member for Children's Services Ward(s): Town;

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTE

DATE	TITLE	Wards
14th September 2010	**The implications for the Council of the White Paper: Equity and Excellence: Liberating the NHS**	All Wards

SYNOPSIS

The NHS White Paper was published in July and introduces a wide ranging reform programme including replacing PCTs with GP Commissioning Consortia and enhancing the public and community voice in NHS decision making.

This report explores the potential of the reforms in enhancing the role of local authorities and in particular what they mean for H&F and include:

- The establishment of a Health & Well-being Board
- The creation of a local Health Watch, as an enhancement to the current role of the Local Involvement Network (LINk)
- The transfer of the local public health function and capacity from PCT to local government
- The impact on the integration agenda between the Council and the PCT.

CONTRIBUTORS

Geoff Alltimes, Joint Chief Executive
Sarah Whiting, Managing Director, NHSHF
James Reilly, Director of Community Services

RECOMMENDATION(S):

The Board is asked to comment on the proposals for inclusion in the Council's response to the consultation and on the recommendations that:

a) The Council explore with the GP Practice Based Commissioning Steering Group (GP PBC) and the PCT the possibility of

establishing a Health & Well-being Board in line with the proposals set out in the White Paper.

b) The Council explore with the GP PBC Steering Group ways in which the Council would support GP commissioning consortia in performing their roles.

CONTACT

David Evans, Ext: 2154

NEXT STEPS

Local GPs will elect a GP Practice Based Commissioning Steering Group (GP PBC) on 3 September, following which the Council and PCT will establish discussions around the model we can develop locally and the transition arrangements.

The Joint Cabinet/PCT Board will meet on 16 September to agree the priorities for the transition period.

The Council will submit its response to the consultation by 5 October 2010.

1. Introduction

1.1 The White Paper Equity & Excellence: Liberating the NHS is the first of three White Papers which will have a significant impact on the role of the Council in health, social care and public health. It was published for consultation which closes on 5 October (11 October for the supporting papers). The other White Papers are:

- Public Health – due December 2010
- Social Care – due July 2011

1.2 Equity & Excellence, sets out the government's strategy for the NHS. Its intention is to create an NHS which is more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability. A briefing providing an overview of the paper was circulated to all members of the Board in July.

1.3 Specific aspects of the White Paper are explored in more detail in five supporting papers:

- Local democratic legitimacy in health (Appendix 1)
- Commissioning for Patients (Appendix 2)
- Regulating healthcare providers
- Transparency in outcomes: a framework for the NHS
- The review of arm's –length bodies

1.4 This report looks in more detail at the enhanced role of the local authority and governance aspects of the following proposals:

- The establishment of a Health & Well-being Board
- The creation of a local Health Watch, as an enhancement to the current role of the Local Involvement Network (LINk)
- The impact on the integration agenda between the Council and the PCT.

2. Focus on voice

2.1 As well as the significant proposal to give responsibility for the commissioning of most health services to GP Commissioning Consortia, the focus of the White Paper is on enhancing patient and local community "voice" in influencing the NHS.

2.2 *Local democratic legitimacy in health* sets out a number of proposals for an enhanced role for local authorities, through elected members. The intention being to bring the perspective of local place – of neighbourhoods and communities - into commissioning plans.

2.3 Local authorities are set to have a role in being able to take a broader, more effective view of health improvement and are uniquely placed to promote integration of local services across the NHS, social care and public health.

3. Health & Well-being Board

3.1 There is a proposal for a statutory obligation for the local authority and commissioners to participate in a local health and well being board. The primary aim would be to promote integration and partnership working between the NHS, social care, public health and other local services. It will allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services and the wider local authority agenda. Neighbouring boroughs may establish a single board covering their combined areas.

3.2 The Health & Well-being Board will have an executive function bringing in partners from across health, social care and public health and will mean that local authorities will have greater responsibility in four areas:

- Supporting local voice, and the exercise of patient choice.
- Promoting joined up commissioning of local NHS services, social care and health improvement.
- Leading on local health improvement and prevention activity.
- Leading joint strategic needs assessment (JSNA) to ensure coherent and co-ordinated commissioning strategies.

3.3 The ambition is to establish an effective partnership between the Council and GP commissioners with two primary accountabilities to;

- the end service user; and
- to the community.

3.4 It is envisaged that the membership of the board would include:

- The Leader of the Council.
- Directors of social care, children's services and public health.
- NHS commissioners; GP consortia and (where relevant) the NHS Commissioning Board.
- Representation from the local HealthWatch.
- Representation from the voluntary sector and other public services would be at the discretion of the local authority.
- Where appropriate, providers may also be involved.

3.5 The White Paper documentation asks explicitly for responses to the question whether these boards are a necessary mechanism or should be optional, left to voluntary local determination. Without such a board it is hard to see how individual and community voice will be centre stage, also how accountability for significant levels of joint resources and activity would be managed or how the specific duties placed on the statutory bodies can be fulfilled.

3.6 The Health & Well Being Boards are intended to be a mechanism by which the "voice" of patients/users, the community and their elected representatives influence the local agenda of the commissioning bodies for health delivery and improvements. They are also the proposed mechanism by which the commissioning bodies i.e. Councils

and GP Consortia, will drive their agreed integration agendas and support these with combined resources and where joint accountability over pooled resources can be most easily exercised.

3.7 The proposal indicates that the two primary commissioning bodies: the GP Consortia and the Council must be members and that the Council is to lead and chair (this would not necessarily be followed in the leadership arrangements for any subsidiary boards) with the Leader and other executive members participating.

3.8 In this transitional period the Board could be established in a shadow form to build on the current arrangements where the Council Cabinet and PCT Board meet to set some joint priorities, steer future plans and be informed of progress.

3.9 The Board, will exercise substantial oversight and sign off rights over service reconfiguration plans, with a power to refer them to the National Commissioning Board or Secretary of State. It will also set plans, commit resources and oversee and sign off changes to substantive parts of the parent organisations business which will distinguish it from other forms of partnership working.

3.10 The White Paper allows for the possibility that a Health & Well Being Board can be established which covers more than one location which offers the opportunity to explore combining activity for a wide range of functions across NHS and Council with our counterparts in Westminster and Kensington & Chelsea.

3.11 The Board would also have a role in enabling the NHS Commissioning Board to assure itself that GP consortia are fulfilling their duties effectively.

4. Health Watch

4.1 The collective voice of patients will be strengthened through the establishment of Health Watch England, as an independent consumer champion. Local Involvement Networks (LINks) will be strengthened to be the local version as local Health Watch.

4.2 This will perform a wider role to become a “citizen’s advice bureau” for health and social care with additional funding to cover new responsibilities, including:

- NHS complaints advocacy services, currently a national function which will be devolved to local authorities who will commission either the national or local Health Watch to support patients in making a complaint.
- Providing patients and users with information to support individuals to exercise greater choice.
- Ensuring some degree of direct public accountability

4.3 Local authorities will be responsible for ensuring that local Health Watch are operating effectively and putting in place better arrangements if necessary.

4.4 In H&F both the council and the PCT have invested and supported a range of organisations and processes to increase the engagement and empowerment of individual and community. This paper assumes that the Council accept the spirit of this reform and will seek to realise the vision of engaging and empowering consumers and community interests more robustly and routinely.

4.5 Consideration will also need to be given to whether the support arrangements for Health Watch are established at the level of the three localities. However, given the mission to engage individuals and communities it is envisaged that however organised, Health Watch will need to be very present in each of the localities.

5. Health Improvement through a local Public Health Service

5.1 Some responsibility for health improvement and public health functions will be transferred directly to local authorities from the NHS. This will complement a new national public health service. This is in recognition that local government has a significant role in affecting the wider determinants of health and in delivering health improvements.

5.2 Details of what this will mean in practice are expected in the Public Health White Paper in December, although the Director of Public Health will be employed directly by the Council. Key issues which remain to be determined include:

- Clarity over what services, staff and resources will transfer from PCTs to local authorities.
- The resource allocation formula for core public health functions, and the process by which this will be channelled to local authorities.
- In London there is already a strand of work going on between NHS London, London Councils and the GLA on the division of labour.

5.3 Details are still awaited, however for illustrative purposes the services expected to comprise the broad public health function are listed in Table 1:

Table 1: Potential public health model – for illustrative purposes only
Core Public Health Services
• Screening • Immunisation • Smoking cessation • Environmental health (already within local government). • Health protection / Emergency Planning
Public health upstream – preventative services
• Working through Council departments to promote health and prevent illness / injury (advocacy, advice, training in generic public health skills etc) • Working with and through school health services and children's centres
Assessment, evaluation, analysis and intelligence
• JSNA, Health Impact Assessments and whole systems evaluation • Provide data, intelligence and information for commissioning and performance management • Evidence gathering of best practice, cost effectiveness etc. • Support Local Health Watch through the provision of data, information and training
Community and public engagement
• Social marketing and information, education and communication • Local Expert Patient Programmes and community-based providers (especially in third sector)

6. Implications for integration in H&F

6.1 The White Paper reaffirms the mandate for councils and GP consortia to continue deeper integration and duties of partnership. The issue for the Council is how to sustain the momentum with GP consortia. The Council is already signed up to deep integration with the PCT as demonstrated by the commissioning teams for children's and adult's health, social care and supported housing services. This already brings together £395m in commissioning services.:

- Children's(£15m)
- Adult social care and supported housing (£104m).
- PCT spend (£276.5m).

6.2 In order to progress the reform agenda it is necessary to focus on what needs to happen during the transition period. The PCTs in the sector are working to develop arrangements for transition that meet the management cost target i.e. 67% reduction by 2013. This is being discussed with councils and GP PBC with a view to producing proposals for consultation in the Autumn.

6.3 Locally, the Council is interested in exploring the potential opportunities of integration across the health and social care system with the GP PBC, PCT, neighbouring boroughs and providers.

6.4 It is imperative to set the pace if service improvement and financial targets are to be achieved. Initial discussions indicate that the GP PBC, PCT and Council would want to take up these opportunities in shadow form sooner rather than later in the course of 2011, however, there will be risks involved in such an approach, namely:

- The disruption the transition arrangements will create and the impact that they could have on financial control and service performance.
- The GP Consortium may choose to continue some of these proposals and not others.

6.5 The implications of the White Paper will be also discussed at the Joint Council Cabinet/PCT Board Meeting (16 September) and the Overview and Scrutiny Board (21 September).

7. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE SERVICES

7.1 The Council is already committed to close integration with the PCT through the commissioning teams for children's and adult health, adult social care and supported housing services involving budgets of around £395m per annum.

7.2 Establishment of an effective partnership between the Council and the GP commissioners will be essential for the further development of cost effective services within the resources likely to be available for the Council and Health in the future.

7.3 Implementation of the arrangements for Public Health will depend in practice upon the level of funding allocated through the new national funding arrangements.

8. COMMENTS OF THE ASSISTANT DIRECTOR (LEGAL AND DEMOCRATIC SERVICES)

8.1 There are no direct legal implications at this stage.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Equity & Excellence: Liberating the NHS Supporting papers: - Local democratic legitimacy in health - Commissioning for Patients - Regulating healthcare providers - Transparency in outcomes: a framework for the NHS - The review of arm's –length bodies	David Evans, ext 2154	Finance & Corporate Services

NHS

Equity and excellence:

Liberating the NHS

DH Department of Health

Equity and excellence: Liberating the NHS

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Foreword

The NHS is a great national institution. The principles it was founded on are as important now as they were then: free at the point of use and available to everyone based on need, not ability to pay. But we believe that it can be so much better – for both patients and professionals.

That's why we've set out a bold vision for the future of the NHS - rooted in the coalition's core beliefs of freedom, fairness and responsibility.

We will make the NHS more accountable to patients. We will free staff from excessive bureaucracy and top-down control. We will increase real terms spending on the health service in every year of this Parliament.

Our ambition is to once again make the NHS the envy of the world. *Liberating the NHS* - a blend of Conservative and Liberal Democrat ideas - sets out our plans to do this.

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving front-line staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.

Prime Minister

Deputy Prime Minister

Secretary of State for Health

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1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

2. We will increase health spending in real terms in each year of this Parliament.

3. Our goal is an NHS which achieves results that are amongst the best in the world.

Putting patients and public first

4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

    a. Shared decision-making will become the norm: *no decision about me without me*.

    b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

    c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.

    d. The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

    e. The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.

    f. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.

    g. We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.

Improving healthcare outcomes

5. To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all:

    h. The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification.

    i. A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire cannot go undetected.

    j. Quality standards, developed by NICE, will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards.

    k. We will pay drug companies according to the value of new medicines, to promote innovation, ensure better access for patients to effective drugs and improve value for money. As an interim measure, we are creating a new Cancer Drug Fund, which will operate from April 2011; this fund will support patients to get the drugs their doctors recommend.

    l. Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice.

    m. Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality.

Autonomy, accountability and democratic legitimacy

6. The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level:

    n. The forthcoming Health Bill will give the NHS greater freedoms and help prevent political micromanagement.

    o. The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia.

    p. To strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.

q. We will establish an independent and accountable NHS Commissioning Board. The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. We will limit the powers of Ministers over day-to-day NHS decisions.

r. We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.

s. Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.

t. We will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.

u. We will ring-fence the public health budget, allocated to reflect relative population health outcomes, with a new health premium to promote action to reduce health inequalities.

Cutting bureaucracy and improving efficiency

7. The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change:

v. The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes.

w. The Government will reduce NHS management costs by more than 45% over the next four years, freeing up further resources for front-line care.

x. We will radically delayer and simplify the number of NHS bodies, and radically reduce the Department of Health's own NHS functions. We will abolish quangos that do not need to exist and streamline the functions of those that do.

Conclusion: making it happen

8. We will maintain constancy of purpose. This White Paper[1] is the long-term plan for the NHS in this Parliamentary term and beyond. We will give the NHS a coherent, stable, enduring framework for quality and service improvement. The debate on health should

no longer be about structures and processes, but about priorities and progress in health improvement for all.

9. This is a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS. We are setting out plans for managing change, including the transitional roles of strategic health authorities and primary care trusts. Implementation will happen bottom-up.

Many of the commitments made in this White Paper require primary legislation and are subject to Parliamentary approval.

1. Liberating the NHS

Our values

1.1 It is our privilege to be custodians of the NHS, its values and principles. We believe that the NHS is an integral part of a Big Society, reflecting the social solidarity of shared access to collective healthcare, and a shared responsibility to use resources effectively to deliver better health.

1.2 We are committed to an NHS that is available to all, free at the point of use, and based on need, not the ability to pay. We will increase health spending in real terms in each year of this Parliament.

1.3 The NHS is about fairness for everyone in our society. It is about this country doing the right thing for those who need help. We are committed to promoting equality[2] and will implement the ban on age discrimination in NHS services and social care to take effect from 2012. The NHS Commissioning Board will have an explicit duty to address inequalities in outcomes from healthcare services.

1.4 We will uphold the NHS Constitution, the development of which enjoyed cross-party support. By 2012, the Government will publish the first statement of how well organisations are living by its letter and spirit.[3] The NHS Constitution codifies NHS principles and values, and the rights and responsibilities of patients and staff. It is about mutuality; and our proposals in chapter 2 for shared decision-making by patients, their carers, and clinicians will give better effect to this principle. It is also about NHS-funded organisations being good employers; and our plans in chapter 4 will give organisations and professionals greater freedoms, leading to better staff engagement and better patient care.

1.5 Current statutory arrangements allow the Secretary of State a large amount of discretion to micromanage parts of the NHS.[4] We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved. We will legislate to establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities. We will use our powers in order to devolve them.

The NHS today

1.6 At its best, the NHS is world-class. The people who work in the NHS are among the most talented in the world, and some of the most dedicated public servants in the country. Other countries seek to learn from our comprehensive system of general

practice, and its role as the medical home for patients, providing continuity of care and coordination. The NHS has an increasingly strong focus on evidence-based medicine, supported by internationally respected clinical researchers with funding from the National Institute for Health Research, and the National Institute for Health and Clinical Excellence (NICE). Other countries admire NHS delivery of immunisation programmes. Our patient participation levels in cancer research are the highest in the world.[5]

1.7 We will build on the ongoing good work in the NHS. We recognise the importance of Lord Darzi's work, in putting a stronger emphasis on quality.

1.8 Compared to other countries, however, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare,[6] rates of mortality from some respiratory diseases and some cancers,[7] and some measures of stroke[8] have been amongst the worst in the developed world.[9] In part this is due to differences in underlying risk factors, which is why we need to re-focus on public health. But international evidence also shows we have much further to go on managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions;[10] the incidence of MRSA infection has been worse than the European average;[11] and venous thromboembolism causes 25,000 avoidable deaths each year.[12]

1.9 The NHS also scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Too often, patients are expected to fit around services, rather than services around patients. The NHS is admired for the equity in access to healthcare it achieves; but not for the consistency of excellence to which we aspire. Our intention is to secure excellence as well as equity.

Our vision for the NHS

1.10 We can foresee a better NHS that:

- **Is genuinely centred on patients and carers;**
- **Achieves quality and outcomes that are among the best in the world;**
- **Refuses to tolerate unsafe and substandard care;**
- **Eliminates discrimination and reduces inequalities in care;**
- **Puts clinicians in the driving seat and sets hospitals and providers free to innovate, with stronger incentives to adopt best practice;**

- **Is more transparent, with clearer accountabilities for quality and results;**
- **Gives citizens a greater say in how the NHS is run;**
- **Is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices;**
- **Is more efficient and dynamic, with a radically smaller national, regional and local bureaucracy; and**
- **Is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.**

1.11 This is our vision. It is based on our commitment to NHS values and principles, and is about building on what is best in the NHS today, and striving for continual improvement, while being open and honest about shortcomings. Our strategy to implement this vision draws inspiration from the coalition principles of freedom, fairness and responsibility[13].

1.12 The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic. The Government will liberate the NHS from excessive bureaucratic and political control, and make it easier for professionals to do the right things for and with patients, to innovate and improve outcomes. We will create an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patients they serve and the taxpayers who fund them.

1.13 The current architecture of the health system has developed piecemeal, involves duplication, and is unwieldy. Liberating the NHS, and putting power in the hands of patients and clinicians, means we will be able to effect a radical simplification, and remove layers of management. We will build on key aspects of the existing arrangements: for example, a number of GP consortia are likely to emerge from practice-based commissioning clusters and Monitor will become the economic regulator.

Improving public health and reforming social care

1.14 Liberating the NHS will fundamentally change the role of the Department. Its NHS role will be much reduced and more strategic. It will focus on improving public health, tackling health inequalities and reforming adult social care.

1.15 We will set out our programme for public health in a White Paper later this year. The forthcoming Health Bill will support the creation of a new Public Health Service, to integrate and streamline existing health improvement and protection bodies and

functions, including an increased emphasis on research, analysis and evaluation. It will be responsible for vaccination and screening programmes and, in order to manage public health emergencies, it will have powers in relation to the NHS matched by corresponding duties for NHS resilience.

1.16 PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service. The Department will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

1.17 The Department will continue to have a vital role in setting adult social care policy. We want a sustainable adult social care system that gives people support and freedom to lead the life they choose, with dignity. We recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including carers. We will seek to break down barriers between health and social care funding to encourage preventative action. Later this year we will set out our vision for adult social care, to enable people to have greater control over their care and support so they can enjoy maximum independence and responsibility for their own lives. The Department will continue to work closely with the Department for Education on services for children, to ensure that the changes in this White Paper and the subsequent public health White Paper support local health, education and social care services to work together for children and families.

1.18 The Department will establish a commission on the funding of long-term care and support, to report within a year. We understand the urgency of reforming the system of funding social care. The Commission will consider a range of ideas, including both a voluntary insurance scheme and a partnership scheme. As a key component of a lasting settlement for the social care system, we will reform and consolidate the law underpinning adult social care, working with the Law Commission.

1.19 The Government will bring together the conclusions of the Law Commission and the Commission on funding of long-term care, along with our vision, into a White Paper in 2011, with a view to introducing legislation in the second session of this Parliament to establish a sustainable legal and financial framework for adult social care.

The financial position

1.20 We know that the reforms that we are proposing in this White Paper will take place against the backdrop of a very challenging financial position. In the Coalition Agreement, the Government said that the single greatest priority for the next Parliament will be to reduce the deficit. It is now even more pressing that we

implement the reforms set out here in order to increase productivity and efficiency in the NHS.

1.21 We will increase NHS spending in real terms in each year of this Parliament. Despite this, local NHS organisations will need to achieve unprecedented efficiency gains, if we are to meet the costs of demographic and technological changes, and even more so if we are to achieve quality and improve outcomes. Large cuts in administrative costs will provide an important but still modest contribution. In the next five years, the NHS will only be able to increase quality through implementing best practice and increasing productivity. This will be difficult work. Inevitably, as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration. This is a hard truth which any government would have to recognise.

1.22 All of this means we have a responsibility to ensure that funding is used as efficiently as possible. The proposals laid out in this White Paper are a part of this. They are intended to put the NHS onto a sustainable footing, so that everyone in the system – from the Department to groups of GP practices – is accountable for the best use of funding. We are very clear that there will be no bail-outs for organisations which overspend public budgets.

Implementing our NHS vision

1.23 Our strategy is about making changes for the long-term; not just for this Parliament, but beyond. Experience in other sectors and abroad shows that embedding change takes time, and requires ongoing adaptation. The Department is committed to evidence-based policy-making and a culture of evaluation and learning.

1.24 Many will welcome our vision and clarity of intention, our insistence on transparency, and our sense of real urgency. Others may find it too challenging. Throughout, we will maintain constancy of purpose. This White Paper is our strategy for the NHS during this Parliamentary term, so that it is liberated to deliver the best quality care over the longer-term. In the next five years, the coalition Government will not produce another long-term plan for the NHS.

1.25 The NHS will face very significant challenges along the way. The new financial context will require difficult local decisions in the NHS, irrespective of this White Paper.[14] We will be open and honest about what this means.

1.26 These reforms will make the NHS more responsive and transparent, better able to withstand the funding pressures of the future. Once they are in place, it will not just be the responsibility of government, but of every commissioner, every healthcare provider and every GP practice to ensure that taxpayers' money is used to achieve the best possible outcomes for patients.

1.27 The following chapters set out how we will bring about this long-term transformation through:

- putting patients and the public first;
- focusing on improvement in quality and healthcare outcomes;
- autonomy, accountability and democratic legitimacy; and
- cutting bureaucracy and improving efficiency.

1.28 These plans are interconnected and mutually reinforcing. The final chapter sets out plans for making it happen. The Department will take forward work to manage the transition and flesh out further policy details in partnership with external organisations, seeking their help and expertise.

2. Putting patients and the public first

Shared decision-making: nothing about me without me

2.1 The Government's ambition is to achieve healthcare outcomes that are among the best in the world. This can only be realised by involving patients fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone.

2.2 Healthcare outcomes are personal to each of us. The outcomes we experience reflect the quality of our interaction with the professionals that serve us.[15] But compared to other sectors, healthcare systems are in their infancy in putting the experience of the user first, and have barely started to realise the potential of patients as joint providers of their own care and recovery. Progress has been limited in making the NHS truly patient led.[16] We intend to put that right.

2.3 We want the principle of "shared decision-making" to become the norm: *no decision about me without me*. International evidence shows that involving patients in their care and treatment improves their health outcomes,[17] boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment.[18] It can also bring significant reductions in cost, as highlighted in the Wanless Report,[19] and in evidence from various programmes to improve the management of long-term conditions.[20] This is equally true of the partnership between patients and clinicians in research, where those institutions with strong participation in clinical trials tend to have better outcomes.

2.4 The new NHS Commissioning Board will champion patient and carer involvement, and the Secretary of State will hold it to account for progress. In the meantime, the Department will work with patients, carers and professional groups, to bring forward proposals about transforming care through shared decision-making.

An NHS information revolution

2.5 Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available.

2.6 The Government intends to bring about an NHS information revolution, to correct the imbalance in who knows what. Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health. The information revolution is also about new ways of delivering care,

such as enabling patients to communicate with their clinicians about their health status on-line. We will provide a range of on-line services which will mean services being provided much more efficiently at a time and place that is convenient for patients and carers, and will also enable greater efficiency.

2.7 Information generated by patients themselves will be critical to this process, and will include much wider use of effective tools like Patient-Reported Outcome Measures (PROMS), patient experience data, and real-time feedback. At present, PROMs, other outcome measures, patient experience surveys and national clinical audit are not used widely enough. We will expand their validity, collection and use. The Department will extend national clinical audit to support clinicians across a much wider range of treatments and conditions, and it will extend PROMs across the NHS wherever practicable.

2.8 We will also encourage more widespread use of patient experience surveys and real-time feedback. We will enable patients to rate services and clinical departments according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong. We will also require that staff feedback around the quality of the patient care provided in organisations is publicly available. As in many other services, this feedback from patients, carers and families, and staff will help to inform other people with similar conditions to make the right choice of hospital or clinical department and will encourage providers to be more responsive.[21] The Department will seek views on how best to ensure this approach is developed in a coherent way.

2.9 Information will improve accountability: in future, it will be far easier for the public to see where unacceptable services are being provided and to exert local pressure for them to be improved. There is compelling evidence that better information also creates a clear drive for improvement in providers. Our intention is for clinical teams to see a meaningful, risk-adjusted assessment of their performance against their peers, and this assessment should also be placed in the public domain. The Department will revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes. Subject to evaluation, we will extend quality accounts to all providers of NHS care from 2011 and continue to strengthen the independent assurance of quality accounts to ensure the content is accurate and fair. We will ensure that nationally comparable information is published, in a way that patients, their families and clinical teams can use.

2.10 More information about commissioning of healthcare will also improve public accountability. Wherever possible, we will ensure that information about services is published on a commissioner basis. We will also publish assessments of how well commissioners are performing, so that they are held to account for their use of public money.

Information to support choice and accountability

In future, there should be increasing amounts of robust information, comparable between similar providers, on:

- **Safety**: for example, about levels of healthcare-associated infections, adverse events and avoidable deaths, broken down by providers and clinical teams;
- **Effectiveness**: for example, mortality rates (this could include mortality from heart disease, and one year and five year cancer survival), emergency re-admission rates; and patient-reported outcome measures; and
- **Experience**: including information on average and maximum waiting times; opening hours and clinic times; cancelled operations; and diverse measures of patient experience, based on feedback from patients, families and carers.

2.11 We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers. The patient will determine who else can access their records and will easily be able to see changes when they are made to their records. We will consult on arrangements, including appropriate confidentiality safeguards, later this year.

2.12 Our aim is that people should be able to share their records with third parties, such as support groups for patients, who can help patients understand their records and manage their condition better. We will make it simple for a patient to download their record and pass it, in a standard format, to any organisation of their choice.

2.13 We intend to make aggregate data available in a standard format to allow intermediaries to analyse and present it to patients in an easily understandable way. Making aggregated, anonymised data available to the university and research sectors also has the potential to suggest new areas of research through medical and scientific analysis. There will be safeguards to protect personally identifiable information. We will consider introducing a voluntary accreditation system, which will allow information intermediaries to apply for a kitemark to demonstrate to the public that they meet quality standards.

2.14 Patients and carers will be able to access the information they want through a range of means, to ensure that no individual or section of the community is left out. In addition to NHS Choices, a range of third parties will be encouraged to provide information to support patient choice. Assistance will be provided for people who do not access on-line health advice, or who would particularly benefit from more intensive support.

2.15 We will ensure the right data is collected by the Health and Social Care Information Centre to enable people to exercise choice. We will seek to centralise all data returns in the Information Centre, which will have lead responsibility for data collection and assuring the data quality of those returns, working with other interested parties such as Monitor and the Care Quality Commission. We will also review data collections with a view to reducing burdens, as outlined in chapter 5. The forthcoming Health Bill will contain provisions to put the Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system.

2.16 Providers will be under clear contractual obligations, with sanctions, in relation to accuracy and timeliness of data. Along with commissioners, they will have to use agreed technical and data standards to promote compatibility between different systems. The NHS Commissioning Board will determine these standards but they will include, for example, record keeping, data sharing capabilities, efficiency of data transfer and data security. We will clarify the legal ownership and responsibilities of organisations and people who manage health data. This may require primary legislation and we will consult on arrangements later this year.

2.17 The Department will publish an information strategy this autumn to seek views on how best to implement these changes.

Increased choice and control

2.18 In future, patients and carers will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes. People want choice,[22] and evidence at home and abroad shows that it improves quality.[23] We are also clear that increasing patient choice is not a one-way street. In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle.

2.19 The previous Government made a start on patient choice, but its focus was narrow, concentrating mainly on choice of provider. Although limited progress has been made on choice of provider for first elective appointment, the policy has not been implemented fully and momentum has stalled. It has remained the case for several years that just under half of patients recall that their GP has offered them choice.[24] The Department will increase that significantly. We will explore with the profession and patient groups how we can make rapid progress towards this goal.

2.20 However, we do not see choice as just being about where you go and when, but a more fundamental control of the circumstances of the treatment and care you receive.

Extending choice

The Government will:

- Increase the current offer of **choice of any provider** significantly, and will explore with professional and patient groups how we can make rapid progress towards this goal;

- Create a presumption that all patients will have choice and control over their care and treatment, and **choice of any willing provider** wherever relevant (it will not be appropriate for all services – for example, emergency ambulance admissions to A&E);

- Introduce **choice of named consultant-led team** for elective care by April 2011 where clinically appropriate. We will look at ways of ensuring that Choose and Book usage is maximised, and we intend to amend the appropriate standard acute contract to ensure that providers list named consultants on Choose and Book;

- **Extend maternity choice** and help make safe, informed choices throughout pregnancy and in childbirth a reality – recognising that not all choices will be appropriate or safe for all women – by developing new provider networks. Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage;

- Begin to introduce choice of treatment and provider in some **mental health services** from April 2011, and extend this wherever practicable;

- Begin to introduce choice for **diagnostic testing**, and **choice post-diagnosis**, from 2011;

- Introduce **choice in care for long-term conditions** as part of personalised care planning. In **end-of-life care**, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need;

- Give patients more information on **research studies** that are relevant to them, and more scope to join in if they wish;

- Give every patient a clear **right to choose to register with any GP practice** they want with an open list, without being restricted by where they live. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but

equally that they can stay with their GP if they wish when they move house.

- Develop **a coherent 24/7 urgent care service in every area of England** that makes sense to patients when they have to make choices about their care. This will incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians; and

- Consult on **choice of treatment** later this year including the potential introduction of new contractual requirements.

2.21 In implementing proposals for extending choice, the Department will consult widely. We will need to tackle a range of issues, including: professional and patient engagement; reform to payment systems so that money follows the patient and enables choices to work; information availability and accessibility to enable choice of treatment, including decision aids, particularly in mental health and community services; support to patients with different language needs and patients with disabilities to ensure that they can exercise choice; ensuring that local commissioners fully support rather than restrict choice; and maximising use of Choose and Book. We will consult on choice of treatment later this year, including the potential introduction of new contractual requirements on providers, and collecting and publishing information on whether this is happening, to support patients.

2.22 The previous Government recently started a programme of personal health budget pilots. International evidence, and evidence from social care, shows that these have much potential to help improve outcomes, transform NHS culture by putting patients in control, and enable integration across health and social care. As part of personalised care planning, the Department will encourage further pilots to come forward and explore the potential for introducing a right to a personal health budget in discrete areas such as NHS continuing care. We also recognise that introducing personal budgets is operationally complex and the Government will use the results of the evaluation in 2012 to inform a wider, more general roll-out.

2.23 We expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14. In future, the NHS Commissioning Board will have a key role in promoting and extending choice and control. It will be responsible for developing and agreeing with the Secretary of State guarantees for patients about the choices they can make, in order to provide clarity for patients and providers alike, ensuring the advice of Monitor is sought on any implications for competition. The Government will require the NHS Commissioning Board to develop an implementation plan as one of its first tasks, working with

patient and professional groups; and the Secretary of State will hold it to account for progress.

Patient and public voice

2.24 We will strengthen the collective voice of patients, and we will bring forward provisions in the forthcoming Health Bill to create HealthWatch England, a new independent consumer champion within the Care Quality Commission. Local Involvement Networks (LINks) will become the local HealthWatch, creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the HealthWatch arrangements they commission.

2.25 We will also look at existing mechanisms, including relevant legislation, to ensure that public engagement is fully effective in future, and that services meet the needs of neighbourhoods.

2.26 All sources of feedback, of which complaints are an important part, should be a central mechanism for providers to assess the quality of their services. We want to avoid the experience of Mid-Staffordshire, where patient and staff concerns were continually overlooked while systemic failure in the quality of care went unchecked. Building on existing complaints handling structures, we will strengthen arrangements for information sharing. Local HealthWatch will also have the power to recommend that poor services are investigated.

The role of HealthWatch

At local level:

- Local HealthWatch organisations will ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care;
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with;
- Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership functions, described in chapter 4. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating

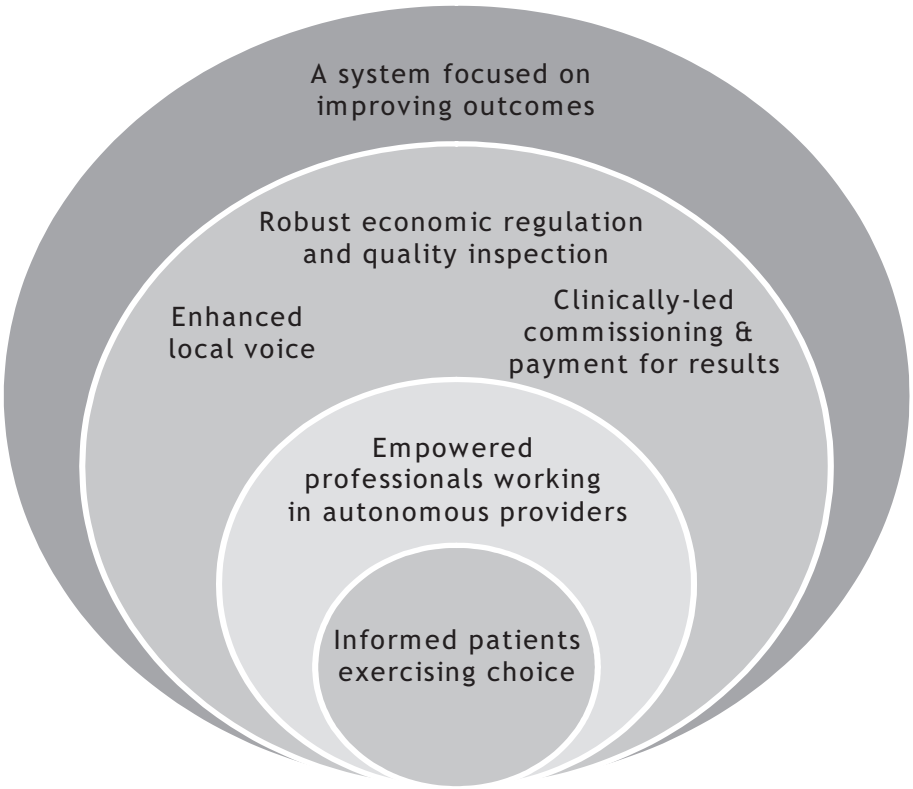
effectively, and for putting in place better arrangements if they are not; and

- Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

At national level:

- HealthWatch England will provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes;
- HealthWatch England will provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care;
- HealthWatch England will provide advice to the NHS Commissioning Board, Monitor and the Secretary of State; and
- Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services.

Figure 1



3. Improving healthcare outcomes

3.1 The primary purpose of the NHS is to improve the outcomes of healthcare for all: to deliver care that is safer, more effective, and that provides a better experience for patients. Building on Lord Darzi's work, the Government will now establish improvement in quality and healthcare outcomes as the primary purpose of all NHS-funded care. This primary purpose will be enshrined in statute, the NHS Constitution, and model contracts for services, ensuring that the focus is always on what matters most to patients and professionals.

3.2 We will start by discarding what blocks progress in the NHS today: the overwhelming importance attached to certain top-down targets. These targets crowd out the bigger objectives of reducing mortality and morbidity, increasing safety and improving patient experience more broadly – including for the most vulnerable in our society. We have already revised the NHS Operating Framework for 2010/11, setting out how existing targets should be treated this year. Some targets are clinically justifiable and deliver significant benefits. Others, that have no clinical relevance, have been removed. In future, performance will be driven by patient choice and commissioning; as a result, there will be no excuse or hiding place for deteriorating standards and our proposals will drive improving standards.

3.3 This will help ensure that patient safety is placed above all else at the heart of the NHS, and that there are no longer any production line approaches to healthcare, which measure the volume but ignore the quality. There cannot be a trade-off between safety and efficiency. Our information revolution will play an important role in this, boosting transparency so that failings do not go undetected. It will help foster a culture of active responsibility where staff and patients are empowered to ask, challenge and intervene.

3.4 We will replace the relationship between politicians and professionals with relationships between professionals and patients. Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use. The Government believes that outcomes will improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish. In future, the Secretary of State will hold the NHS to account for improving healthcare outcomes. The NHS, not politicians, will be responsible for determining how best to deliver this within a clear and coherent national policy framework.

The NHS Outcomes Framework

3.5 The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care, which provide for clear and unambiguous accountability, and enable better joint working. The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care.

3.6 A new NHS Outcomes Framework will provide direction for the NHS. It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS.

3.7 In turn, the NHS Outcomes Framework will be translated into a commissioning outcomes framework for GP consortia, to create powerful incentives for effective commissioning.

3.8 The NHS Outcomes Framework will span the three domains of quality:

- the effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient-reported outcomes;
- the safety of the treatment and care provided to patients; and
- the broader experience patients have of the treatment and care they receive.

For example, effectiveness goals might include how we compare internationally on avoidable mortality and morbidity across a range of conditions. The criteria used will ensure that we do not exclude outcomes for key groups and services such as children, older people and mental health.

3.9 The Department will launch a consultation on the development of the national outcome goals. We are committed to working with clinicians, patients, carers and representative groups to create indicators that are based on the best available evidence. Later this year, in the light of the Spending Review, the Government will issue the first NHS Outcomes Framework. We intend it will be available to support NHS organisations in delivering improved outcomes from April 2011, with full implementation from April 2012.

3.10 The NHS Commissioning Board will work with clinicians, patients and the public at every level of the system to develop the NHS Outcomes Framework into a more comprehensive set of indicators, reflecting the quality standards developed by NICE. The framework and its constituent indicators will enable international comparisons wherever possible, and reflect the Board's duties to promote equality and tackle inequalities in healthcare outcomes. It will ensure that clinical values direct

managerial activity and that every part of the NHS is focusing on the right goals for patients. The main purpose of the programme of reform set out in this White Paper is to change the NHS environment so that it is easier to progress against those goals.

3.11 It is essential for patient outcomes that health and social care services are better integrated at all levels of the system. We will be consulting widely on options to ensure health and social care works seamlessly together to enable this.

Developing and implementing quality standards

3.12 Progress on outcomes will be supported by quality standards. These will be developed for the NHS Commissioning Board by NICE, who will develop authoritative standards setting out each part of the patient pathway, and indicators for each step. NICE will rapidly expand its existing work programme to create a comprehensive library of standards for all the main pathways of care. The first three on stroke, dementia and prevention of venous thromboembolism were published in June. Within the next five years, NICE expects to produce 150 standards. To support the development of quality standards, NICE will advise the National Institute for Health Research on research priorities.

3.13 Each standard is a set of 5-10 specific, concise quality statements and associated measures. These measures act as markers of high quality, cost-effective patient care. They are about excellence, derived from the best available evidence and are produced collaboratively with the NHS and social care professionals, along with their partners, service users and carers. The standards will be developed in a way that makes sense for patients, and they will extend beyond NHS care, informing the work of local authorities and the Public Health Service. They will include information for clinicians and patients on relevant and ongoing research studies that are key to improving evidence for better outcomes.

3.14 With the increasing importance of coherent joint arrangements between health and social care, the standards will cover areas that span health and social care. We will expand the role of NICE to develop quality standards for social care. The Health Bill will put NICE on a firmer statutory footing, securing its independence and core functions and extending its remit to social care.

NICE quality standard for venous thromboembolism (VTE)

Quality statements:

- All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
- Patients/carers are offered verbal and written information on VTE prevention

as part of the admission process.

- Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.
- Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.
- Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
- Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
- Patients are offered extended (post-hospital) VTE prophylaxis in accordance with NICE guidance.[25]

3.15 Commissioners will draw from the NICE library of standards as they commission care. GP consortia and providers will agree local priorities for implementation each year, taking account of the NHS Outcomes Framework. NICE quality standards will be reflected in commissioning contracts and financial incentives. Together with essential regulatory standards, these will provide the national consistency that patients expect from their National Health Service.

Research

3.16 The Government is committed to the promotion and conduct of research as a core NHS role. Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities. Research is even more important when resources are under pressure – it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy. A thriving life sciences industry is critical to the ability of the NHS to deliver world-class health outcomes. The Department will continue to promote the role of Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research and Care, to develop research and to unlock synergies between research, education and patient care.

Incentives for quality improvement

3.17 The absence of an effective payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and increase patient choice. In future, the structure of payment systems will

be the responsibility of the NHS Commissioning Board, and the economic regulator will be responsible for pricing. In the meantime the Department will start designing and implementing a more comprehensive, transparent and sustainable structure of payment for performance so that money follows the patient and reflects quality. Payments and the 'currencies' they are based on will be structured in the way that is most relevant to the service being provided, and will be conditional on achieving quality goals.

3.18 The previous administration made progress in developing payment by results in acute trusts. The mandatory scope has changed little since 2005/06, and has not incentivised results throughout the system. The Department will:

- implement a set of currencies for adult mental health services for use from 2012/13, and develop currencies for child and adolescent services;
- develop payment systems to support the commissioning of talking therapies;
- mandate in 2011/12 national currencies for adult and neonatal critical care;
- review payment systems to support end-of-life care, including exploring options for per-patient funding;
- accelerate the development of pathway tariffs for use by commissioners;
- accelerate the development of currencies and tariffs for community services;
- implement in 2011/12 further incentives to reduce avoidable readmissions and encourage more joined-up working between hospitals and social care for services following discharge; and
- link quality measures in national clinical audits to payment arrangements.

3.19 The Department will also refine the basis of current tariffs. We will rapidly accelerate the development of best-practice tariffs, introducing an increasing number each year, so that providers are paid according to the costs of excellent care, rather than average price. 2011/12 will see the introduction of best-practice tariffs for interventional radiology, day-case surgery for breast surgery, hernia repairs and some orthopaedic surgery. The Department will also introduce the latest version of the International Classification of Disease (ICD) 10 clinical diagnosis coding system from 2012/13, and explore the scope for developing a benchmarking approach, with greater local flexibility, including for local marginal rates.

3.20 If providers deliver excellent care in line with commissioner priorities, the commissioner will be able to pay a quality increment. The Department will extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals. The CQUIN framework will

be important for the implementation of NICE quality standards and improving patient experience and patient-reported outcomes. And in future, if providers deliver poor quality care, the commissioner will also be able to impose a contractual penalty. In particular, we will proceed with work to impose fines for an extended list of "never events", such as wrong site surgery, from October 2010.[26]

3.21 The principle of rewarding quality will also apply in primary care. In general practice the Department will seek over time to establish a single contractual and funding model to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision. Our principle is that funding should follow the registered patient, on a weighted capitation model, adjusted for quality. We will incentivise ways of improving access to primary care in disadvantaged areas.

3.22 Following consultation and piloting, we will introduce a new dentistry contract, with a focus on improving quality, achieving good dental health and increasing access to NHS dentistry, and an additional focus on the oral health of schoolchildren. The community pharmacy contract, through payment for performance, will incentivise and support high quality and efficient services, including better value in the use of medicines through better informed and more involved patients. Pharmacists, working with doctors and other health professionals, have an important and expanding role in optimising the use of medicines and in supporting better health. Pharmacy services will benefit from greater transparency in NHS pricing and payment for services.

3.23 The Government will also reform the way that drug companies are paid for NHS medicines, moving to a system of value-based pricing when the current scheme expires. This will help ensure better access for patients to effective drugs and innovative treatments on the NHS and secure value for money for NHS spending on medicines. As an interim measure, the Department is creating a new Cancer Drug Fund, which will operate from April 2011; this fund will help patients get the cancer drugs their doctors recommend.

4. Autonomy, accountability and democratic legitimacy

4.1 The Government's reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver.

GP commissioning consortia

4.2 In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices. This change will build on the pivotal and trusted role that primary care professionals already play in coordinating patient care, through the system of registered patient lists.

4.3 Primary care professionals coordinate all the services that patients receive, helping them to navigate the system and ensure they get the best care (of course, they do not deliver all the care themselves). For this reason they are best placed to coordinate the commissioning of care for their patients while involving all other clinical professionals who are also part of any pathway of care.

4.4 Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare.

4.5 GP-led purchasing has history. Practice-based commissioning was an attempt by the last Government to build on the successful parts of previous Conservative approaches, such as total purchasing pilots. There have been some examples of practice-based groups making progress, in spite of a flawed policy framework that confuses the respective responsibilities of GPs and PCTs, and fails to transfer real freedom and responsibility to GP practices. Our model is neither a recreation of GP

fundholding nor a complete rejection of practice-based commissioning. Fundholding led to a two-tier NHS; and practice-based commissioning never became a real transfer of responsibility. So we will learn from the past, and offer a clear way forward for GP consortia.

4.6 The Government will shortly issue a document setting out our proposals in more detail, and providing the basis for fuller engagement with primary care professionals, patients and the public. We will then bring forward legislation in the forthcoming Health Bill.

The role of GP commissioning consortia

- We envisage putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.
- Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.
- The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.
- GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.
- A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. We envisage that the NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia, and we

envisage a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary.

- GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.

- GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.

- GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.

- GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

- We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.

- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.

- GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch

will provide evidence about local communities and their needs and aspirations.

4.7 A number of PCTs have made important progress in developing commissioning experience which we will be looking to capitalise on during the transition period. Through the transitional arrangements, we will seek to ensure that existing expertise and capability in primary care trusts (PCTs) is maintained during the transition period where this is the wish of GP consortia.

4.8 Primary care trusts will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be driven bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible, and early adopters promoting best practice.

4.9 The final shape of these proposals will depend upon our consultation findings and developing clear arrangements for managing financial risk. Our indicative timetable is for:

- a comprehensive system of GP consortia in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs;
- following passage of the Health Bill, consortia to take on responsibility for commissioning in 2012/13;
- the NHS Commissioning Board to make allocations for 2013/14 directly to GP consortia in late 2012; and
- GP consortia to take full financial responsibility from April 2013.

An autonomous NHS Commissioning Board

4.10 To support GP consortia in their commissioning decisions we will create a statutory NHS Commissioning Board. This will be a lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice. The NHS Commissioning Board will provide leadership for quality improvement through commissioning: through commissioning guidelines, it will help standardise what is known good practice, for example improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and enabling community access to care and treatments. It will play its full part in promoting equality in line with the Equality Act 2010. It will not manage providers or be the NHS headquarters.

4.11 The Board will promote patient and carer involvement and choice, championing the interests of the patient rather than the interests of particular providers. It will involve patients as a matter of course in its business, for example in developing

commissioning guidelines. To avoid double jeopardy and duplication, it will take over the current CQC responsibility of assessing NHS commissioners and will hold GP consortia to account for their performance and quality. It will manage some national and regional commissioning. It will allocate and account for NHS resources. It will have a role in supporting the Secretary of State and the Public Health Service to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS. It will promote involvement in research and the use of research evidence.

The role of the NHS Commissioning Board

The Board will have five main functions:

1. **Providing national leadership on commissioning for quality improvement:**

    - setting commissioning guidelines on the basis of clinically approved quality standards developed with the advice of NICE in a way that promotes joint working across health, public health and social care;
    - designing model contracts for local commissioners to adapt and use with providers;
    - designing the structure of tariff and other financial incentives, whilst Monitor will set tariff levels;
    - hosting some clinical commissioning networks, for example for rarer cancers and transplant services, to pool specialist expertise;
    - setting standards for the quality of NHS commissioning and procurement;
    - making available accessible information on commissioner performance; and
    - tackling inequalities in outcomes of healthcare.

2. **Promoting and extending public and patient involvement and choice:**

    - championing greater involvement of patients and carers in decision-making and managing their own care, working with commissioners and local authorities;
    - promoting personalisation and extending patient choice of what, where and who, including personal health budgets; and
    - commissioning information requirements for choice and for

accountability, including through patient-reported measures.

3. **Ensuring the development of GP commissioning consortia:**

   - supporting and developing the establishment and maintenance of an effective and comprehensive system of GP consortia; and
   - holding consortia to account for delivering outcomes and financial performance.

4. **Commissioning certain services** that cannot solely be commissioned by consortia, in accordance with Secretary of State designation, including:

   - GP, dentistry, community pharmacy and primary ophthalmic services;
   - national specialised services[27] and regional specialised services set out in the Specialised Services National Definitions Set;[28] and
   - maternity services.

5. **Allocating and accounting for NHS resources:**

   - allocating NHS revenue resources to GP consortia on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability;
   - managing an overall NHS commissioner revenue limit, for which it will be accountable to the Department of Health; and
   - promoting productivity through better commissioning.

The Board would not have the power to restrict the scope of the services offered by the NHS.

Establishing the Board and managing the transition

4.12 The Board will be established in shadow form as a special health authority from April 2011. In 2011/12 it will develop its future business model, organisational structure and staffing. It will be converted by the forthcoming Health Bill into a statutory body, with its own powers and duties, and will go live in April 2012.

4.13 Changes in the way that strategic health authorities (SHA) operate will help pave the way for the NHS Commissioning Board. From this year SHAs will separate their commissioning and provider oversight functions. They will support the Board during its preparatory year, and have a critical role during the transition in managing finance

and performance. It will be for the NHS Commissioning Board to decide what, if any, presence it needs in different parts of the country. SHAs will be abolished as statutory bodies during 2012/13. From 2012 the Board will perform those national functions relevant to its new role that are currently carried out by the Department of Health. It will be subject to clear controls over management costs and consultancy spend.

A new relationship between the NHS and the Government

4.14 At present the Secretary of State enjoys extraordinarily wide powers over the NHS. It is intended that the forthcoming Health Bill will introduce provisions to limit the ability of the Secretary of State to micromanage and intervene. The forthcoming Health Bill will formalise the relationship between the government and the NHS, to improve transparency and increase stability, while maintaining the necessary level of political accountability for such large amounts of taxpayers' money.

The NHS role of the Secretary of State

The key NHS-related functions of the Secretary of State will include:

- **Setting a formal mandate for the NHS Commissioning Board.** This will be subject to consultation and Parliamentary scrutiny, and will include specific levels of improvement against a small number of outcome indicators.
- **Holding the NHS Commissioning Board to account.** In addition to delivery of improvements against the agreed outcome indicators, the Secretary of State will hold the Board to account on delivering improvements in choice and patient involvement, and in maintaining financial control. Clear financial controls and associated financial instructions will be set by the Secretary of State in line with the Department's continued Parliamentary accountability for expenditure and HM Treasury requirements.
- **Arbitration.** The Secretary of State will have a statutory role as arbiter of last resort in disputes that arise between NHS commissioners and local authorities, for example in relation to major service changes.
- **The legislative and policy framework.** Responsibility for Department of State functions will remain with the Secretary of State. This includes determining the comprehensive service which the NHS provides, and developing and publishing national service strategies which will enable the roles of NHS, public health services and social care services to be better coordinated.

- **Accounting annually to Parliament** for the overall performance of the NHS, public health and social care systems.

4.15 In future, the Secretary of State will be obliged to lay out a short formal mandate for the NHS Commissioning Board. This will be subject to public consultation and Parliamentary scrutiny, including by the Health Select Committee. The mandate is likely to be over a three year period, updated annually. The mandate will set out the totality of what the Government expects from the NHS Commissioning Board on behalf of the taxpayer for that period. This will comprise progress against outcomes specified by the Secretary of State, and objectives in relation to its core functions. Should the Government wish, by exception, to impose additional performance requirements on the Board in-year, it will on each occasion be obliged to lay a report in Parliament to explain why. The Secretary of State will also lose existing powers to intervene in relation to any specific commissioner other than in discharging defined statutory responsibilities. To ensure transparency, a public record will be made of all meetings between the Board and the Secretary of State.

Local democratic legitimacy

4.16 Following the establishment of the NHS Commissioning Board and a comprehensive network of GP consortia, PCTs will no longer have NHS commissioning functions. To realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing, the Government will transfer PCT health improvement functions to local authorities and abolish PCTs. We expect that PCTs will cease to exist from 2013, in light of the successful establishment of GP consortia. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service.

4.17 The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, we will establish new statutory arrangements within local authorities – which will be established as "health and wellbeing boards" or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda.

4.18 We will simplify and extend the use of powers that enable joint working between the NHS and local authorities. It will be easier for commissioners and providers to adopt partnership arrangements, and adapt them to local circumstances.

4.19 These arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. While NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia, our aim is to ensure coherent and coordinated local commissioning strategies across all three services, for example in relation to mental health or elderly care. The Secretary of State will seek to ensure strategic coordination nationally; the local authority's new functions will enable strategic coordination locally. It will not involve day-to-day interventions in NHS services. The Government will consult fully on the details of the new arrangements.

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

Freeing existing NHS providers

4.20 Autonomy in commissioning will be matched by autonomy for providers. Previous governments have tried to give greater freedom to providers, most recently through the introduction of foundation trusts. Yet the policy was flawed from the outset by the

controls imposed upon foundation trusts by Whitehall. Meanwhile, the drive to extend foundation status across the NHS has lost momentum, leaving reform half completed.

4.21 Our ambition is to create the largest and most vibrant social enterprise sector in the world. The Government's intention is to free foundation trusts from constraints they are under, in line with their original conception, so they can innovate to improve care for patients. In future, they will be regulated in the same way as any other providers, whether from the private or voluntary sector. Patients will be able to choose care from the provider they think to be the best. As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into employee-led social enterprises that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients. For many foundation trusts, a governance model involving staff, the public and patients works well but we recognise that this may not be the best model for all types of foundation trust, particularly smaller organisations such as those providing community services. We will consult on future requirements: we envisage that some foundation trusts will be led only by employees; others will have wider memberships. The benefits of this approach will be seen in high productivity, greater innovation, better care and greater job satisfaction. Foundation trusts will not be privatised.

4.22 Ahead of bringing forward legislation, we intend to consult on options for increasing foundation trusts' freedoms – while ensuring financial risk is properly managed – including:

- abolishing the arbitrary cap on the amount of income foundation trusts may earn from other sources to reinvest in their services and allowing a broader scope, for example to provide health and care services;
- enabling foundation trusts to merge more easily; and
- whether we should enable foundation trusts to tailor their governance arrangements to their local needs, within a broad statutory framework that ensures any surplus and any proceeds are reinvested in the organisation rather than distributed externally.

4.23 Within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust and in due course, we will repeal the NHS trust legislative model. A new unit in the Department of Health will drive progress and oversee SHAs' responsibilities in relation to providers. In the event that a few NHS trusts and SHAs fail to agree credible plans, and where the NHS trust is unsustainable, the Secretary of State may as a matter of last resort apply the trust administration regime set out in the Health Act 2009.[29] From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. Financial control will be maintained during the transition, with the Department, Monitor and SHAs taking any necessary steps.

4.24 The Government will apply a consistent approach across all types of NHS services. We will end the uncertainty and delay about the future of community health services currently provided within PCTs. We will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an "any willing provider" approach for community services, reducing barriers to entry by new suppliers. In future, all community services will be provided by foundation trusts or other types of provider.

4.25 Special statutory arrangements will be made for the three high secure psychiatric hospitals (Broadmoor, Rampton and Ashworth), allowing them to benefit from the independence of foundation status while retaining appropriate safeguards to reflect their role in the criminal justice system.

Economic regulation and quality inspection to enable provider freedom

4.26 Providers will no longer be part of a system of top-down management, subject to political interference. Instead, they will be governed by a stable, transparent and rules-based system of regulation. Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.

4.27 As now, the Care Quality Commission will act as quality inspectorate across health and social care for both publicly and privately funded care. In addition, we will develop Monitor, the current independent regulator of foundation trusts, into an economic regulator from April 2012, with responsibility for all providers of NHS care from April 2013. Providers will have a joint licence overseen by both Monitor and CQC, to maintain essential levels of safety and quality and ensure continuity of essential services.

The role of the Care Quality Commission

We will strengthen the role of CQC as an effective quality inspectorate by giving it a clearer focus on the essential levels of safety and quality of providers. In relation to the NHS, CQC's responsibilities will include:

Licensing - Together with Monitor, CQC will operate a joint licensing regime, with CQC being responsible for licensing against the essential safety and quality requirements. Where services fail to meet these essential levels, providers will be subject to enforcement action, including the possibility of fines and suspension of services.

Inspections - CQC will inspect providers against the essential levels of safety and quality. Inspection will be targeted and risk-based. CQC will carry out

inspections of providers in response to information that it receives about a provider. This information will come through a range of sources including patient feedback and complaints, HealthWatch, GP consortia and the NHS Commissioning Board. Where inspection reveals that a provider is not meeting essential levels of safety and quality, CQC will take enforcement action to bring about improvement.

The role of Monitor

Monitor will be turned into the economic regulator for the health and social care sectors, with three key functions:

- **Promoting competition**, to ensure that competition works effectively in the interests of patients and taxpayers. Like other sectoral regulators, such as OFCOM and OFGEM, Monitor will have concurrent powers with the Office of Fair Trading to apply competition law[30] to prevent anti-competitive behaviour;

- **Price regulation**. Where price regulation is necessary, Monitor's role will be to set efficient prices, or maximum prices, for NHS-funded services, in order to promote fair competition and drive productivity. In setting prices, Monitor will be required to consult the NHS Commissioning Board and take account of patients and taxpayers' interests including the need to secure the most efficient use of available resources; and

- **Supporting continuity of services**. Primary responsibility for ensuring continuity of services will lie with the NHS Commissioning Board and local commissioners. However, Monitor will also play a role in ensuring continued access to key services in some cases. Monitor will be responsible for defining regulated services that will be subject to special licence conditions and controls.

Monitor's levers to ensure that essential services are maintained will include:

- powers to protect assets or facilities required to maintain continuity of essential services;

- authorising special funding arrangements for essential services that would otherwise be unviable (with the agreement of the NHS Commissioning Board, and subject to rules on state aid);

- powers to levy providers for contributions to a risk pool; and

- intervening directly in the event of failure, including power to trigger a special administration and regime.

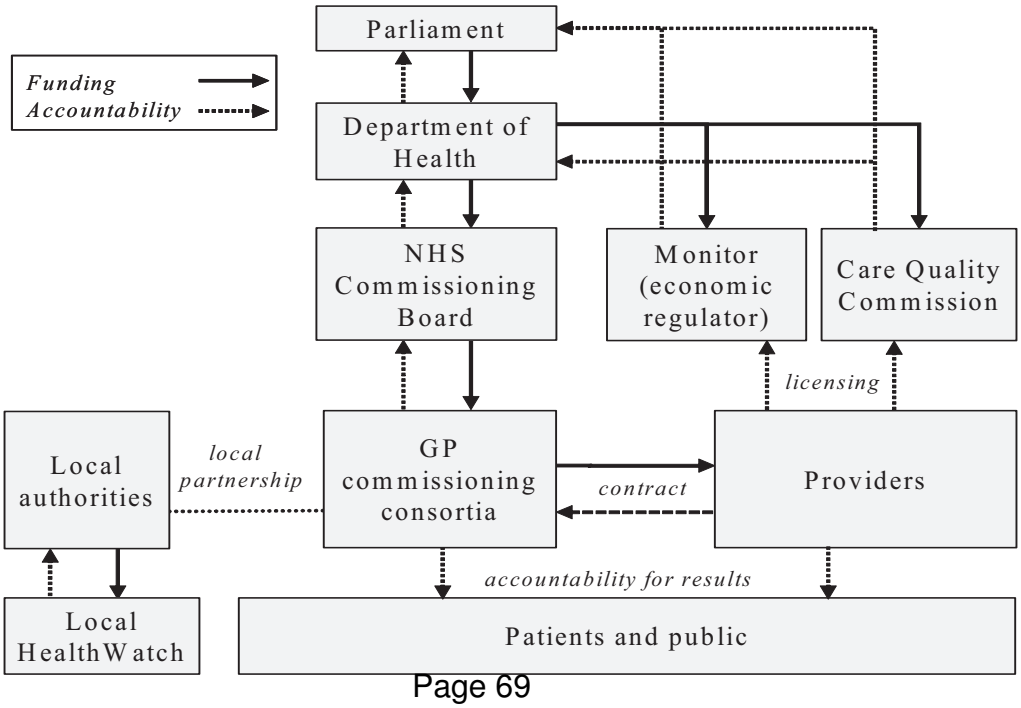
Monitor's scope and powers

4.28 Like other sectoral regulators, we propose that Monitor should have proactive, "*ex ante*" powers to protect essential services and help open the NHS social market up to competition, as well as being able to take "*ex post*" enforcement action reactively. *Ex ante* powers would enable Monitor, for instance, to protect essential assets; require monopoly providers to grant access to their facilities to third parties; or conduct market studies and refer potential structural problems to the Competition Commission for investigation. To minimise the risks of excessive regulation, the need for *ex ante* powers would be reviewed over time. In most regulated industries, the focus of competition regulation is on preventing anti-competitive behaviour by powerful suppliers. However, within the NHS social market, there is also scope for purchasers to act anti-competitively, for example by failing to tender services or discriminating in favour of incumbent providers. Monitor will be able to investigate complaints of anti-competitive purchasing and act as arbiter.

4.29 Monitor's powers to regulate prices and license providers will only cover publicly-funded health services. However, its powers to apply competition law will extend to both publicly and privately funded healthcare, and to social care.

4.30 The Government will shortly issue a document setting out our proposals on foundation trusts and economic regulation in more detail, for consultation, prior to bringing forward provisions in the forthcoming Health Bill.

Figure 2



Valuing staff

4.31 Staff who are empowered, engaged and well supported provide better patient care. We will therefore promote staff engagement, partnership working and the implementation of Dr Steve Boorman's recommendations to improve staff health and wellbeing.[31] We will also extend the principles of autonomy, not only by giving professionals more control of the way that NHS services are commissioned and provided, but also in our approach to staff training, education and pay.

Training and education

4.32 Each year several billion pounds are spent on central funding of education and training for NHS staff through the Multi-Profession Education and Training levy, in addition to investment by NHS organisations in their own staff. A top-down management approach led by the Department of Health does not allow accountability for decisions affecting workforce supply and demand to sit in the right place. It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.

4.33 In future, the Department will have a progressively reducing role in overseeing education and training. The system will be designed to ensure that education and training commissioning is aligned locally and nationally with the commissioning of patient care. Our vision is that:

- Healthcare employers and their staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans.
- Education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists and pharmacists. Similar mechanisms will be put in place for nurses and midwives and the allied health professions. They will work with employers to ensure a multi-disciplinary approach that meets their local needs.
- The professions will have a leading role in deciding the structure and content of training, and quality standards.
- All providers of healthcare services will pay to meet the costs of education and training. Transparent funding flows for education and training will support the level playing field between providers.
- The NHS Commissioning Board will provide national patient and public

oversight of healthcare providers' funding plans for training and education, checking that these reflect its strategic commissioning intentions. GP consortia will provide this oversight at local level.

- The Centre for Workforce Intelligence will act as a consistent source of information and analysis, informing and informed by all levels of the system.

4.34 The Department will publish proposals for consultation in due course. Reforms will be managed and introduced carefully to ensure that the changes do not de-stabilise individual providers.

NHS pay

4.35 Ministers currently exercise substantial control over pay levels and contractual arrangements for NHS staff. In the short term, the need for fiscal consolidation is paramount and this will require sustained pay restraint across the public sector. The NHS must play its part as the largest public service in the country. We will pursue the Coalition Agreement and policies announced in the Budget on 22 June in relation to public sector pay restraint.

4.36 Pay decisions should be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff. However, it is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions. In the short term, the Budget announced that pay will be frozen for two years for those earning more than £21,000 and the Government will ask the Pay Review Bodies to make recommendations on pay for those earning below this threshold, with a minimum increase of £250 for each year of the freeze. In the longer term, we will work with NHS employers and trade unions to explore appropriate arrangements for setting pay. However, while ministers will retain responsibility for determining overall resources and affordability, we would expect employers to take the lead in providing advice on staffing and cost pressures. Employers would also be responsible for leading negotiations on new employment contracts. In line with our aim of a decentralised system, the main incentives for financial management and efficiency will in future come from tariff-setting and a transparent regulatory framework – not from central government controls on providers' pay and internal processes.

NHS pensions

4.37 The Government has announced that Lord John Hutton will chair an independent review of public pensions, including those in the NHS. This wide ranging review will look not only at the affordability and sustainability of public service pensions but will also consider issues such as access, the impact on labour market mobility between the public and private sectors, and the extent to which pensions may act as a barrier to greater plurality of provision of public services. We will consider the findings of that review in due course but remain committed to ensuring that pension solutions are found that are fair to the workforce in the health service and fair to the taxpayer.

5. Cutting bureaucracy and improving efficiency

5.1 The Government has guaranteed that health spending will increase in real terms in every year of this Parliament. With that protection comes the same obligation for the NHS to cut waste and transform productivity as applies to other parts of the public sector.

5.2 This discipline is also required to meet the costs of demographic change and new technologies. Since its inception, the NHS budget has risen by an average of over 4% in real terms each year; so even with our spending commitment, the NHS will face a sustained and substantial financial constraint. We will not cut the NHS as happened in the 1970s in a previous financial crisis. Meeting this challenge will require difficult local decisions, and that would be true under any government. The scale of the NHS productivity challenge may prompt calls during this Parliament for even bigger increases in NHS resources; but the reality is that there is no more money.

Cutting bureaucracy and administrative costs

5.3 So our first task is to increase the proportion of resource available for front-line services, by cutting the costs of health bureaucracy. Over the past decade, layers of national and regional organisations have accumulated, resulting in excessive bureaucracy, inefficiency and duplication. The Government will therefore impose the largest reduction in administrative costs in NHS history. Over the next four years we will reduce the NHS's management costs by more than 45%.

5.4 Reduction on this scale cannot be met by cutting all organisations equally; instead, it can only be realised by radically simplifying the architecture of the health and care system. The Government's plans for decentralisation, set out in the previous chapter, will bring major savings. PCTs – with administrative costs of over a billion pounds a year – and practice-based commissioners, will together be replaced by GP consortia. The Department will radically reduce its own NHS functions. Strategic health authorities will be abolished.

5.5 The Department will shortly publish a review of its arm's-length bodies. Subject to Parliamentary approval, we will abolish organisations that do not need to exist. We will streamline those functions that need to remain, to cut cost and remove duplication and burdens on the NHS. In future, the Department will impose tight governance over the costs and scope of all its arm's-length bodies. For example, to prevent duplication and aid transparency, the Secretary of State will consider, for any particular arm's-length body, setting out an explicit list of functions that it is not to undertake, to complement the positive list of what it is expected to do. In future, quangos' independence will be about how they perform clear and agreed functions, not the freedom to assume new roles.

5.6 The Government does not embark upon these changes lightly. Taken together, they amount to a major delayering, which will cause significant disruption and loss of jobs, and incur transitional costs between now and 2013, even as we are cutting the management cost of the NHS. But it has rapidly become clear to us that the NHS simply cannot continue to afford to support the costs of the existing bureaucracy; and the Government has a moral obligation to release as much money as possible into supporting front-line care.

5.7 At present, there are over 260,000 data returns[32] to the Department of Health. Later this year, the Department will initiate a fundamental review of data returns, with the aim of culling returns of limited value. This will ensure that the NHS information revolution described in chapter 2 is fuelled by data that are meaningful to patients and clinicians when making decisions about care, rather than by what has been collected historically. We will consult on the findings prior to implementation.

5.8 The Government will cut the bureaucracy involved in medical research. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification.

5.9 As a further measure to support front-line services, the Department of Health will apply cuts to its budgets for centrally managed programmes, such as consultancy services and advertising spend. NHS services will increasingly be empowered to be the customers of a more plural system of IT and other suppliers.

5.10 We are moving to a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management. Within that context, we are committed to reducing the overall burdens of regulation across the health and social care sectors. We will therefore undertake a wide-ranging review of all health and social care regulation, with a view to making significant reductions.

5.11 The reforms outlined in this White Paper will themselves have one-off costs. We will ensure these are affordable within the requirements of the wider Spending Review, while ensuring funding is focused on front-line patient care.

Increasing NHS productivity and quality

5.12 The reforms in this White Paper will provide the NHS with greater incentives to increase efficiency and quality:

- Patients will be more involved in making decisions about their own health and care, improving outcomes and reducing costs.
- Patient choice will reward the most efficient, high quality services, reducing expenditure on less efficient care.
- The NHS information revolution will also lead to more efficient ways of providing care, such as on-line consultations. Greater transparency will make it easier to compare the performance of commissioners and providers.
- Prices will be calculated on the basis of the most efficient, high quality services rather than average cost.
- Payment will depend on quality of care and outcomes, not just volume. Penalties for poor quality will encourage providers to get care right first time.
- The NHS will be freed from inefficient micromanagement of meeting targets like the 98% requirement for A&E waits, and associated performance management bureaucracy.
- Commissioners and providers will focus on implementing best practice to achieve improvements in outcomes, supported by a comprehensive library of NICE standards, the work of the NHS Commissioning Board, model contracts and continued research.
- GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.
- Local authorities' new functions will help unlock efficiencies across the NHS, social care and public health through stronger joint working.
- Existing providers will be set free and will be in charge of their own destiny, without central or regional management or support. This will be supported by a system of economic regulation overseen by Monitor that will drive efficiency. It will include a rules-based special administration regime. Hidden bail-outs will end.

5.13 Taken together, these ten changes will bring about a revolution in NHS efficiency. In the long term, they will help put the NHS on a more sustainable and resilient financial footing. The Department recognises that full implementation will take time; in particular the migration away from current risk pooling arrangements across SHAs.

Enhanced financial controls

5.14 As well as providing incentives for greater efficiency, the new arrangements will provide for enhanced financial control:

How the NHS will manage its resources

- NHS services will continue to be funded by the taxpayer. The Department of Health will receive funding voted by Parliament, and will remain accountable to Parliament and HM Treasury for NHS spend.
- The NHS Commissioning Board will be accountable to the Department for living within an annual NHS revenue limit, and subject to clear financial rules. This arrangement will introduce greater financial transparency between the Government and the NHS. The NHS Commissioning Board will allocate resources to GP consortia on the basis of need.
- GP consortia will have a high level of freedom; but in return they will be accountable to the NHS Commissioning Board for managing public funds. They will be subject to transparent controls and incentives for financial performance, and will enjoy a clear relationship with their constituent practices. Consortia will be required to take part in risk-pooling arrangements overseen by the NHS Commissioning Board; the Government will not bail out commissioners who fail. Regulations will specify a failure regime for commissioners.
- Commissioners will be free to buy services from any willing provider; and providers will compete to provide services. Providers who wish to provide NHS-funded services must be licensed by Monitor, who will assess financial viability.
- Providers of essential services may be required to take part in risk-pooling arrangements to ensure that, if a provider becomes financially unsustainable, Monitor will be able to step in and keep essential services running, without recourse to the Department of Health. The Government will not provide additional funding for failing providers. Monitor will be able to allow transparent subsidies where these are objectively justified, and agreed by commissioners.

Making savings during the transition

5.15 We will implement the reforms in this White Paper as rapidly as is possible. But the NHS cannot wait for them all to be in place to begin to deliver improvements in

quality and productivity. Patients are rightly demanding the former, and the national economic position requires the latter.

5.16 The NHS has understood for some time the need to make extremely challenging improvements in productivity and efficiency. Work has begun to release £15-20 billon of efficiency savings for reinvestment across the system over the next four years whilst driving up quality. Achieving this ambition will be extremely challenging, but it is essential; and it will be given a boost by our reforms as they come on stream.

5.17 The existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency. Work has started on implementing what is required, for example by improving care for stroke patients, the "productive ward programme", increased self-care and the use of new technologies for people with long-term conditions.[33] Further efficiencies can, and need to, be made from improving energy efficiency and developing more sustainable forms of delivery across the NHS, for example through working with the Carbon Trust and similar bodies on carbon reduction programmes that reduce energy consumption and expenditure.

5.18 SHAs and PCTs have a current role in supporting QIPP. In discharging this, and to pave the way for the new arrangements, they should seek to devolve leadership of QIPP to emerging GP consortia and local authorities as rapidly as possible, wherever they are willing and able to take this on. The Department will require SHAs and PCTs to have an increased focus on maintaining financial control during the transition period, and they will also be supported in this task by Monitor. The Department will not hesitate to increase financial control arrangements during the transition, wherever that is necessary to maintain financial balance; in such instances, central control will be a necessary precursor to subsequent devolution to GP consortia.

6. Conclusion: making it happen

Engaging external organisations

6.1 This White Paper sets out the Government's strategy for liberating the NHS in the current Parliamentary term and beyond. It provides clarity of purpose: a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world. It provides certainty, through a clear policy framework to support that ambition, with increased autonomy and clear accountability at every level in the NHS.

6.2 Much work now needs to be undertaken over the next two to three years, both to manage the transition, as well as to flesh out the policy details. The Department will take this forward in partnership with external organisations, seeking their help and expertise in developing proposals that work in practice, for example on shared decision-making and choice.

6.3 The implementation of all these reforms, and the detailed approach we take, will be subject to broad consultation – with local government, patients and the public, as well as external organisations. The Government will formally consult wherever it is appropriate to do so, for example on strengthening the NHS Constitution, and on draft regulations.

6.4 The Government will shortly publish more detailed documents seeking views on commissioning for patients (the implementation of the NHS Commissioning Board and GP consortia); local democratic legitimacy in health; freeing providers and economic regulation; and the NHS outcomes framework. The report of the arm's-length bodies review will also be published shortly. Later this year, the Government will also publish for consultation a NHS information strategy, and a document on the move to a provider-led education and training system.

6.5 To support the ownership of the strategy within the NHS and to inform the implementation of this White Paper, the Department of Health will carry out a series of consultation activities with: patients, their representative groups and the public; NHS staff, their representative and professional bodies; local government; and the voluntary, social enterprise and independent sectors. This will run in parallel to the formal consultation on the proposals above.

6.6 We will need to ensure, through our consultation exercises and broader policy work, that the system is financially sustainable through the transition, as well as in the longer term. The proper management of financial risk will be of particular importance.

Proposals for legislation

6.7 Many of the changes in this White Paper require primary legislation. The Queen's Speech included a major Health Bill in the legislative programme for this first Parliamentary session. The Government will introduce this in the autumn. The principal legislative reforms will include:

- Enabling the creation of a **Public Health Service**, with a lead role on public health evidence and analysis;
- Transferring **local health improvement functions** to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
- Placing the **Health and Social Care Information Centre**, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining **improvement in healthcare outcomes** as the central purpose of the NHS;
- Making the **National Institute for Health and Clinical Excellence** a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;
- Establishing the independent **NHS Commissioning Board**, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- Placing **clear limits on the role of the Secretary of State** in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
- Giving **local authorities new functions** to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
- Establishing a statutory framework for a **comprehensive system of GP consortia**, paving the way for the abolition of PCTs;
- Establishing **HealthWatch** as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local

HealthWatch;

- Reforming the **foundation trust** model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthorisation and enabling the abolition of the NHS trust model;
- Strengthening the role of the **Care Quality Commission** as an effective quality inspectorate; and
- Developing **Monitor** into the economic regulator for health and social care, including provisions for special administration.

Associated with these changes, reducing the number of **arm's-length bodies** in the health sector, and amending their roles and functions.

6.8 We are clear about the coherent strategy, and we will engage people in understanding this and its implications. We are consulting on how best to implement these changes. In particular, the Department would welcome comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill. Comments should be sent by 5th October 2010, to:

NHSWhitePaper@dh.gsi.gov.uk

or:

White Paper team
Room 601
Department of Health
79 Whitehall
London SW1A 2NS

Managing the transition

6.9 *Liberating the NHS* involves change at every level of the NHS. The policy and legislative framework is just the start. Effective implementation will require a major and sustained implementation effort right across the NHS over a number of years. Change will happen bottom-up, for example by GP consortia having greater say and responsibility as rapidly as possible, and NHS trusts applying for foundation trust status at the earliest opportunity - rather than waiting until 2013. The pace of change will therefore vary across the country according to organisations' readiness to assume their new functions.

6.10 Alongside the White Paper, the Department is issuing a framework for managing the initial steps of the transition. This will include the principles and the values that the Department will hold itself to, to ensure that the transition is managed fairly and transparently, and in a way that respects staff and the contribution they make. Some organisations will disappear as we simplify NHS administration, and free resources to support front-line services. But the need for good managers performing essential functions, such as managing finance and contracts, will remain. There will be opportunities for managers to start new roles, and help build a more innovative and responsive NHS, for example supporting GP consortia, and within the NHS Commissioning Board.

Timetable for action

6.11 The high level timetable below outlines the Government's proposed timetable (subject to Parliamentary approval for legislation).

Commitment	**Date**
Further publications on: • framework for transition • NHS outcomes framework • commissioning for patients • local democratic legitimacy in health • freeing providers and economic regulation	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: • vision for adult social care • information strategy • patient choice • a provider-led education and training • review of data returns	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010

Commitment	Date
Introduction of choice for: • care for long-term conditions • diagnostic testing, and post-diagnosis	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery	2011/12
NHS Outcomes Framework fully implemented	By April 2012

Commitment	Date
Majority of reforms come into effect: • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

Glossary

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Commissioning for Quality and Innovation (CQUIN) framework – the CQUIN framework enables those commissioning care to pay for better quality care, helping promote a culture of continuous improvement.

Currencies – in a tariff-based payment system, payments are made for defined units of healthcare (such as an out-patient appointment with a consultant). These are known as currencies.

Foundation trusts – NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control, enabling them to be more responsive to the needs of local populations.

Health Bill – proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health Bill will bring forward the legislative changes required for the implementation of the proposals in this White Paper.

Law Commission – an independent body set up by Parliament to review and recommend reform of the law in England and Wales.

Local Involvement Networks (LINks) – LINks are local organisations in each local authority area set up to represent views of local people on health and social care services. These will become local HealthWatch. Further details are in paragraphs 2.23 to 2.25

National Clinical Audit – Assesses the quality of patient care across all NHS providers by measuring activities and outcomes, using that information to stimulate clinicians to improve their performance, to help patients choose providers, to guide commissioners, and to support regulation and performance management.

National Institute of Health and Clinical Excellence (NICE) – an independent organisation which provides advice and guidelines on the cost and effectiveness of drugs and treatments.

NHS Constitution – the NHS Constitution describes the principles and values of the NHS in England, and the rights and responsibilities of patients, the public and staff.

NHS Operating Framework – the Operating Framework sets out the priorities for the NHS for each financial year. The Government published a revised Operating Framework for this year on 21st June 2010.

Patient Reported Outcome Measures (PROMs) – PROMSprovide information on how patients feel about their own health, and the impact of the treatment or care they receive.

Pay Review Bodies - independent bodies which make recommendations on public sector pay in the light of evidence submitted by the Government, employers, staff and others.

Payment by Results – provides a transparent system for paying providers of healthcare services. By using the tariff and currencies to link payment to activity the system is designed to reward efficiency and support patient choice.

Personal health budget – an extension of personalised care planning, that gives people more choice and control over the services they receive by giving them more control over the money that is spent on their care.

Primary care trusts (PCTs) – the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services such as district nursing, for a local area.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Quality accounts – a report on the quality of services published annually by providers of NHS care. Quality accounts are intended to enhance accountability to the public.

Spending Review – the Spending Review will set out the Government's priorities, and spending plans to meet these priorities, for the period 2011/12 to 2014/15.

Strategic health authorities (SHAs) – the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

Tariff – in relation to payment by results, the tariff it the calculated price for a unit of healthcare activity.

Value-based pricing – a mechanism for ensuring patients can get access to the medicines they need by linking the prices the NHS pays drug providers to the value of the treatment.

Venous thromboembolism (VTE) – a condition in which a blood clot (thrombus) forms in a vein. An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system.

Notes

[1] This White Paper applies only to the NHS in England. The devolved administrations in Scotland, Wales and Northern Ireland are responsible for developing their own health policies.

[2] European Union and domestic legislation prohibit discrimination on a number of grounds at work or in employment services, when providing goods, facilities or services to the public or disposing of or managing premises, in relation to education, when exercising public functions and by associations. The Equality Act 2010 which received Royal Assent on 8th April 2010 will replace existing anti-discrimination laws with one single Act and prohibit discrimination on a number of grounds such as sex, race, disability, age, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership.

[3] Section 6 Health Act 2009 places a duty on the Secretary of State to publish a report every three years on how the NHS Constitution has affected patients, staff, carers and members of the public, with the first report by 5 July 2012.

[4] For example, the Secretary of State has power in section 7 of the NHS Act 2006 to delegate functions to NHS bodies (other than NHS foundation trusts) and power in section 8 to direct those bodies as to the exercise of their functions. The Secretary of State also has powers to require information from NHS bodies, powers in relation to the allocation of their funding and various powers to intervene in certain NHS bodies.

[5] National Cancer Research Network, National Institute for Health Research, www.ncrn.org.uk

[6] Nolte, E., McKee, C.M, *Measuring the Health of Nations: analysis of mortality amenable to healthcare.* BMJ 2003; 327:1129; (2003).

[7] EUROCARE-4, www.eurocare.it

[8] OECD *In-hospital case-fatality rates within 30 days after admission for ischemic stroke (2007)*

[9] OECD, *Health at a Glance 2009,* (2009).

[10] OECD, *Health at a Glance 2009*, (2009).

[11] European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008).

[12] House of Commons Health Committee. *The prevention of venous thromboembolism in hospitalised patients*. Second report of session 2004-5. (2007).

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[14] Chote, R., Crawford, R., Emmerson, C., Tetlow, G., *Britain's Fiscal Squeeze: the Choices Ahead*, Institute for Fiscal Studies (2009).

[15] World Health Organization defines a high performing health system as one that should be "responsive to people's needs and preferences, treating them with dignity and respect when they come in contact with the system", *The Tallinn Charter: Health Systems for Health and Wealth Draft Charter*. WHO, (2008).

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[19] One of the three future scenarios modelled in the report was a "fully engaged" scenario where patients and the public were more engaged in their health, contributing to significantly lower demands on the health service in the longer-term. Wanless, D., *Securing our Future Health: Taking a Long-Term View*, (2002).

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Radcliffe, Bate, P., Robert G., *Bringing User Experience to Healthcare Improvement*. (2007).

[22] The 2009 British Social Attitudes Survey shows that over 95% of people think that there should be at least some choice over which hospital a patient attends and what kind of treatment they receive.

[23]Centre for Healh Economics, *Evaluation of the London Patient Choice project system wide impacts*, University of York (2004).

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[25] www.nice.org.uk/aboutnice/qualitystandards/vteprevention/

[26] Department of Health, *Guidance on the NHS Standard Contract for Acute Services, 2010/11.*

[27] National services are defined each year in Regulations, currently there are 52. Examples include: heart and liver transplants. www.opsi.gov.uk/si/si2010/uksi_20100405_en_1

[28] Regional services (34 in all) are defined in the Specialised Services National Definition Set (SSNDS). Examples include spinal injuries, specialised cancer care, burn care and bone marrow transplantation. www.ncg.nhs.uk/index.php/key-documents/specialised-services-national-definitions-set/

[29] Sections 65A to 65Z3 of the NHS Act 2006.

[30] See, for example, the description of how concurrency works between Ofcom and OFT, set out on Ofcom's website at www.ofcom.org.uk/about/accoun/oft/

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NHS

Liberating the NHS:

Commissioning for patients

A consultation on proposals

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
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Document Purpose	Consultation/Discussion
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Circulation List	
Description	One of the central features in Liberating the NHS is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. This document sets out, and seeks views on, the intended arrangements for GP commissioning and the NHS Commissioning Board.
Cross Ref	Equity and Excellence: Liberating the NHS and supporting documents
Superseded Docs	N/A
Action Required	For views on the specific questions posed.
Timing	**By 11 October 2010**
Contact Details	The White Paper Team Room 601 Department of Health 79 Whitehall SW1A 2NS www.dh.gov.uk/liberatingthenhs
For Recipient's Use	

Contents

1. Introduction

1.1 The White Paper *Equity and Excellence: Liberating the NHS* sets out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2 *Liberating the NHS* makes clear the Government's policy intentions and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise. An analytical strategy published alongside *Liberating the NHS* sets out our plans to use the consultation and engagement activity to inform the development of Impact Assessments to be published later in the year. It also provides an initial indication of what benefits, costs and risks will be analysed.

1.3 This document, *Commissioning for patients,* provides further information on our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It seeks views on a number of specific consultation questions. Examples of existing practice and evidence that support respondents' views are encouraged.

1.4 This is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- Regulating healthcare providers
- Local democratic legitimacy in health
- The review of Arm's-Length Bodies
- Transparency in outcomes: a framework for the NHS.

1.5 The Government will publish a response prior to the introduction of a Health Bill later this year.

Overview

1.6 When we think about the NHS, we often think of the individuals and organisations that provide care for patients, such as GPs, hospitals and community health professionals. But providers of NHS healthcare cannot exist in a vacuum. One of the most fundamental responsibilities in the NHS is to decide what services will best meet the needs of patients and local communities and to commission these services in ways that ensure high-quality outcomes, maximise patient choice and secure efficient use of NHS resources.

1.7 This is the central theme of NHS commissioning – understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality.

1.8 One of the central features of the proposals in *Liberating the NHS* is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs, practice nurses and other primary care professionals are already supporting patients in managing their health, promoting continuity and co-ordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside individual patients and alongside the full range of other health and care professionals.

1.9 As set out in the parallel document *Local democratic legitimacy in health*, we plan to put in place robust oversight arrangements for local democratic accountability with local authorities playing a key role. They will lead the statutory joint strategic needs assessment, which will inform the commissioning of health and care services and promote integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health. They will support joint commissioning and pooled budget arrangements, where parties agree this makes sense, and will undertake a scrutiny role in relation to major service redesign. One option for doing this is through the creation of statutory health and wellbeing boards within local authorities.

1.10 *Liberating the NHS* also sets out proposals to establish an independent NHS Commissioning Board. The Board will provide national leadership on commissioning for quality improvement and promote and extend public and patient involvement and choice. It will be responsible for ensuring a comprehensive system of GP commissioning consortia across the NHS, for holding consortia to account and for commissioning some services itself. It will allocate and account for NHS resources.

1.11 The forthcoming consultation document on *Regulating healthcare providers* will also set out a proposed role for a new independent economic regulator of health and social care, to act as a champion for patients, setting prices where needed, protecting patient choice, and helping to ensure continuity of services.

1.12 This document sets out our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It serves as the starting point for a programme of consultation and engagement with patients and the public, GPs and other health and care professionals, local government, and voluntary sector, social enterprise and independent sector organisations. We would like your views on how to deliver the greatest possible benefits from these new commissioning arrangements, on how to develop the partnerships on which their success will depend, on how GP consortia can best work with the NHS Commissioning Board, and on the other specific questions identified below.

Current commissioning arrangements

1.13 For the past decade, commissioning responsibilities have largely rested with primary care trusts (PCTs) and to some extent the primary care groups that preceded them. The previous Government made belated attempts to strengthen PCT commissioning through its programme of 'world class commissioning'. But the weaknesses of the system have lain much deeper than the capacity of staff working in PCTs. Commissioning has been too remote from the patients it is intended to serve. It has been divorced from GPs' clinical responsibilities, such as referral, with efforts to create 'practice based commissioning' lacking reality and not sufficiently empowering. It has been beset by political interference and micro-management, with a rhetoric of PCTs being free to reflect local health priorities but the reality of having to pursue targets and Ministerial demands.

Proposed commissioning arrangements

1.14 Our proposals for GP commissioning and the NHS Commissioning Board mark a fundamental break with this past. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public.

1.15 Our proposed model will not mean all GPs, practice nurses and other practice staff having to be actively involved in every aspect of commissioning. Their predominant focus will continue to be on providing high-quality primary care to their patients. It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect their views of their patients' needs and their own referral intentions. It will be a requirement for every GP practice to be part of a consortium and to contribute to its goals, not least in ensuring that as a practice they provide services in ways that support high-quality outcomes and efficient use of NHS resources.

1.16 Nor will the practitioners who lead the consortia need to carry out all commissioning activities themselves. Whilst it is likely that they will coordinate most of the clinical aspects of commissioning themselves, consortia will be able to employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers, for instance to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes. Consortia will have the freedom to decide which aspects of commissioning activity they undertake fully themselves and which aspects require collaboration across several consortia, for instance through a lead commissioner managing the contract with a large hospital or commissioning low-volume services not covered by national and regional specialised services.

1.17 GP consortia will also be supported by the role of the NHS Commissioning Board in developing commissioning guidelines, model contracts and tariffs.

1.18 Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards, means that PCTs will no longer have a role. We expect that PCTs will cease to exist from April 2013, in light of the successful establishment of GP consortia. A number of PCTs have made important progress in developing commissioning experience. We will be looking to capitalise on that existing expertise and capability in the transitional period, where this is the wish of GP consortia.

1.19 PCTs will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible and early adopters promoting best practice.

Purpose of this document

1.20 This document sets out in more detail:

- **responsibilities (Section 3):** the scope of the services for which consortia and the NHS Commissioning Board will be responsible, their responsibilities as commissioners of these services, and the relationship between the responsibilities of the NHS Commissioning Board, GP consortia and individual GP practices

- **establishment of GP consortia (Section 4):** the statutory form that consortia will take, the bottom-up way in which we will invite GP practices to form consortia and arrangements for authorisation by the NHS Commissioning Board

- **freedoms, controls and accountabilities (Section 5):** the freedoms and flexibilities that consortia will have to decide how best to commission services and how they will be held accountable, both to the patients and local communities they serve and to the NHS Commissioning Board, for the outcomes they achieve and for control of resources

- **partnerships (Section 6):** how we envisage that consortia and the NHS Commissioning Board will work with patients and the public, with local government, and with other health and care professionals to secure more patient-centred and integrated delivery of care

- **implementation and next steps (Section 7):** the timetable for the transition to GP practice commissioning and the establishment of the NHS Commissioning Board, and the practical steps we propose that PCTs should take with GP practices and current practice-based commissioning

groups to begin this transition, including action to help ensure that consortia will be supported by excellent clinical leadership and excellent information.

2. Summary of key points

Responsibilities of GP consortia

2.1 In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning most healthcare services to groups of GP practices.

2.2 Consortia of GP practices will commission the great majority of NHS services on behalf of patients, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services.

2.3 Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice. The NHS Commissioning Board will also commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

2.4 The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources. They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

2.5 Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services and public health.

2.6 Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

Relationship between consortia and individual practices

2.7 The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

The role of the NHS Commissioning Board

2.8 To support consortia in their commissioning decisions we will create a statutory NHS Commissioning Board, which will:

- provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
- promote and extend public and patient involvement and choice
- ensure the development of consortia and hold them to account for outcomes and financial performance
- commission certain services that are not commissioned by consortia, such as the national and regional specialised services
- allocate and account for NHS resources.

2.9 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for their performance.

Establishment of GP consortia

2.10 The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

2.11 Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

2.12 Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively, notwithstanding their ability to work with other consortia to manage financial risk.

Freedoms and accountabilities

2.13 We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning. Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

2.14 Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. At the same time, the economic regulator and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition, for instance by ensuring wherever possible that any willing provider has an equal opportunity to provide services. The Department will discuss with the NHS the safeguards that will be needed to ensure these objectives, particularly with regard to consortia commissioning services from general practice (over and above the primary care services that they already have a duty to provide).

2.15 The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling duties such as public and patient involvement and partnership with local authorities. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

2.16 We propose that the NHS Commissioning Board, supported by NICE, will develop a commissioning outcomes framework so that there is clear, publicly available information on the quality of healthcare services commissioned by consortia, including patient-reported outcome measures and patient experience, and their management of NHS resources. The framework would also seek to capture progress in reducing health inequalities.

2.17 We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that

practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources.

2.18 The NHS Commissioning Board will need powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure. We propose working with the NHS to develop criteria or triggers for intervention.

Partnership

2.19 Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local HealthWatch bodies) and patient participation groups, and with community partners.

2.20 The proposed new local authority health and wellbeing boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

2.21 We will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

Implementation

2.22 Our proposed implementation timetable is:

In 2010/11

- GP consortia to begin to come together in shadow form (building on practice-based commissioning consortia, where they wish)

In 2011/12

- a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form

In 2012/13

- formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body

In 2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers.

3. Responsibilities

Scope of GP commissioning

3.1 The principle underpinning the scope of GP commissioning will be that commissioning responsibilities – and accompanying NHS resources – should be devolved as close to the patient as possible.

3.2 We intend that consortia will, therefore, be statutorily responsible for commissioning the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services and mental health and learning disability services. Consortia will be responsible for meeting prescribing and associated costs. It will be for consortia to decide on a case-by-case basis whether to commission services themselves, or to make appropriate arrangements with another commissioning organisation (for instance a lead consortium).

3.3 There will, however, be some exceptions, where it makes sense for the NHS Commissioning Board to have responsibility – and the accompanying share of the NHS budget – for commissioning services. The proposed exceptions are:

- **primary medical care**: the Board will be responsible for holding contracts with individual GP practices in their role as providers of primary medical care, although we envisage a key role for consortia in driving up quality of general practice (see paras 3.14-3.22 below)

- **other family health services**: the Board will commission primary dental services, community pharmacy (and other dispensing services) and primary ophthalmic services. Consortia will, however, be able to commission services from primary care contractors, for instance if they wish to commission optometrists to help manage glaucoma

- **national and regional specialised commissioning**: the Board will have responsibility for commissioning certain highly specialised services, i.e. those covered by the Specialised Services National Definitions Set such as heart transplants, spinal injuries, burns and renal dialysis, which the Board will commission at the appropriate level. This will ensure that patients with rare conditions can be sure of high-quality and cost-effective treatment and are treated equitably with people who have more common conditions. It will also help ensure more effective implementation of Sir

David Carter's 2007 review of specialised commissioning. The Board will need to facilitate strong engagement of consortia in these arrangements and ensure a smooth interface between GP commissioners and specialised services

- **maternity services**: we propose that the Board plays the lead role in commissioning maternity and newborn care services, with a view to promoting choice across a range of settings and services

- **health services for those in prison or custody**: we propose that the Board works with criminal justice agencies and GP consortia to determine the most appropriate arrangements for prison health services.

3.4 There may of course be other services, such as low-volume services outside the scope of national or regional specialised commissioning, that are better commissioned for larger populations than those of individual consortia. We propose that consortia, in accordance with their duties of partnership and engagement, should have the freedom and the responsibility to decide for themselves at what level (for instance through a lead consortium) these services are best commissioned.

Questions

- 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?

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

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

- 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?

Duties and responsibilities of GP consortia

3.5 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. These budgets will need to reflect an appropriate share of healthcare resources to include both people registered with practices in the consortium and local residents who are not registered with any GP practice.

3.6 Consortia will be responsible for managing their combined budget and for deciding how best to use these resources to meet the healthcare needs of the patients for whom they are responsible. Just as PCTs are currently the responsible commissioner for people registered with a GP practice in their area (even if they live elsewhere), the consortium will be the responsible commissioner for any patients registered with its constituent practices. Cross-border arrangements with Scotland and Wales will be unaffected.

3.7 In addition to their responsibilities for registered patients, consortia will be responsible for ensuring the provision of comprehensive emergency services for any person in their area.

3.8 The specific accountabilities, responsibilities and duties of consortia will be set out through primary and secondary legislation. This will include accountability and responsibility for:

- determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities
- determining what services are required to meet these needs and ensuring the appropriate clinical and quality specification of these services
- entering into and managing contracts with providers
- monitoring and improving the quality of healthcare provided through these contracts
- providing oversight, with the NHS Commissioning Board, of healthcare providers' training and education plans.

3.9 The legislation will also set out a consortium's duties in relationship to financial management, including:

- ensuring that expenditure does not exceed its allocated resources
- requirements in relation to reporting, audit and accounts.

3.10 Consortia will have duties in relation to equality and human rights and in relation to data protection and freedom of information.

3.11 Consortia will have duties to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, services for carers, and to cooperate with local authorities and other agencies in relation to criminal justice.

3.12 Consortia will have a duty to inform, engage and involve the public in identifying needs, planning services and considering any proposed changes in how those services are provided. Where this is likely to result in changes in the configuration of services, consortia will be expected to report on the likely impact of those changes and the impact of public involvement on their commissioning decisions.

3.13 Section 5 of this document sets out proposals for how consortia are held to account for how they carry out their responsibilities and duties.

Relationship between consortia and individual GP practices

3.14 The duties and responsibilities set out above will apply to the consortium. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

3.15 We will discuss with the BMA and the profession how primary medical care contracts can best reflect specific new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.

3.16 With the exception of a management allowance (see para 5.2 below), the consortium's commissioning budget will be used exclusively for commissioning of patient care. It will be distinct from the income that GP practices earn under their primary medical care contract, from which they both meet their practice expenses and derive their personal income. However, health outcomes for patients will of course depend both on the quality of the services that GP practices provide and on the quality of GP commissioning. We therefore propose (as set out in para 5.17 below) that a proportion of GP practice income should be linked to the overall outcomes that practices achieve collaboratively through their role in a commissioning consortium.

3.17 We also propose to work with the BMA and the profession to reform the Quality and Outcomes Framework (QOF) so that it better reflects individual practices' contribution to health outcomes. The QOF made an initial

contribution to improving patient care when introduced in 2004, but it is now failing to deliver any significant degree of continuous quality improvement for patients. A large number of QOF indicators reward GP practices for the processes they carry out, such as keeping registers of patients with long-term conditions or measuring blood pressure, and reflect standards of care that one would routinely expect from any GP practice. We want the QOF to focus more on the health outcomes that are achieved for patients and to provide incentives for continuous improvements in quality of care.

3.18 By the same token, the performance of consortia as commissioners will be closely bound up with the quality of services provided by their constituent practices. The effective identification and management of long-term conditions, the accessibility and responsiveness of GP services, and decisions on referrals and prescribing all have a major impact both on the overall quality of patient care and on the efficient use of NHS resources. We therefore propose that consortia should play a key role in working with individual GP practices to drive up the quality of primary medical care and improve overall utilisation of NHS resources.

3.19 Whilst care will be needed to protect against conflicts of interest, the NHS Commissioning Board should have the power, where it judges it appropriate, to ask consortia to carry out on its behalf some aspects of the work involved in managing primary medical services contracts, for instance by promoting quality improvement, reviewing and benchmarking practice performance and ensuring clinical governance requirements are met. This would enable consortia to apply peer review and challenge in the first instance to areas where there appear to be unwarranted variations in practice or outcomes, for instance in relation to prescribing or the systems in place to support management of long-term conditions. The Board would retain overall responsibility for commissioning and contractual decisions.

3.20 The role of GP consortia in helping promote quality and review practice performance will also help ensure that action to ensure good financial management sits alongside and complements GPs' clinical responsibilities to patients and their role in supporting patient choice. This means promoting innovations that improve both quality and productivity, whilst challenging any behaviours that are inappropriate both for good clinical care and for efficient use of NHS resources.

3.21 The Government intends to work with the profession to move over time towards a single contractual and funding model for GP practices to promote quality improvement, deliver fairness for all practices, support free patient choice and remove unnecessary barriers to new providers. This model would

reflect the fundamental aspects of primary care services - those services that every patient should expect to be able to receive at their GP practice.

3.22 A consortium may need to arrange for some of its GP practices to provide primary care services over and above those that they already have a duty to provide, subject to safeguards (discussed in section 5) to ensure fairness, transparency and competition. We will take forward further work to identify the most suitable contractual framework for services of this kind.

Questions

- How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?
- 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?
- What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

The role of the NHS Commissioning Board

3.23 To provide overall leadership on commissioning, we will create a NHS Commissioning Board with an appropriate infrastructure. The Board will be an independent statutory authority with a Chair, Chief Executive and both executive and non-executive board members and will be free to determine its own organisational shape, structure and ways of working. It will carry out some functions currently performed by the Department of Health, SHAs and PCTs, as set out below, but will be a lean organisation, performing those functions in a more streamlined way.

3.24 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. It will be responsible for reporting the consolidated financial position of consortia as part of its financial reporting obligations.

3.25 The Secretary of State will set the NHS Commissioning Board an annual mandate, based on a multi-year planning cycle, which will be subject to public

consultation and Parliamentary scrutiny. This will cover the totality of what the Government expects from the Board on behalf of the taxpayer, including progress against outcomes specified by the Secretary of State in the NHS Outcomes Framework, delivering improvements in choice and patient involvement and tackling inequalities in outcomes of healthcare. The Board will in turn hold consortia to account for their performance. The new system will be set out in primary and secondary legislation.

3.26 *Liberating the NHS* sets out five broad functions for the NHS Commissioning Board:

i) providing national leadership on commissioning for quality improvement

3.27 The NHS Commissioning Board will provide a framework to support GP consortia in commissioning services, including:

- setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE, in a way that promotes joint working across health, public health and social care. These will be used as the basis for developing the NHS Outcomes Framework into a more comprehensive set of indicators and making available accessible information on commissioner performance

- designing model NHS contracts for consortia to adapt and use with providers and setting standards for the quality of NHS commissioning and procurement

- designing the structure of tariff and other financial incentives whilst the economic regulator will set tariff levels

- having a role in determining technical and data standards to ensure there is consistency in the information that commissioners and providers are using, and compatibility between information systems

- where appropriate and by agreement with consortia, hosting some commissioning networks, for example for cancer, targeted health services for ill and disabled children, and coronary heart disease.

ii) promoting and extending public and patient involvement and choice

3.28 As well as involving patient and professional representative bodies in carrying out its work, the NHS Commissioning Board will take the lead in promoting and extending public and patient involvement and choice in the NHS by:

- championing effective patient and public involvement and engagement in commissioning decisions, and greater involvement of patients and carers in

decision-making and managing their own care, working with consortia, local authorities, patient groups and HealthWatch

- developing and agreeing with the Secretary of State the guarantees for patients about the choices they can make, taking account of advice from the economic regulator on the implications for competition, in order to provide clarity for patients and providers alike

- promoting and extending information to support meaningful choice of what care and treatment patients receive, where it is provided and who provides it, including personal health budgets

- commissioning information requirements for choice and for accountability, including patient-reported experience and outcome measures.

iii) ensuring the development of GP consortia and holding them to account

3.29 The NHS Commissioning Board will:

- support and develop the establishment and maintenance of an effective and comprehensive system of GP consortia; and

- hold consortia to account for delivering outcomes and financial performance.

iv) commissioning certain services that are not commissioned by consortia

3.30 The NHS Commissioning Board will have statutory responsibility for commissioning some services that it would be less appropriate for consortia to commission. These will include primary medical care, other family health services, maternity services, prison health services, and national and regional specialised services.

v) allocating and accounting for NHS resources

3.31 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. The Board will allocate resources on the basis of seeking to secure equivalent access to NHS services for all, relative to the prospective burden of disease.

3.32 The Board will have overall responsibility for financial stability of commissioners and for accounting to the Secretary of State for NHS commissioning expenditure, underpinned by robust financial management measures at consortium level.

3.33 The Board will have limited powers, to be set out in legislation, to intervene where for example a consortium is failing to fulfil its statutory duties or there is a significant risk that a consortium will fail to do so.

Questions

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

4. Establishment of GP consortia

Organisational form

4.1 We intend that consortia, once established, will be statutory public bodies, with powers and responsibilities set out through primary and secondary legislation. By that time, each consortium would need to have chosen its own Accountable Officer and Chief Financial Officer (with the latter officer potentially discharging this role for more than one consortium).

4.2 We believe that consortia should be held to account for the outcomes they achieve and for their fulfilment of appropriate duties, rather than for the way in which they constitute themselves. We do not intend to set out detailed or prescriptive requirements in relation to the internal governance of a consortium, beyond essential requirements for example in relation to areas such as financial probity and accountability (e.g. statutory accounting as determined by the NHS Commissioning Board), reporting (e.g. to publish a commissioning plan and report on expenditure) and audit.

Questions

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

Forming consortia

4.3 We intend, subject to discussion with the BMA and the wider profession, that every practice, i.e. every holder of a primary medical care contract (whether it be a GP partnership, nurse-led partnership, voluntary organisation, social enterprise or independent sector organisation), should be required to be a member of a consortium, as a corollary of holding a list of registered patients.

4.4 Consortia will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent care), to have responsibility for commissioning services for people who are not registered with a practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding. For these purposes, they will need to have boundaries that interlock so that taken together they cover the entire country.

4.5 We do not, however, propose to issue a Whitehall blueprint for the geography of consortia. We believe that GP practices should have the flexibility within the legislative framework, subject to having the geographic focus described above, to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. This might include preserving groupings used for practice-based commissioning, where they have been successful. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia across the country. We envisage a reserve power for the Board to assign practices to consortia, if necessary, but only as a last resort.

4.6 Nor do we wish to be unduly prescriptive about the size of consortia. There have been widespread variations in the size and population coverage of PCTs, and there is no evidence to suggest a single 'right' size. The NHS Commissioning Board will nonetheless need to satisfy itself that consortia are of sufficient size to manage financial risk and allow for accurate allocations.

4.7 We would encourage consortia to begin to form on a shadow basis in 2010/11 (building on practice-based commissioning consortia, where they wish), and, where they are ready to do so, begin to take on some responsibilities from PCTs, in line with the vision set out in this document.

Questions

- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
- Should there be a minimum and/or maximum population size for GP consortia?

Authorisation

4.8 We propose that the NHS Commissioning Board will have the duty and powers to authorise consortia, once it is satisfied that they have the necessary arrangements and capacity to fulfil their statutory duties and accountabilities and that there is clarity about the geographical area that they cover for the purposes set out above. There will need to be a rigorous process to ensure that consortia are able to fulfil duties in relation to financial accountability and control. Where a consortium does not fulfil any minimum requirements for authorisation, the Board will need to be explicit in setting out the steps that need to be taken and the interim arrangements.

4.9 There will also need to be flexibility to allow consortia to evolve in terms of the groups of practices that they bring together and to ensure that new primary care providers are able to join consortia.

5. Freedoms, controls and accountabilities

Freedoms

5.1 Within the scope of NHS services as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, supported by the national framework of quality standards, tariffs and national contracts established by the NHS Commissioning Board. They will be able to adapt model contracts to include the quality dimensions that they judge will produce the best outcomes, subject to ensuring that patients have choice of any willing provider that can perform to these quality standards.

5.2 We propose that commissioning budgets will include a maximum allowance to cover management costs. Consortia will be free to decide how best to use this management allowance to carry out commissioning activities. Consortia are likely to carry out a number of commissioning activities themselves. In other cases, they may choose to act collectively, for instance by adopting a lead commissioner model to negotiate and monitor contacts with large hospital trusts or with urgent care providers. They may also choose to buy in support from external organisations, including local authorities and private and voluntary sector bodies. This could include, for instance, analytical activity to profile and stratify healthcare needs, procurement of services, and contract monitoring.

5.3 Consortia will also have the freedom to arrange for some commissioning activities to be undertaken at a sub-consortium or practice level, where that is appropriate and where the necessary internal controls are in place.

5.4 These freedoms are intended to ensure that GPs and other clinicians are able to focus their input on those aspects of commissioning that will most benefit from their clinical insight and expertise, alongside their core duties of care for patients.

5.5 In the transition to consortia taking on statutory commissioning responsibilities, we envisage that PCTs will provide many of these functions in support of shadow consortia, alongside the many organisations that already exist to provide commissioning support. We envisage that over time a more competitive market will develop for supplying some of these services.

Questions

- How can GP consortia best be supported in developing their own capacity and capability in commissioning?
- What support will GP consortia need to access and evaluate external providers of commissioning support?

Managing financial risk

5.6 Consortia will need to have sufficient freedoms to invest resources in ways that achieve the best and most cost-efficient outcomes for patients.

5.7 At the same time, consortia will need to manage resources in ways that control financial risk and enable them to meet their responsibility for breaking even on their commissioning budget. A key issue will be managing volume risk in the new system. There are two broad categories of risk in the system:

- risks from unavoidable and natural fluctuations in the healthcare needs of a population, which are often described as 'insurance risk'
- risks arising from controllable activities, such as poor prescribing or referral practices, sometimes known as 'service risk'.

5.8 The challenge for risk management is helping commissioners deal with the insurance risk through some form of risk pooling, while ensuring that commissioners are responsible for managing service risk. Empirically it can be difficult to separate out those risks. This means that the approach to managing financial risk will need to be carefully thought through and evolve over time as new evidence comes to light.

5.9 We envisage that the NHS Commissioning Board will have a significant role in managing financial risk, for example through oversight of risk pooling within and between consortia. Consortia should have a level of flexibility in deciding how best to manage financial risk within the overall regime set by the NHS Commissioning Board to encourage good financial management. The principles for managing underspends and overspends, including whether any planned and managed underspends may be carried over to future years to invest in services and whether any actual overspends will be deducted from the following year's allocation, will be agreed between the NHS Commissioning Board, the Department of Health and HM Treasury. Key criteria are likely to be:

- minimising exposure to uncontrollable 'insurance risk'
- allowing for the maximum proportion of funds to be allocated direct to patient services
- ensuring the right arrangements to manage the impact of over- or under-spending by consortia, without a disproportionate amount of money needing to be held back as contingency
- ensuring sufficient incentives and disciplines to manage financial risk properly, and service risk in particular, at the local consortium level.

5.10 These arrangements will need to complement the incentives for consortia to manage risk, which will include benefits for good financial management such as the proposed quality premium (see para 5.17). The NHS Commissioning Board will have intervention powers in the event of poor financial management (see paras 5.18-5.21).

Questions

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

Transparency and fairness in investment decisions

5.11 It is essential that consortia have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. At the same time, the economic regulator and NHS Commissioning Board will need to develop and maintain a framework that ensures transparency, fairness and patient choice. We propose that, wherever possible, services should be commissioned that enable patients to choose from any willing provider.

5.12 This will be particularly important where a consortium proposes to commission services from one or more of its constituent practices. Consortia will be commissioning organisations and will not be able to provide services in their own right. It is essential, however, that individual practices or groups of practices have the opportunity to provide new services (over and above the primary care services that they already have a duty to provide), where this will provide best value in terms of quality and cost. This will not happen if the muddled and over-bureaucratised approach that has too often characterised

'practice-based commissioning' is allowed to continue. Further work will be taken forward with the NHS to develop a framework that allows commissioning of new services whilst guarding against real or perceived conflicts of interest.

5.13 This will require transparency over how commissioning decisions are made and the value of services commissioned from GP practices. Where services are commissioned on an 'any willing provider' basis, there are established protocols that can be used or adapted to report and audit the pattern of referrals from GP practices that are also themselves a provider or part of a provider consortium. We would also anticipate that, where GP practices wish to bid in a major procurement, the procurement could be managed by another party such as the NHS Commissioning Board or a local authority.

Questions

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

Accountability to patients and the public

5.14 The NHS Commissioning Board will be responsible for developing an assurance process that enables consortia to be accountable for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the duties placed upon them, for instance in relation to promoting equality and working in partnership.

5.15 We propose that the NHS Commissioning Board, supported by NICE and working with patient and professional groups, will develop a commissioning outcomes framework that measures the health outcomes and quality of care (including patient-reported outcome measures and patient experience) achieved by consortia, with an appropriate adjustment for patient mix. This would, for instance, assess the health outcomes achieved for people with long-term conditions, the quality of urgent care and acute hospital care, and health outcomes for people with long-term mental health conditions or a learning disability. It would include measures to reflect the consortium's duties to promote equality and to assess progress in reducing health inequalities.

5.16 This framework would allow the NHS Commissioning Board to identify the contribution of consortia to achieving the priorities for health improvement in

the NHS Outcomes Framework, against which the Secretary of State will hold the Board to account, whilst also being accountable to patients and local communities on a wider set of measures. It would also enable consortia to benchmark their performance and identify priorities for improvement.

5.17 GP practices already make a key contribution to the overall quality of patient care and to the effective use of NHS resources. Coming together in consortia to commission healthcare on behalf of patients will empower them to collaborate more effectively in pursuit of high-quality outcomes for patients. We therefore propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that they achieve collaboratively through commissioning consortia and the effectiveness with which they manage financial resources. We propose that this 'quality premium' should be paid in the first instance to the consortium and that the consortium would be free to decide how best to apportion it between its member practices. This premium would need to be funded from within existing resources.

Questions

- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
- Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
- What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Accountability for the use of public resources

5.18 The primary legislation will need to allow for the NHS Commissioning Board to intervene in the event that a consortium is unable to fulfil its duties effectively, for instance in the event of financial failure or a systemic failure to meet the healthcare needs of patients, or where there is a significant risk of failure. This could include powers for the Board to make continued authorisation dependent upon remedial action and, in the last resort, to take over the consortium's commissioning responsibilities or assign them to a third party (e.g. a neighbouring consortium).

5.19 We propose working with the profession and the NHS to develop criteria or triggers for intervention, which could be reflected in the consortium's terms of authorisation, and to consult on these at a later date. We envisage that any intervention would typically be a staged process so that, wherever possible, a consortium has the opportunity to take remedial action itself rather than have commissioning responsibilities withdrawn. Any process would need to be in accordance with a transparent statutory framework of rules.

5.20 We consider that GP practices, like any other provider of NHS services, have a responsibility to use public resources responsibly and in the public interest. We anticipate that enabling GP practices to work alongside other health and care professionals through commissioning consortia will enhance their ability to fulfil this responsibility.

5.21 In any circumstances where there are concerns that an individual practice is causing ineffective or wasteful use of NHS resources, the consortium of which it is a part would be expected to work with that practice to address the relevant issues. If problems persisted and there were concerns that a practice was not meeting its contractual duties, the NHS Commissioning Board would need to address this as part of its responsibility for managing primary care contracts.

6. Partnership

Patients and the public

6.1 One of the principal aims of GP commissioning is to make decisions more sensitive and responsive to the needs and wishes of patients and the public. Good communication and engagement with the public will, therefore, be vital. Both GP consortia and the NHS Commissioning Board will need to find and evolve efficient and effective ways of harnessing public voice so that commissioning decisions are increasingly shaped by people's expressed needs and wants.

6.2 As part of the development of GP commissioning and the NHS Commissioning Board, we will promote:

- patient, carer and public involvement in decision-making
- responsiveness to the views and feedback of patients, carers and the public
- accountability to local people for the decisions about their health services made by consortia on their behalf.

6.3 We are not starting with a clean sheet. Commissioners will need to establish and nurture new relationships with:

- local HealthWatch (currently Local Involvement Networks) and the national body HealthWatch England, the new independent consumer champion that we propose to establish as part of the Care Quality Commission
- the Patient Participation Groups that GP practices are increasingly using to help make their own services more responsive to patient wishes
- local authorities, who will have a new enhanced role in promoting public involvement in decisions about service priorities and changes to local services and in responding to any public concerns about inadequate involvement
- local voluntary organisations and community groups, who often work with, and represent, the most disadvantaged and marginalised patients and carers.

6.4 The NHS Commissioning Board will be expected to ensure that practices provide accessible information to the public on the range of services they provide and that GP consortia provide information on performance against their commissioning plans.

6.5 We want to ensure that the prime focus is on developing the behaviours and cultures that will encourage and facilitate public participation and patient voice, rather than being over-reliant on the legal framework.

Questions

- How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
- 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?
- How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?
- 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?

Local government and public health

6.6 Under the proposals set out in the parallel document *Local democratic legitimacy in health*, local government will have an enhanced responsibility for promoting partnership working and integrated delivery of public services across the NHS, social care, public health and other services. One way in which this could occur is through health and wellbeing boards which would include representatives from GP consortia and, where relevant issues are being discussed, representation from the NHS Commissioning Board.

6.7 Local government will also have an enhanced role in public health, with direct responsibility and funding (allocated to local Directors of Public Health) for improving the health of local communities, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity.

6.8 This enhanced role for local government will provide a framework through which GP consortia alongside other partners:

- contribute to a joint assessment of the health and care needs of local people and neighbourhoods
- ensure that their commissioning plans, and relevant joint commissioning plans, reflect the health needs identified in these assessments
- draw on the advice and support of the proposed health and wellbeing board in relation to population health
- identify ways of achieving more integrated delivery of health and adult social care, for instance through pooled budgets or lead commissioning arrangements (e.g. a local authority becoming the lead commissioner for some older people services)
- support improvements in children's health and wellbeing
- play a systematic and effective part in arrangements for safeguarding of children and protection of vulnerable adults
- cooperate with the criminal justice system, for instance in relation to tackling misuse of drugs and alcohol, offender health services and assessment of violent offenders.

6.9 We envisage that bringing GP practices together into consortia for commissioning purposes will also help provide a more effective conduit for the involvement of individual practices in these areas of partnership working.

6.10 Where there are currently Care Trusts that bring together responsibility for commissioning health and social care services, their healthcare responsibilities will need to transfer to GP consortia in line with the proposals set out in this document. The framework described above is designed to enable GP consortia to work with local government to ensure that the benefits achieved through Care Trusts can be sustained and built upon.

Questions

- 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?
- 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?

Other health and care professionals

6.11 Given their key role in co-ordinating care, GP practices are well placed to lead on commissioning care for patients. However, we expect consortia to involve relevant health and social care professionals from all sectors in helping design care pathways or care packages that achieve more integrated delivery of care, higher quality, better patient experience and more efficient use of NHS resources.

6.12 Some of the most successful current examples of clinical commissioning have come when practice-based commissioning groups have engaged other health and care professionals in this way. This has often been driven by innovative use of data and information to throw a spotlight on the pattern of care received by patients with long-term conditions, particularly those with complex health problems. These types of analysis can show clinicians how the current system too often leads both to sub-optimal patient care and to inefficiency at the interfaces between primary care, community health services and specialist care. In time, we would expect to see this approach apply across the whole pathway, including health and social care.

6.13 We firmly believe that the GP practice and the registered patient list should form the essential building block of commissioning consortia, but successful commissioning will clearly also be dependent on the wider involvement of other health and care professionals. We will not fall into the trap of prescribing top-down processes or governance requirements to say how this should be achieved. We will, however, work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

Questions

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

7. Implementation and next steps

7.1 PCTs will have an important task over the next two years in supporting GP practices to prepare for these new arrangements. Our indicative timetable is for:

2010/11

- GP consortia to begin to form on a shadow basis (building on practice-based commissioning consortia, where they wish) and, where they are ready to do so, begin to take on some responsibilities from PCTs, supported by indicative budgets

2011/12

- a comprehensive system of shadow GP consortia in place, taking on increased responsibility from PCTs, including increased responsibility for the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- the NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP consortia

2012/13

- formal establishment of GP consortia, together with indicative allocations
- the NHS Commissioning Board to be established as an independent statutory body
- the NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14

2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers

Preparing for GP commissioning

7.2 There will be a number of practical next steps that PCTs will need to take with GP practices and existing practice-based commissioning groups during 2010/11, which we will discuss with the NHS and with the profession. This will include identifying the likely future shape of consortia and enabling them to start taking increasing responsibility for making commissioning decisions on behalf of PCTs. This will mean PCTs increasingly putting management resources at the disposal of shadow consortia and working with them during the transition to ensure that appropriate skills and knowledge are retained.

7.3 PCTs will also need to work alongside shadow consortia to forge relationships with patient and public groups and with the range of external partners identified in Section 6 of this document.

7.4 In addition to these practical steps, we think there will be a number of areas where it is essential that early progress is made in preparing for the challenge of future commissioning arrangements. These include:

- **clinical leadership**: we will work with the National Leadership Council and professional representative groups to explore how best to provide support and development for GPs and other clinicians who would like to take on leadership roles within commissioning consortia

- **information**: we will work with the profession and the wider NHS to identify how best to support consortia in the significant challenge of accessing accurate, real-time data that can be translated into information to support efficient and effective care along the patient pathway and to understand the relationship between patient needs, service provision, health outcomes and financial expenditure

- **financial transactions**: we will work with the profession and the NHS to ensure effective systems that enable consortia to track expenditure, reconcile activity and expenditure, and minimise transaction costs.

Engagement

7.5 Through *Liberating the NHS* and this document, we are setting out further detail on our plans for GP commissioning and the NHS Commissioning Board. We are inviting individuals and groups to engage with the policy design and are specifically asking for views on its implementation.

7.6 This engagement will be aligned with, and conducted in, close collaboration with the engagement activities for the broader White Paper to achieve a joined up and consistent approach.

7.7 Through this engagement, we will seek to build understanding, increase support, invite views, and prepare for the forthcoming changes in commissioning. Successful and effective engagement is an ongoing, two-way process and we will be using existing channels to take this forward.

7.8 Responses to the questions in this document should be sent to NHSWhitePaper@dh.gsi.gov.uk by 11 October.

Conclusion

7.9 Commissioning NHS services carries with it the responsibility to deploy public resources in ways that best improve health and healthcare for the public and local communities.

7.10 In future, people will have the confidence of knowing that their GP is not only their advocate in the healthcare system but part of a wider group of health and care professionals – a commissioning consortium – whose job it is to ensure that empowered patients have access to the right care, in the right place, at the right time.

7.11 The public will have the confidence that these commissioning decisions are being made within an overall framework that enshrines the principles and values of the National Health Service and promotes consistently high standards of quality.

7.12 Local communities will have the confidence that their locally elected representatives have the overarching responsibility for promoting joined-up health and social care services that are responsive to local patient and community voice.

7.13 We look forward to your active engagement in helping shape these new commissioning arrangements and helping deliver the maximum benefits for NHS patients.

Annex

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator

Department of Health

3E48, Quarry House

Leeds

LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available on the Department of Health website by the end of this year.

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
14th September 2010	Carers' Strategy Review – Progress Update	All

SYNOPSIS

This paper updates the committee on the carers' strategy action plan for adult carers.

CONTRIBUTORS

Steven Falvey, Senior Commissioning Manager – Carers, CSD, LBHF and NHS H&F

RECOMMENDATION:

The committee is asked to note the report and make recommendations.

CONTACT

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NEXT STEPS

Lead officer to consider comments and recommendations made by committee members.

1. EXECUTIVE SUMMARY

1.1 A mid-point review of the borough's carers' strategy for adult and young carers commenced in May 2008. The main purpose was to evaluate progress to date and to produce a revised strategy with a new action plan to deliver the outcomes the council wants to achieve for carers by 2011.

1.2 This report provides an update on the action plan for adult carers.

1.3 Good progress has been made and what follows is a summary across the seven identified key outcomes, extracted from the main report:

Identified outcome	Progress
A voice	• The carers' strategy group (CSG) has been established with strengthened representation from the council, carers and key stakeholders. • LINk steering group representatives now attend CSG meetings. • Guidance for staff on carers and carers' assessment practice has been developed with an accompanying training package.

Information	• The carers' information pack was updated in November 2009. In August 2010, the pack was replaced with a promotional leaflet outlining the new interim support arrangements - both have been widely circulated.
	• The carer page on the council's website has been fully updated.
	• The quality and outcomes framework+ scheme is now in its second year. In relation to meeting the needs of carers, year 1 results are:
	  • Carers 1 - carer status is recorded for 100% of individuals newly registered on or after December 01 2008 - 12/26 practices achieved this indicator.
	  • Patient experience 7 - 100% of carers who are newly registered with the practice on or after December 01 2008 have a record of being advised by the practice that they can ask social services for an assessment of their own needs - 13/26 practices achieved this indicator.
	  • Patient experience 8 - the practice has a system in place for taking the special needs of carers into account, including when allocating appointments and issuing prescriptions - 25/25 practices achieved this indicator.
	  • Patient experience 9 - a named carer is recorded

	for at least 90% of patients on the learning disability register - 20/26 practices achieved this indicator. • Information relating to the new interim support arrangements will be circulated to all GPs to assist them in signposting carers to the H&F carer helpline.
Time off	• A pilot scheme to provide carers with individual budgets ran between January 2009 – March 2010. Approximately 147 budgets were processed with over £96k being allocated. • 117 emergency care plans have been completed with alert cards issued and information uploaded onto the care provider's database.
Emotional support	• Eight carer support groups have been set up at venues across the borough. • In addition, specialist carer support groups are running for carers of people with learning disabilities, mental health needs, substance misuse issues, on-going memory problems (dementia) and ex-carers.
Financial security	• 135 carer small grants were approved for 09/10. The amount allocated totalled £45,812. • The council has produced a flyer, specifically for carers, to promote availability of the carer's allowance and benefit advice.
Recognition, health and wellbeing	• The borough's local area agreement (LAA) 09/10 target for carers - NI 135: 'carers receiving needs assessment or review and a specific carer's service, or advice and information' was achieved. • In line with the strategy action plan, an additional two full time health trainers have been recruited for 2010/11. This brings the total to four.
Quality services	• Following the unsuccessful procurement exercise to tender the carer support service, interim arrangements have been put in place to provide support for carers whilst the council undertakes a review to inform a re-tendering exercise. • As of August 2010, carers have been able to access services locally, with support groups and drop-in services being held in different areas of the borough, rather than being based in one central location. • In addition to these activities, a dedicated helpline has been set up which acts as a first point of contact for people needing information and advice or requiring more specialist support.

SELECT COMMITTEE REPORT

1. BACKGROUND

1.1 Hammersmith and Fulham carers' strategy was developed in partnership with the PCT and voluntary sector, following extensive consultation, and covers the period from 2005 -2010/11.The strategy is based on the carers' compass, developed by king's fund, which identified seven key outcomes for carers:

- A voice
- Information
- Time off
- Emotional support
- Financial security
- Recognition, health and wellbeing
- Quality services

1.2 Having reached the mid-point in our action plan, it was felt to be a good time to take stock and evaluate progress against the key objectives in the original strategy. A review commenced in May 2008.

1.3 The review included within its scope services to carers of adults, those who care for disabled children and young people and carers.

1.4 As well as evaluate progress to date, the main purpose of the review was to produce a revised strategy that will lead to an increase in the number of carers receiving support and carers being able to continue for longer with the right support. The aim was to develop a revised action plan to deliver the outcomes the council wants to achieve by 2011.

1.5 The key finding from the review was that only a small minority of the total carers in the borough are being identified and receiving services. In order to improve this, it is clear that carer support services need to outreach into the community and link with services, resources and networks that carers are already engaged with, rather than expecting carers to come to a single, central resource. The revised action plan reflects this direction of travel.

1.6 Some of the key recommendations of the review were as follows:

- Commission a new carer support service based on an outreach model.
- Implement a plan to ensure that carers can access the information they need.
- Establish a carers' strategy group accountable for ensuring implementation of the action plan with strengthened representation from carers, the council and partner agencies.

- Increase the capacity for setting up and maintaining carers' support groups.
- Increase the funding for the carer small grant scheme. This scheme provides a grant to carers to buy any goods or services that will support them in their caring role.
- Increase the number of carers' assessments carried out to provide carers with information and access to help.
- Increase the number of health trainers for carers. Their remit is to help carers to maintain and improve their own health and raise awareness of carers' issues amongst health professionals.

1.7 As part of the overall review, children's services undertook a review of the young carer's service. This led to a set of priorities and an action plan for a revised offer for young carers. Children's services will report on the young carers' service to the education scrutiny panel.

1.8 This report provides a progress update on the action plan for adults.

2. PROGRESS REPORT ON THE ADULT CARERS' STRATEGY ACTION PLAN

2.1 The senior carers' commissioner post, joint funded with the PCT, was successfully recruited to in October 2009. Since then good progress has been made in key areas of the action plan. The following is a summary of the highlights across priority areas. For more detail, please refer to the full adult carer action plan at appendix 1 – Hammersmith and Fulham carers' strategy action plan 2009/11.

2.2

A Voice	
Action	Progress
Make the carers' strategy group (CSG) accountable for ensuring implementation of action plan	• The CSG has been established with strengthened representation from the council, carers and key stakeholders. • The remit of the group is to make the council and its partners accountable for the strategy and developing new ideas and to evaluate progress against key objectives and priorities set out in the action plan. • Carers are actively being sought across all care groups to become involved in the group. • Additionally, carers are also being sought to become involved in supporting the management and development of services for carers and express areas of interest e.g. interview panels, staff training, research, service development and event planning. • Training will be offered to those carers to prepare them in dealing with professionals in a statutory and formal environment, with carers receiving payment for their involvement, respite costs and

	other expenses.
Influence H&F LINk to make carer's issues important	• LINk steering group representatives, including the manager of the Community, Interpreting, Translating and Access Service (C.I.T.A.S), now attend CSG meetings.
Develop a process for sustainable involvement of carers in training of social care staff	• Guidance on 'carers and carers' assessment practice' for staff has been developed. This guidance covers: policy, exclusions, law, definitions, delegation, information about carers and the carers' assessment process. • To accompany this, a draft training package for H&F staff has also been devised. • Carers, who have expressed interest, will be involved in the delivery of this training.
Provide training for carers in safeguarding adults	• To represent carers, the commissioning manager for carers attends both the safeguarding adults committee and the 'involvement and information' sub-group. • Research has been undertaken seeking national examples of existing training available for carers on safeguarding. Both Liverpool and Buckinghamshire currently deliver safeguarding training specifically for carers. • An action plan is being developed.

2.3

Information	
Action	Progress

Implement a plan to ensure that carers can access the information they need	• The carers' information pack was updated in November 2009.
	• As part of a drive to reach new or 'hidden' carers and circulate information into the community:
	  • 1200 information packs, with a cover letter offering further information, were mailed out to 120 GPs, pharmacists, places of worship and libraries during March.
	  • 3868 information packs were mailed out to registered blue badge holders. Separate promotional material relating to the health trainers service and emergency care planning service was included.
	  • The pack was available from H&F advice (145 King Street).
	  • Carers who were assessed as part of the carer individual budget pilot (see below) also received a copy of the information pack.
	  • Carer support services were advertised in 24 of the borough's 34 GP surgeries through the life channel. The advert was first shown

	between November 2009 - January 2010, followed by a second showing between February – April 2010. A review will be undertaken to look at utilising dental surgeries to reach 'hidden carers' in June 2010.
	• A meeting was held at C.I.T.A.S in May 2010 to discuss how best to meet the needs of, and reach carers of BME groups. Carer support service team members will attend their 'Adult and Social Care Forum' in September and November 2010.
	• The council's website has been fully updated with the latest advice and information relating to carers and support.
	• In August 2010, the information pack was replaced with a promotional leaflet outlining the new support arrangements for carers. This was circulated to:
	  • Over 1000 people on the council and H&F Carers Centre database
	  • Approximately 900, 3rd sector organisations
	  • Key stakeholders
	• A full sized advert promoting support services was placed in H&F News.
	• The carer support service customer information advisor will be responsible for ensuring information is kept up to date.

Assist implementation of local quality outcomes framework for carers	• QOF+ is a local extension of the national quality and outcomes framework (QOF) developed in partnership with the department of primary care and imperial college and launched in December 2008.
	• It is a major primary care quality improvement initiative that aims to address key areas of health inequality in the borough and lead to high quality care for all.
	• In relation to meeting the needs of carers, the results from year one are as follows:
	  • Carers 1 - carer status is recorded for 100% of individuals newly registered on or after December 01 2008 - 12/26 practices achieved this indicator.
	  • Patient experience 7 - 100% of carers who are newly registered with the practice on or after December 01 2008 have a record of being advised by the practice that they can ask social services for an assessment of their own needs - 13/26 practices achieved this indicator.

	• Patient experience 8 - the practice has a system in place for taking the special needs of carers into account, including when allocating appointments and issuing prescriptions - 25/25 practices achieved this indicator. • Patient experience 9 - a named carer is recorded for at least 90% of patients on the learning disability register - 20/26 practices achieved this indicator. • The scheme is now in its second year and year 1 indicators have been reviewed. The indicator 'Carers 1' has been replaced with: • Carers 2 - The practice encourages carers to self identify using posters and new patient registration forms and provides leaflets to all carers informing them of special provisions made to assist carers. Posters and leaflets should also be accessible in local community languages other than English. • The other indicators have remained the same although: • Patient experience 7 is now Carers 3 • Patient experience 8 is now Carers 4 • Patient experience 9 is now Carers 5 • To assist GPs with the 'Carers 3' indicator, carer support service information will be circulated in August 2010.

2.4

Time Off	
Action	Progress
Develop a workable model for offering respite (short break) services through self directed support	• In line with the council's self directed support agenda, a pilot scheme to provide carers with individual budgets ran between January 2009 - March 2010. • The purpose of the carers individual budget (CIB) is to provide carers with a one off, direct cash payment to purchase services/products to alleviate the stress of caring and to support them to continue in their caring role. Outcomes for carers can include: • To have a short break • To remain in employment • To access education/training • To improve health and well-being • To access leisure/social activities • To improve the home environment. • To be eligible for the pilot scheme, carers had to be: • Over 18

	• Be caring for an adult person who is living at home and is a resident of Hammersmith and Fulham • Be providing on going regular and substantial care • Have had a carers assessment or agree to undertake an assessment • Be assessed as needing support in their caring. • Of the 147 assessments completed and processed, 67 were new assessments. • The amount allocated totalled over £96k. • An evaluation form has been developed and will be circulated to all participants in August 2010. • The evaluation will inform the process for allocating individual budgets to carers who care for someone who is FACS eligible.
Provide support to plan for emergencies and a service to care for the cared-for person during such emergencies	• H&F Carers Centre managed the emergency care planning service (ECPS), which commenced in April 2008. • The service provides carers with peace of mind by ensuring that alternative short-term, home-based care can be put in place if the carer experiences an emergency. • To date 117 plans have been completed with alert cards issued and information uploaded onto the care provider's database. • As of August 2010, the service was brought in-house as part of the new support service arrangements. Carers will be offered this assessment as part of the standard offer by social worker/assessment officers.

2.5

Emotional Support	
Action	Progress
Increase the capacity for setting up and maintaining carers' support groups, aiming for self-sufficiency	• As of August 2010, 8 carer support groups were set up across the borough. • Specialist support groups were set up for people with learning disabilities, mental health needs, substance misuse issues, on-going memory problems (dementia) and ex-carers. • These informal groups give carers a chance to meet other people in similar situations, to talk about their experiences and alleviate some of the isolation felt by carers.

2.6

Financial Security	
Action	Progress

Increase the funding for the small grants' scheme and develop a simple administrative process that can be administered by the carers' support service	• Carers can apply for a carer small grant to help them in their caring role. • A one-off grant of up to £350 can be used to pay for an item or service carers, such as, a short break, mobile phone, washing machine or gardening. • This grant is available to carers regardless of whether the cared for person is FACS eligible. The carer must be providing at least thirty of hours of support. • 135 grants were approved through the small grants scheme for 2009/10. • The amount allocated totalled £45,812. • As of August 2010, the administrative process was revised and social workers and assessment officers will be responsible for processing grant applications. • The carers' social worker will be responsible for overseeing the scheme and monitoring expenditure.
Council to promote availability of council tax reductions for carers who qualify	• The council's benefit service has produced a flyer, specifically for carers, to promote availability of the carer's allowance and benefit advice. One to one advice will be given and will cover entitlements relating to council tax reduction.

2.7

Recognition, Health and Wellbeing	
Action	Progress
Increase the number of carers' assessments carried out.	• The borough's local area agreement (LAA) target for carers is NI 135: 'carers receiving needs assessment or review and a specific carer's service, or advice and information'. • The definition of the indicator is 'the number of carers whose needs were assessed or reviewed by the council in a year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year'. • For 2009/10, the LAA target was 24.5%. • The borough achieved it's target with 1077 carers being assessed jointly or separately, whilst 4128 adults received a community based service – 26.1%
Establish carers' health trainers to meet the	• The health trainer programme is a national initiative aiming to encourage and enable individuals from disadvantaged communities to make healthier choices.

needs highlighted by carers during consultation. Increase number of workers from two to 4-6	• Health trainers offer individuals tailored advice, motivation and practical support to individuals who want to adopt healthier lifestyles. • Staying put services won the contract to recruit health trainers for carers and successfully recruited two full time health trainers (funded through PCT health gains money). • During their first year, 56 carers accessed the service. • In line with the strategy action plan, an additional two full time health trainers have been recruited for 2010/11.

2.8

Quality Services	
Action	Progress
Develop wider range of support services for carers of people with substance misuse issues	• A specialist support group for carers of people with substance misuse issues, Relative Connections, runs twice weekly. • New publicity material has been developed and distributed to all GPs and substance misuse services in July 2010.
Commission carers' support service based on an outreach model	• Committee members will be aware of the council's decision not to award the contact for the carer support service following the procurement exercise that concluded in May 2010. • Interim arrangements, which deliver all aspects of the planned services, have been put in place to provide support for carers whilst the council undertakes a review to inform a re-tendering exercise. • As of August 2010, carers are able to access services locally, with support groups and drop-in services being held in different areas of the borough rather than being based in one central location. • In addition to these activities, a dedicated helpline has been set up which acts as a first point of contact for people needing information and advice or requiring more specialist support. • Please refer to appendix 2 – carer support service leaflet, for more information on the interim support arrangements. • Please also refer to appendix 3 – pathways to support, which outlines how carers can access support.

3. Appendices:

Appendix 1 - Hammersmith and Fulham carers' strategy action plan 2009/11 - Adults

Appendix 2 - Carers Support Service Leaflet

Appendix 3 - Pathways to Support

4. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE SERVICES

4.1 There are no financial implications of this report, which updates the committee on the carers' strategy action plan for adult carers.

5. COMMENTS OF THE ASSISTANT DIRECTOR (LEGAL AND DEMOCRATIC SERVICES)

5.1 There are no direct legal implications for the purposes of this report.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Review of carers' strategy 2009	Steven Falvey ext.5032	CSD

Appendix 1

Carers' Strategy
Revised Action Plan
For Adult Carers
March 2009 – April 2011*

1. A Voice

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
1.1 Make the Carers' Strategy Group accountable for ensuring implementation of the action plan with strengthened representation from carers, the Council and partner agencies. Agree monitoring and evaluation framework as a means of determining how well the outcomes of the revised strategy are being met.	Carers' Commissioning Manager	April 2010 June 2010	The group to be responsible for making the Council and its partners accountable for the Strategy and developing new ideas. Representatives from the Carers' Forum feeding into and out of the Strategy Group. Annual Carers' Summit held in Carers' Week	Incidental expenses to be met through existing commissioning budget	Numbers attending meetings increased from current position Monitoring and evaluation framework developed
1.2 Carers' Strategy Group to produce a Carers' Charter outlining the rights	Carers' Commissioning Manager	January 2011	Increased recognition of the role and rights of carers	Costs included in Strategy Group membership (see	Charter published

and entitlements of carers				above)	
1.3 Work to influence H&F LINK to make carers' issues important.	Carers' Commissioning Manager Hestia (host organisation)	November 09 ongoing	Carers' issues are addressed in every service	Cost to be met by Hestia as part of contract	Carers included in all service developments including Self Directed Support
1.4 Develop a process for the sustainable involvement of carers in the training of social care staff	Learning & Development Consultant	April 2010	Increased awareness of the needs of carers	Not yet costed – to be met from training budget	
1.5 Provide training for carers in safeguarding adults	Learning & Development Consultant Safeguarding Adults Manager	January 2010	Carers aware of safeguarding issues	Not yet costed – to be met from training budget	Numbers of carers receiving training increased year on year
1.6 Involve carers in the development of Self Directed Support (see 3.1)	Carers' Commissioning Manager	April 2010	Individual respite provided meeting the needs of carers and those they care for		

2. Information

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
2.1 Implement a plan to ensure that carers can access the information they need, to include: • Process for ensuring	Communications Manager Carers' Commissioning	February 2010 ongoing	Carers able to access up to date clear information	• Initial cost for updating and distributing information £10,500	Information updated annually. 2 articles on carers in H&F

that information is kept updated • Procedure for H&F Direct to identify carers from general callers • Information available at H&F Advice • Core information available in accessible language and in a range of formats (e.g. on the internet, in booklet form etc.) • Information available from a central point but also in a range of services and sites throughout the borough • Information to be available in GP surgeries through the TV Life Channel • Proactively seek to make contact with carers e.g. by contacting carers of blue badge holders	Manager Assistant Director Residents Direct			• Printing, distribution costs etc. £5k Cost of Life Channel to be calculated and funded through PCT	News

2.2 To assist implementation of local Quality Outcomes Framework for carers, work up content for training and awareness programme for GPs and other primary care workers	Primary Care Commissioning Manager	April 2010	GPs and other primary care workers aware of the particular needs of carers	PCT funding – cost to be estimated by Jan Adamson	Numbers of primary care workers trained increased year on year

3. Time Off

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
3.1 Develop a workable model for offering respite services through self directed support to include: • Develop an assessment process to determine individual allocations • Consult existing users in order to get the design right • Assess impact on existing in-house services • Market development • Establish feasibility of setting up pooled budget (PCT and all care groups	Head of Assessment Head of Commissioning Carers' Commissioning Manager Head of Performance and Information	April 2010	Individual respite provided meeting the needs of carers and those they care for	To be funded through Resource Allocation System (RAS) linked to carers' assessments, subject to confirmation. To be jointly funded by PCT DoH allocation of additional monies	Numbers of carers receiving self-directed support increased year on year

3.2 Promote the use of Assistive Technology to benefit carers, including: • Hold regular demonstration and assessment surgeries for carers • Use of trusted assessors	Head of Hospital Assessment & Community Support	09-10 benchmark - 20 carers 10-11 50carers 11-12 100 carers	Increased time off and peace of mind for carers	09-10 - £5,000 10-11 – £10,000	Numbers of carers using Assistive Technology increased year on year
3.3 Provide support to plan for emergencies and a service to care for the cared-for person during such emergencies	Carers' Commissioning Manager	09/10 – 150 carers with emergency plans 10/11 – 300 carers with care plans	Plans in place and access available to emergency support for carers.	£74,000 (Cost funded through specific government grant)	Numbers of carers with emergency plans increased as per targets
3.4 Explore in detail the viability of commissioning residential respite in partnership with other West London authorities	Head of Procurement	April 2010	Increased choice and flexibility for carers	Cost implications to be included in exploration	Jointly commissioned respite available

4. Emotional Support

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
4.1 Increase the capacity for setting up and maintaining carers' support groups, aiming for self-sufficiency	Carers' Commissioning Manager	10/11 – 15 groups 11/12 – 25 groups	Increased support, peer support and social networks for carers	To be included as part of Carers' Support Service – see 7.1	Number of groups increased year on year
4.2 Provide support to carers to make plans for when their caring role ends	Carers' Commissioning Manager	May 2010	Carers more prepared for the next stage of their	To be included as part of Carers' Support Service –	Number of carers with life plans

			lives	see 7.1	

5. Financial Security

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
5.1 Increase the funding for the Small Grants' Scheme and develop a simple administrative process that can be administered by the Carers' Support Service	Carers' Commissioning Manager	May 2010	More carers receive Small Grants	£70K	Number of small grants increased from baseline
5.2 Audit and review HR policies and procedures of the Council and PCT in line with the requirements of the Work and Families Act 2006 which extended the right to carers to request flexible working. Develop positive carers' recruitment policies in line with the Disability Equality Scheme.	Assistant Director Human Resources	May 2010	Increased employment opportunities and support for carers	Officer time	Recruitment policy in practice
5.3 Council to promote availability of council tax reductions for those carers who qualify[1]	Assistant Director Residents' Services	November 2009	Financial savings for carers	Officer time	Numbers of carers receiving discount increased year on year

[1] To qualify carers must provide care for 35 hours or more, live in the same property, not be the spouse or partner, or parent if the cared-for is under 18, and the cared-for person must receive the higher rate of Disability Living Allowance or ~Attendance Allowance

5.4 Carers' issues to be addressed as part of the Personal and Community Development Learning Partnership	Carers' Commissioning Manager Head of Engagement, Partnership and Development	November 2010	Increased opportunity for carers to take up training and education for employment and leisure. Detailed Action Plan to be procuced	No direct cost implications identified at this point	Numbers of carers in training and education increased year on year
5.5 Carers' issues incorporated into the Work Matters Strategy Seek to influence the use of extra DoH funding to Job Centres	Head of Regeneration	On-going Baseline – 40.7% of carers working. Targets to be set	Increased employment opportunities and support for carers	Funding to Job Centres from DoH to be confirmed	Numbers of carers in employment increased from baseline
5.6 Explore the feasibility of developing a discount scheme for carers to include council services and the local retail/service sector	Carers' Commissioning Manager	November 2010	Financial savings for carers	Cost implications to be explored as part of feasibility study	Number of discounts available

6. Recognition, health and well-being

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
6.1 Increase the number of carers' assessments carried out. Develop a workable model for implementing the trusted assessor model to include: • Define who could become trusted assessors and what they can assess • Explore potential for ex carers to become trusted assessors Identify young carers through adult carers' assessments	Head of Assessment Head of Hospital Assessment & Community Support Head of Occupational Therapy	08/09 -23.5% 09/10 – 24.5% 10/11 – 25.5%	See targets. Carers' needs recognised. More "hidden" carers identified.	Secondment to get the service up and running for 6 months – £25k Ongoing trusted assessor costs will be met through existing commissioned services and/or the PCT Training costs to be identified	LAA measure
6.2 Establish Carers' Health Development Workers to meet the needs highlighted by carers during consultation. Increase number of workers from two to 4-6	Carers' Commissioning Manager Carers' Strategy Group	April 2010	Carers' health improved	PCT to fund. £40.5k per worker	Number of carers whose health has improved from baseline measurement

6.3 Expand the existing Expert Carers' Programme (this will be enhanced by Caring with Confidence if bid successful)	Expert Patient Programme Manager	April 2010	Improved health and well-being of carers	PCT funding, Judith Ralphs to confirm cost per course.	Number of carers whose health has improved from baseline measurement
6.4 Establish Carers' Champions in each GP practice	Primary Care Commissioning Manager	October 2011	Increased recognition of carers' needs within primary care	PCT funding – Jan Adamson to confirm	Number of Carers' Champions
6.5 Explore the feasibility of funding a dedicated Carers' Worker in Imperial College NHS Trust. This would link with the role of the Carers' Health Development Worker	Carers' Commissioning Manager Head of Hospital Assessment & Community Support	November 2010	Support and advice provided to carers at "point of crisis", particularly those who are just about to or have just become carers	Cost to be explored as part of feasibility study	Number of carers whose health has improved from baseline measurement

7. Quality Services

Action	Lead Officers	Target Date	Outcomes	Resources ££	Measures
7.1 Commission Carers' Support Service to include: • Services based on an outreach model • Provision of support groups, information and	Carers' Commissioning Manager	April 2010	High quality services for carers delivered in their own communities. Increased numbers of carers receiving	£250k	LAA target. Framework for measuring outcomes agreed with provider

advice, counselling and alternative therapies • Research to identify suitable venues for services • Development of a provider network • Development and facilitation of the Carers' Forum			services		
7.2 Create a full time commissioning role as a joint post with the PCT in order to oversee delivery of the revised strategy	Head of Commissioning	October 2010	Revised strategy delivered	£60k (includes Finance support and publicity costs)	Revised strategy delivered
7.3 Ensure carer involvement in the quality assurance programme currently being developed by Adult Social Care division	Quality Assurance Manager Carers' Strategy Group	April 2010	Quality services for carers	No direct extra cost	Number of carers involved in QA programme
7.4 Involve carers in the monitoring and evaluation of home care contracts	Assistant Head of Procurement Carers' Strategy Group	January 2010	Services that meet carers' needs as well as those they care for	£5,000 for payments to carers	Survey to assess increased carer satisfaction with service
7.5 Develop wider range of support services for carers	Substance Misuse	November 2009	Carers of people with substance	Already funded through Substance	Measures agreed by

of people with substance misuse issues to include: • Identify and distribute information to carers via service providers • Develop a carers' support group through Family Therapy Service (see Drugs Strategy and Alcohol Strategy)	Commissioning Manager		misuse issues have their particular needs recognised and provided for	Misuse budget	Substance Misuse service
7.6 Increase support to carers of people with mental health needs to include: • Carers' lead in each CMHT and hospital ward • Provision of timely and appropriate information • Training for staff and carers (See Mental Health Carers' Strategy)	WLMHT	October 2009 ongoing	Carers' issues addressed by WLMHT. Increased numbers of carers' assessments	Already funded through WLMHT	Measures agreed by WLMHT

*

Please note – revised timescales due to delay in recruitment to commissioning manager post
Action plan - September 2009-October 2010

Appendix 2

h&f putting residents first

Carer support services

Hammersmith & Fulham Council

www.lbhf.gov.uk/supportingyourchoice

We support our carers

- In Hammersmith & Fulham we recognise the major role played by carers in supporting people in the community who are frail, ill or disabled.
- We believe that carers should have equal access to services that take full regard of age, gender, disability, race, culture, sexuality, faith and class.
- We recognise the importance of consulting with carers and believe that the services we develop should be guided by that consultation.
- We believe in the carer's right to be supported so that they can continue to care for as long as they wish.
- We aim to provide services to carers that are seamless, flexible and responsive.
- We recognise the importance of all agencies working together to plan and develop services for and with carers.
- We recognise carers as individuals who are entitled to an assessment of their own needs and we will support carers to maintain and develop the independence of the person for whom they care.

How we can help you

If you care for someone living in Hammersmith & Fulham we can help you access advice, information and support through the following:

Customer Information Advisor - is employed by the council and works in H&F Advice. They are your first point of contact and they manage both the dedicated telephone help line and email address. They have a good knowledge of carers' rights and services and where to get more specialist help if it is needed.

Carers' Support Worker- runs the support groups and the drop in information and advice groups. They are also employed by the council and have a good knowledge of carers' rights and services.

Carers' Health Trainers – Health trainers are employed by 'Staying Put' Services, part of Shepherds Bush Housing Group. They specifically support carers and will help run some of the groups. In their caring role, health trainers are skilled at helping people develop techniques to support their own health and well-being. Health

trainers support carers to gain a balance in their lifestyle from improving eating habits to increasing exercise, learning to relax or managing time.

Social workers are also available to undertake a full assessment of your needs if you need regular support such as respite. They can also assist you to apply for one-off small grants to help you with your caring duties and to set up an emergency care plan.

Carers' support groups

Meet weekly at locations across the borough. These informal groups give carers a chance to meet other people in similar situations, to talk about their experiences and alleviate some of the isolation felt by many carers.

You do not need to make an appointment to attend and you can turn up on the day. Newcomers are welcome.

You can telephone them to confirm details.

Monday

10.00am-12.00pm
The Club House
Samuel Lewis Trust Dwellings
Lisgar Terrace, West Kensington
London W14

Bus: 9, 10, 27, 28, 49, 391 and C1
Tube: West Kensington

12.30am-2.30pm
Irish Cultural Centre
Blacks Road, Hammersmith
London W6 9DT

Tel: 020 8563 8232
Tube: Hammersmith

3.30-5.00pm
Imperial Wharf Resource Centre
185 Townmead Road, Fulham
London SW6 2JY

Tel: 020 7384 6950
Bus: 391, 424 and C3
Overland train: Imperial Wharf

Tuesday

2.00-3.30pm
White City Community Centre
1 India Way, White City Estate
London W12 7QT

Tel: 020 8743 4545
Bus: 95, 228 and 283

Wednesday

10.30am-12.00pm
Percy Barton House
33-35 Dawes Road, Fulham
London SW6 7DT

Tel: 020 7386 9387
Bus: 14, 28,211,295,391,414 and 424

Tube: Fulham Broadway

2.00-4.00pm
Irish Cultural Centre
Blacks Road, Hammersmith
London W6 9DT

Tel: 020 8563 8232
Tube: Hammersmith

Thursday

10.00am-12.00pm
Fatima Community Centre
Commonwealth Avenue
White City Estate
London W12 7QR

Tel: 020 8740 0477
Bus: 95, 228 and 283

2.00-4.00pm
Springvale Tenants Hall
Blythe Road
(behind Thackeray Court)
Springvale Estate
West Kensington
London W14 ABB

Buses: 9, 10, 27, 28
Overland Train: Kensington Olympia

Drop-in service

There are weekly drop-in services, where you can get one to one information and advice, one in the north and one in the south of the borough.
No appointment is necessary.

Tuesday
10.00am-2.30pm
Grove Neighbourhood Centre
7 Bradmore Park Road,
Hammersmith
London W6 0DT
Tel: 020 8741 3321
Bus: 27, 94, 190, 237,266, 267,391and H91

Tube: Ravenscourt Park
(Please note from 7 September, the drop in service will be open from 12.30pm-4.30pm

Friday
10.00am-2.30pm
Sunberry Resource Centre
147 Stevenage Road, Fulham
London SW6 6PB
Tel: 020 7385 7537
Bus: 424

Tube: Putney Bridge

Support group for carers of people with learning disabilities

This group meets twice monthly.

First Tuesday of the month
11.00am-1.00pm

These are information sessions with an invited speaker

H&F Mencap Stamford Brook Centre
14-16 Stamford Brook Avenue,
Stamford Brook
London W6 0YD
Tel: 020 8748 5168
Bus: 94, 237 and 272
Tube: Stamford Brook

Starting 7 September 2010

Last Tuesday of the month
11.00am-1.00pm

These are informal peer support sessions

H&F Mencap Stamford Brook Centre
14-16 Stamford Brook Avenue,
Stamford Brook
London W6 0YD
Tel: 020 8748 5168
Bus: 94, 237 and 272
Tube: Stamford Brook

Starting 28 September 2010

Support group for carers of people with substance misuse issues

This support group meets twice weekly.

Wednesday
11.00am-12.30pm
Relative Connections
Family Therapy Centre
Unit 5
1-31 Elkstone Road
North Kensington
London W10 5NT
Tel: 020 8960 0880
Bus: 23, 28, 31 and 328
Tube: Westbourne Park

Thursday
11.00am-12.30pm
Relative Connections
Askham Family Centre
Flat 1
1 Askham Road
Shepherds Bush
London W12 ONW
Tel: 020 8749 6936
Bus: 207, 228, 260, 266 and 272

Support for carers of people with mental health needs

This support group meets twice monthly.

Second Thursday of the month
12.30pm-2.30pm
H&F Mind
62 Blythe Road
Hammersmith
London W6 0HB
Tel: 020 7602 2336
Bus: 72, 220, 283 and 295
Overland train: Kensington Olympia

Last Thursday of the month
5.30pm-7.30pm
H&F Mind
62 Blythe Road
Hammersmith
London W6 0HB
Tel: 020 7602 2336
Bus: 72, 220, 283 and 295
Overland train: Kensington Olympia

Working age onset dementia carers' group

Relatives of younger people with dementia meet on the second Wednesday of every month between 12.00-2.00pm. Please call the H&F Carer Helpline for more information (details below).

Alternative therapies

You will be able to buy these using a carers' grant.

Ex-carers' support group

A support for former carers meets on the first Tuesday of every month.

Young carer support services

For more information about these three services, contact H&F Carers helpline (details below).

Health trainer service for carers

Our health trainer service offers one to one support to carers in Hammersmith and Fulham. They support carers with their physical and emotional wellbeing. Health trainers can help you to improve your diet, quit smoking, increase physical activity, learn to relax and help you access local services.

For more information, please call **020 8996 8939** or email **health.trainers-carers@sbhg.co.uk**

Counselling

It can be helpful to talk things over with someone outside of your family and friends.

To access counselling services, please call Back On Track on **0300 123 1156** or visit **www.backontrack.nhs.uk**.

The service will arrange a convenient time for you to have a confidential telephone conversation with one of their therapists. During this call the therapist will ask you about yourself and your difficulties and will also ask you to complete some questionnaires to help decide what the best treatment for you is.

The trained therapists can help you:

- Understand why you feel as you do
- Support you through difficult times in your life
- Find out what you would like to change
- Learn new ways of coping
- Help you to accept and adjust to life changes and difficulties

If you would like more discussion about the service before you refer, please call the main number and choose option 1. You will be able to speak to a therapist from the service and ask any questions you may have.

Advocacy

If you require advocacy, as a first point of contact, call The Advocacy Service. This service exists to support adults, their family or carers who may be entitled to or are receiving Adult Social Care. HAFAD (Hammersmith and Fulham Action for Disability) provides the service and it is available to those who live in or use services of Hammersmith & Fulham Council.

You can refer yourself or a professional can refer you. A referral form can be completed over the telephone or sent to you by e-mail, fax or post.

Tel: 020 7471 8510 x 130
Fax: 020 7610 9786
Email: advocacy@hafad.org.uk

If you require more specialist advocacy, please telephone the H&F Carers Helpline (details below).

H&F Carer Helpline

020 8753 4616

Freephone
0800 996 1754

Fax
020 8753 5880

Open Monday to Friday, 9.30am - 4.30pm.

The help line is your first point of contact if you need any information or advice about being a carer. You should also telephone this number if you want to apply for a one off carers' small grant (in most instances carers' small grant applications can be done by telephone) or be referred for a full carers' assessment to access regular packages of care such as respite breaks.

You can also contact us via email at:
carersupport@lbhf.gov.uk
and we will respond within two working days.

Comments

We always welcome comments, suggestions or feedback from our carers, which can be sent to:

Senior Commissioning Manager - Carers
77 Glenthorne Road
Hammersmith, London W6 0LJ

Email:
carersupport@lbhf.gov.uk or
youngcarersupport@lbhf.gov.uk

Fax: 020 8753 5880

If you would like any part of this document interpreted into your own language, or produced in large print or braille, please telephone 020 8753 4616 or Freephone 0800 996 1754.

www.lbhf.gov.uk
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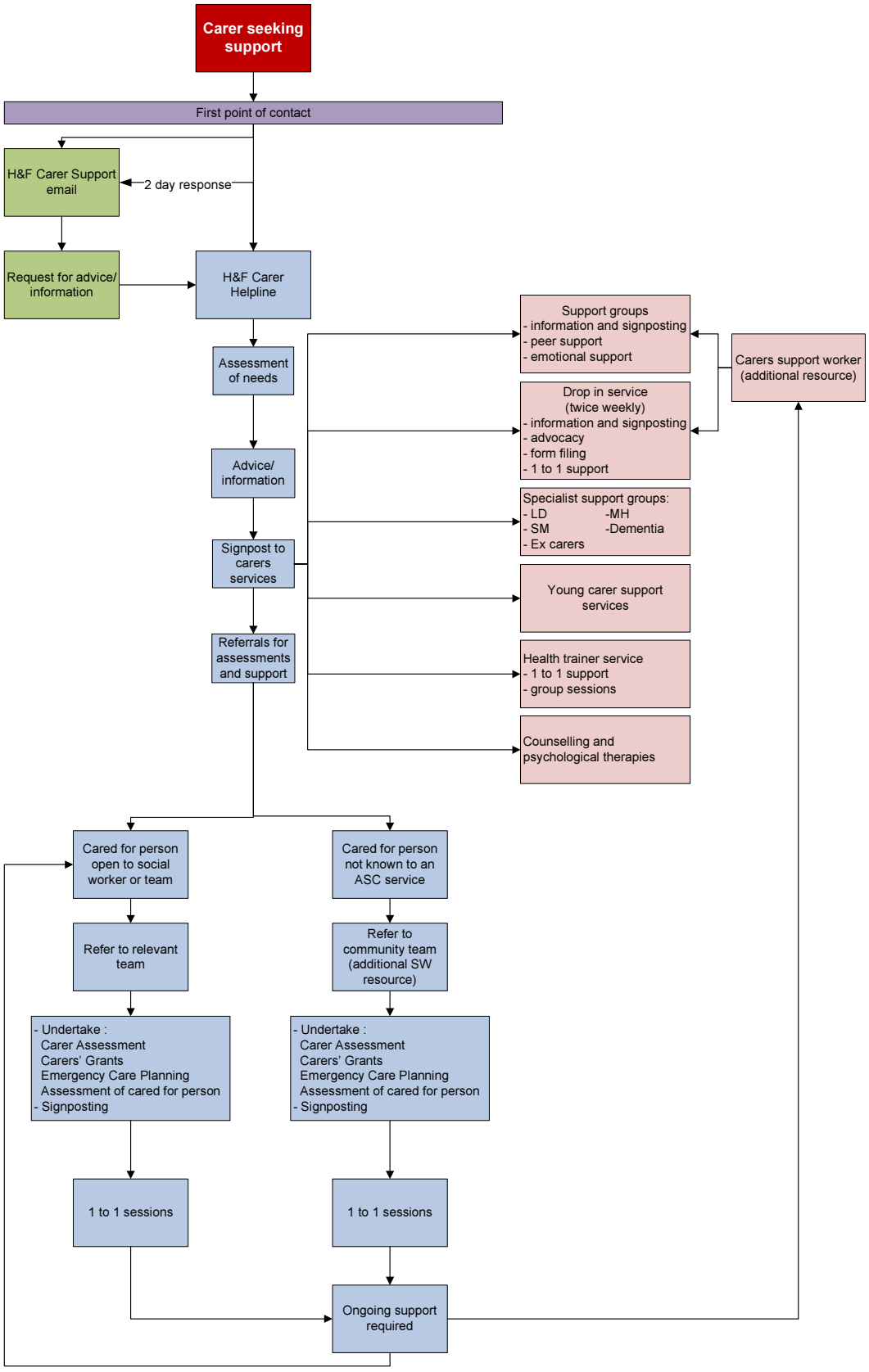
File: Lf.CS Carer Support Services 2010 - 47867 ♻ Printed on paper from sustainable sources


Carer seeking support
First point of contact
H&F Carer Support email
2 day response
Request for advice/ information
H&F Carer Helpline
Assessment of needs
Advice/ information
Signpost to carers services
Referrals for assessments and support
Support groups
- information and signposting
- peer support
- emotional support
Drop in service
(twice weekly)
- information and signposting
- advocacy
- form filing
- 1 to 1 support
Specialist support groups:
- LD -MH
- SM -Dementia
- Ex carers
Young carer support services
Health trainer service
- 1 to 1 support
- group sessions
Counselling and psychological therapies
Carers support worker (additional resource)
Cared for person open to social worker or team
Refer to relevant team
- Undertake :
Carer Assessment
Carers' Grants
Emergency Care Planning
Assessment of cared for person
- Signposting
1 to 1 sessions
Cared for person not known to an ASC service
Refer to community team (additional SW resource)
- Undertake :
Carer Assessment
Carers' Grants
Emergency Care Planning
Assessment of cared for person
- Signposting
1 to 1 sessions
Ongoing support required

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
14 September 2010	Consultation with residents on bringing the housing service back to the Council.	All

SYNOPSIS

The H&F Homes Board has agreed to lead on consulting with residents on the Council's proposal to directly manage the housing service. The presentation outlines the background to the consultation programme. On 29 June the H&F Homes Board agreed that bringing the service back in house was in the best interests of tenants and leaseholders. A report will be presented to Cabinet in January 2011. Before a decision is made by the Council, a comprehensive consultation programme with tenants and leaseholders is required in line with Government guidance.

CONTRIBUTORS

Orla Gallagher,
Interim Director of Housing Services (H&F Homes)

RECOMMENDATION(S):

Members are asked to note the current process being followed to consult with residents.

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

CONTACT

Orla Gallagher,
Interim Director of Housing Services (H&F Homes)
orla.gallagher@hfhomes.org.uk

020 8753 4559

NEXT STEPS

The qualitative and quantitative research will complete on 12 November 2010. After this date the findings of the consultation will be reviewed by EMT with a view of taking a paper to the Cabinet meeting on 10 January 2011.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	H&F Homes Board Report 29 June 2010	Orla Gallagher x4559	H&F Homes
2.	CLG: Review of Arms Length Management Organisations	Orla Gallagher x4559	H&F Homes

Housing, Health & Adult Social Care Select Committee

Orla Gallagher

14 September 2010

Structure

1. Information provided to H&F Homes Board
2. Current consultation programme
3. Timetable
4. Future involvement of the HH & ASC Committee

H&F Homes Board Report

1. Review findings from the Housing Commission
2. Summary of options and recent changes
3. Potential costs and savings

Housing Commission

- 1St Choice: Retain housing under the direct control of the council
- 2nd Choice: Create an ALMO
- Rejected:
  - × LSVT
  - × Private Finance Initiative
  - × Mix and Match options
  - × Community Gateway
  - × Community Based Housing Associations

Current considerations

- The ALMO agreement ends March 2010
- Decent Homes programme scheduled to end March 2011
- Financial and regulatory landscape is changing
- Savings can be made with bringing the service back to the Council

Potential costs and savings

- Reduction in back office functions – IT, HR and central services - £400,000 a year
- Rationalisation opportunities - duplicated services
  - Lettings and Allocations
  - Anti-social behaviour
- One- off cost of consultation - £50,000

Qualitative consultation

1. Started 6 August – Finish November 2010
2. Information to all tenants and leaseholders on the Council's proposal
3. Information to all Tenants and Residents Associations
4. Information on website
5. Dedicated Officer, telephone line, website information
6. Targeted focus groups
7. 150 letters to Community Groups
8. Attendance at residents meetings, forums
9. CITAS support with correspondence

Quantitative Consultation

1. Start September 2010 – Finish 12 November
2. Letter from H&F Homes Board
3. Information Leaflet
4. Consultation questions
5. Resident views on current service delivery
6. Independent Research Company

Timetable and Involvement

July – November:	Consultation on Council Proposal
November – Dec:	Assess resident views
January 2011:	Cabinet considers views and makes a decision

Committee Involvement

1. Regular briefings updates – resident views
2. Attendance at future Committee meetings
3. Assessment of service delivery
4. Review of Resident Involvement Options

Thank you

Questions and comments

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
14 September 2010	Three Boroughs Health Scrutiny Chairmen: Meeting Notes	All

SYNOPSIS

The notes of the Joint Three Boroughs Meeting of Health Scrutiny Chairman held on 23 June 2010 are attached as Appendix A.

The notes of the meeting with Imperial College Healthcare NHS Trust held on 07 July 2010 are attached as Appendix B.

CONTRIBUTORS

Sue Perrin
Extension 2094

RECOMMENDATION(S):

This report is for information only.

Joint Three Boroughs Meeting of Health Scrutiny Chairmen

MEETING NOTES

Joint Meeting of Health Scrutiny Chairmen and Officers
Hammersmith Town Hall, London W6 9JU
23 June 2010

IN ATTENDANCE

LB Hammersmith & Fulham (LBHF)
Councillor Andrew Johnson, Chairman, Housing, Health and Adult Social Care Select Committee (Chairman of the meeting)
Councillor Peter Tobias, Assistant (Health) to the Cabinet Member for Community Care
Sue Perrin, Committee Co-ordinator

RB Kensington and Chelsea (RBKC)
Councillor Christopher Buckmaster, Chairman of the Health Scrutiny Committee

Central London Community Healthcare
Jane Clegg, Director of Operations
Claire Holloway, Managing Director
Murray Keith, Director of Strategy and Business Development

Imperial College Healthcare NHS Trust
Ewan Mathieson, Stakeholder Relations Manager

1. WELCOME AND INTRODUCTIONS

Councillor Johnson welcomed Ms Holloway, Ms Clegg and Mr Keith to the meeting.

2. APOLOGIES FOR ABSENCE

Councillor Sarah Richardson and Simon Lewis, Westminster City Council.

3. NOTES FROM PREVIOUS MEETING

The notes from the meeting held on 21 April 2010 are to be circulated.

Action: RBKC (Gavin Wilson)

4. CENTRAL LONDON COMMUNITY HEALTHCARE (CLCH)

CLCH tabled a paper entitled 'CLCH's Development Plans and update on Foundation Trust Application'.

Ms Holloway stated that the current challenges were:

- The Coalition Government's commitment to 'reduce duplication and the resources spent on administration, and redirect these resources to front-line care'.

- CLCH's commitment to maintain and improve quality and effectiveness against the backdrop of:

  (i) A £18.6 million three year cost reduction target, including £8.2 million in year.
  (ii) An additional 15% reduction in management costs in-year, equivalent to £1.1 million of additional savings.

Ms Holloway responded to a query that CLCH currently had an annual turnover of £147 million, and management costs of £13.8 million in the previous year.

Ms Holloway stated that the new clinical model would move away from the provision of services on the basis of professional grouping, and would be organised around the patient journey. CLCH would work with Imperial College Healthcare NHS Trust and GPs to provide improved joined up care.

The commissioning of services would move from PCTs to GPs. Some GPs had experience of fund holding, but not of the commissioning of a broad range of services, which would include emergency as well as elective services and the wider remit of public health and well being.

Councillor Johnson queried whether the transfer of commissioning to GPs would realise savings. Ms Holloway responded that commissioning would need to be undertaken by larger practices or a consortium of GPs, as they would have little bargaining power on their own, and gave the example of one patient requiring intensive care to highlight the impact of changes in demand on small practices.

PCTs would be working with GPs to provide acute care in the community rather than in hospitals which currently accounted for around 50% of their budgets.

Ms Holloway addressed the specific concerns raised at the previous meeting in respect of the plans for restructuring some children's community health in Kensington and Chelsea on a regional basis, by outlining the following benefits for children's services applying the key principles of the new clinical model:

- Expert clinical leads with access to children best practice knowledge to meet local requirements.

- A dedicated safeguarding nurse.

- Quicker, more responsive and adaptable children's service to address children matters.

- A named senior manager specialising in children's services.

- A dedicated senior borough/relationship manager.

Initially CLCH had been managed on the basis of three boroughs, but Ms Clegg had now been appointed as Director of Operations, responsible for all clinical operations across the three boroughs.

Children's services had not moved away from borough structures, but plans for restructuring in order to deliver higher quality services in future were being informally consulted upon with staff. Patients were being asked about the important aspects of their care pathways and the aspects which were not so good. The proposed model would then be consulted upon. CLCH would consult at all stages.

Ms Holloway outlined the views of CLCH services as obtained from a recent survey of existing patients, which produced 5,000 responses.

Ms Holloway explained service specific PROMs (Patient Reported Outcome Measures) and PREMs (Patient Reported Experience

Measures) to track the ongoing quality of service delivery and the patient experience, in addition to finance and performance targets`.

Ms Holloway then outlined CLCH's journey to achieve NHS community trust status by 1 October 2010, with consultation on NHS foundation trust status in 2011. It was intended that there would be an open culture, with CLCH holding its meetings in public.

In response to a query by Councillor Buckmaster, Ms Holloway stated that initially accountability would be to the SHA, and after abolition of the SHA, to the regional office of the NHS Commissioning Board. Monitor would remain as the financial regulator and the role of the Care Quality Commission would be strengthened in respect of registration and quality of service delivery. Additionally, penalties and improvement notices could be issued in respect of services and ultimately, withdrawal of the contract.

There was likely to be competition from acute providers, GPs undertaking more services themselves and polysystems, for example NHS Kensington & Chelsea and the London Medical Associates were in partnership to deliver GP led services to St. Charles Urgent Care Centre, and Chelsea and Westminster Foundation Trust was providing care in the community for specific services.

In response to queries in respect of funding of the new structure, Ms Holloway stated that the CLCH was currently funded by the PCTs, but this would transfer to GP commissioners.

5. IMPERIAL COLLEGE HEALTHCARE NHS TRUST (ICHT)

Ewan Mathieson met the councillors to informally discuss the quarterly meetings with ICHT. The changes to the scrutiny structures within the boroughs were outlined. Councillor Buckmaster stated that significant changes to the health remit were anticipated at RBKC.

Ewan Mathieson stated that ICHT would be pleased to host an induction event for members of health scrutiny committees.

6. WORK PROGRAMME

It was agreed that the North West London Commissioning Partnership be invited to attend the next meeting.

Action: LBHF (Sue Perrin)

7. DATE OF NEXT MEETING

Wednesday 13 October 2010, 9.30am at Kensington Town Hall.

Appendix B

Notes of the Informal Meeting between Imperial College Healthcare NHS Trust (ICHT) and the Chairmen of the Health Overview and Scrutiny Committees of the London Borough of Hammersmith & Fulham, Royal Borough of Kensington & Chelsea and Westminster City Council held on 07 July 2010.

Present: Imperial College Healthcare NHS Trust
Professor Stephen Smith, Chief Executive/Principal
Claire Perry, Managing Director (Chairman of meeting)
Professor Nick Cheshire, Director of Circulation Sciences and Renal Medicine, CPG4
Rebekah Fitzgerald, Director of Communications
Ewan Mathieson, Stakeholder Relations Manager
Dr Julian Redhead, Director of Medicine, CPG1
Lesley Stephen, Director of Performance, Planning and Information
Professor David Taube, Medical Director, Clinical Services

London Boroughs
Councillor Andrew Johnson – LBHF
Councillor Peter Tobias – LBHF
Councillor Christopher Buckmaster – RBKC
Councillor Sarah Richardson – WCC (meeting only)
Sue Perrin, Co-ordinator – LBHF (notes)

1. Pre-meeting Escorted Visit

Professor Smith, Ms Perry and senior staff and clinicians escorted the OSC Chairmen to the West London Renal and Transplant Centre, the catheter laboratory and cardiac recovery unit, as well as a walk past of key research areas of Hammersmith Hospital.

The OSC Chairman thanked ICHT for arranging the visit. It had been very helpful to see the new developments at Hammersmith Hospital rather than just read about them, and to meet staff.

The OSC Chairmen appreciated the attendance of senior staff and clinicians at the quarterly meetings, and ICHT's willingness to proactively inform and discuss the trust's priorities and planned developments.

2. Notes from 20 January 2010 meeting and matters arising.

The notes of the meeting held on 20 January 2010 were received.

3. Councils Update

(a) RBKC

The committee structure would be finalised in the Autumn.

Key issue: Under the current capitation funding, the PCT was deemed to be 'overfunded' by 20%, and RBKC was concerned at the possibility of cost shunting into Adult Social Care, which had already suffered a budget cut of 25%.

(b) LBHF

The scrutiny committee structure had been streamlined, with Councillor Andrew Johnson as Chairman of the Housing, Health and Adult Social Care Select Committee.

£55 million would be cut from the budget over the next three years.

Underused or poor value for money assets would be sold to cut the £133 million debt mountain and interest payments, which were currently £5 million per annum.

There would be further integration of public services such as those currently provided by the Council and Primary Care Trust, and back office functions, for example human resources and procurement.

(c) WCC

The committee structure had been re-configured and health was within the remit of the Society, Families & Adult Services Policy & Scrutiny Committee; there was no longer a separate Health sub-committee.

LBHF and WCC had merged education services.

LBHF and RBKC shared assistant directors in respect of legal services and highways, although the departments had not merged.

4. NHS London/NHS NW London – Update

ICHT was working with GPs to provide care 'out of hospital' and in the community.

ICHT's budget was ring fenced, but a 7.5% reduction in income was anticipated. The trust was working through internal efficiencies which could be achieved by working more efficiently and in different ways, whilst bringing about improvements for patients; reduced costs and a higher throughput.

The major trauma unit would treat an estimated 500 patients per year, and was scheduled to open in October 2010.

ICHT informed of the pan London review of vascular services, and the ways in which technology was transforming the model of care, making it safer and cheaper and requiring less ITU. The trust's own developments in vascular surgery were required to capitalise on the national and international reputation of ICHT vascular surgery and to ensure the financial stability of the service. However, patients were still having major open heart surgery because the technology was not being applied as widely in some areas as others.

ICHT sought advice on communicating/consulting upon the proposals to establish a North West London Centre. There were approximately 5,500 patients per annum, of whom 25%/30% were from outside the three boroughs. The trust would develop a hub and spoke model. Evidence linked critical mass with improved patient outcomes. There was a need to develop capacity; other sectors had already rationalised vascular services.

Councillor Buckmaster queried the decision making process. Ms Perry responded that the trust would take the decision in line with the criteria that Andrew Lansley expected decisions on NHS service changes to meet.

(They must: focus on improving patient outcomes; consider patient choice; have support from GP commissioners; and be based on sound clinical evidence.)

Councillor Buckmaster advised that the trust should concentrate on quality and services, and then location of hospitals. There was currently a policy vacuum at national level, and the trust should therefore go ahead with its plans, and launch a public information campaign, and provide information in respect of service quality and survival rates.

Councillor Richardson suggested that leaflets broadened the basis of communication and that ICHT should provide information on prevention and lifestyle. WCC had included health information in its publications to residents, for which a payment had been made by the PCT.

Councillor Tobias advised joint communication across the sector, and noted the success of the relationship between the North West London PCTs and the Chairmen of Health Overview and Scrutiny Committees. Additionally, LINks undertook cross borough work.

5. Imperial College Healthcare NHS Trust – Update

(i) Hyper-Acute Stroke Unit (HASU)

Ms Perry stated that ICHT would consider the co-location of the HASU with Major Trauma at St. Mary's Hospital when it had a new building.

(ii) Foundation Trust status

Ms Perry stated that ICHT had met Monitor's requirements in respect of governance and services, but there remained more to be done in respect of the financial position. The expected date for formal trust designation was 1 April 2011.

6. Next Meeting

The next meeting to be held at St. Mary's Hospital in October 2010 would include:

(i) Visit to the Major Trauma Centre
(ii) Update on vascular services
(iii) Proposals for orthopaedic services

Appendix 6

Community Services Department

Housing Glossary and jargon buster

AD	Assistant Director
ADVANCE	ADVANCE, is a local voluntary sector agency that offers information support and advice to people who are experiencing domestic violence.
ADP: Approved Development Programme	This is the annual capital plan drawn up by the Housing Corporation, making funds available to registered social landlords to invest in housing.
Affordable Housing	This includes two sub-categories: social housing, where rent levels are set in line with the Government's rent restructuring regime and intermediate housing which includes a mix of low cost home ownership and other reduced cost rental housing
AGILYSIS	AGILYSIS is LBH&Fs strategic IT partner.
ALMO: Arms Length Management Organisation	A not for profit company set up and owned by a local authority to deal with the day to day management of the housing stock and tenancies. The ownership of the housing stock stays with the Council and it remains as the legal landlord. The ALMO is controlled by a Board of Management - made up of an equal number of Councillors, Residents and expert advisers.
ALG: Association of London Government	The body which brings together Councillors from all the London Boroughs.
Area Housing Forums	These meet monthly and are chaired by a local ward Councillor. Attendance is open to local tenants and residents associations to scrutinise the performance of the Area Housing Office and raise issues of concern.
ASB: anti-social behaviour	Anti-social behaviour - Ranges from dropping litter to serious harassment including racial harassment. Serious perpetrators are small in number but their behaviour has a disproportionate impact on large numbers of ordinary people in a community. There is a new code which comes into force in July 2002 which allows housing authorities to decide that an applicant can be treated as unsuitable for accommodation by reasons of unacceptable behaviour serious enough to make them unsuitable for tenants.
ASBU	Anti Social Behaviour Unit, The Anti Social Behaviour Unit is made up of a number of teams that together works with the Community Safety Unit, Housing Officers, the Police, Youth Offending Service and Voluntary Groups, to take action against perpetrators of Anti Social Behaviour.
Assets	Things that have a relatively high value and last for at least one financial year, e.g. a council house
Assured Tenant	One whose tenancy conditions are controlled by a contract, i.e. tenants of an RSL
Audit Commission	The Audit Commission has responsibility for the external audit of all local authorities. It can either use district auditors who are employed by the Audit Commission or firms of accountants.

B&B: Bed and Breakfast	Bed and Breakfast accommodation used to temporarily house homeless families.
Bed and Breakfast Information Exchange (BABIE)	A database of the standards and costs of hotels, shared annexes and other private sector shared accommodation used by London boroughs for accommodating homeless households. Administered by the GLA, it is being modernised to be accessible to users and will be renamed 'Setting the Standard'
BCA: Basic Credit Approval	A power given by the Government to borrow money up to a set limit to pay for spending on capital projects.
BEC	The Business Enterprise Centre
Beneficial Transfer Scheme	Scheme within the borough where the council offers tenants help to move to a smaller home.
Best Value Implementation Plan	The improvement plan drawn up after a Best Value Review (see also BV and BVR below)
Better Care, Higher Standards Charter	A National Charter that tells people what they can expect if they need care or support from their local housing, health and social services over the long term. Our local BCHS charter was published in 2000 and is updated annually.
BFI	Benefits Fraud Inspectorate.
BGOV: Better Government	Formerly better Government for Older People; is a way of working that involves older people and disabled people in making sure that services meet their needs.
BME	Black & Minority Ethnic.
Borough Partnership (BP)	Hammersmith and Fulham's local strategic partnership (LSP).
British Property Federation (BPF)	A trade association set up to represent to Government the interests of the property owning and investment industry.
BTS	Building and Technical Services.
Budget	A statement of the financial resources available and planned to be used to meet an organisations objectives.
Building Research Establishment (BRE)	A research-based consultancy, certificationand testing business covering the built environment and associated industries.
BUM	Business Unit Manager.
BV: Best Value	A duty on local authorities to review the services they provide for local people and improve them by the best means available ensuring service quality and cost-effectiveness. This must be done in consultation with people who use the services and the wider community.
BVPI: Best Value Performance Indicator	A measure of performance of an essential service area which all local authorities must monitor and report on to Government and the public.

BVPP: Best Value Performance Plan	Best Value Performance Plan – Councils are required to draw up an annual Best Value Performance Plan (BVPP) and their performance is measured against Best Value Performance indicators (BVPI) monitored by the Audit Commission.
BVR: Best Value Review	An investigation into the performance of a local service so it can be improved.
Cabinet	Hammersmith and Fulham's key council decision-making body which consists of the Leader and Council Members who are the Deputies for each department.
CALM: Confidential and Local Mediation	A neighbour mediation service which helps to resolve neighbour disputes.
Capital Budget	A statement of the approved capital schemes and where the funding is to come from.
Capital Expenditure	Money spent on creating a new asset or improving an existing asset so that its life, value or use is enhanced.
Capital Financing Charges	The annual interest and loan repayments on money raised to pay for Capital Expenditure, together with the cost of managing loans.
Capital Receipt	Income raised from the sale of an asset.
Catch up repairs	The level of repairs outstanding that are needed to bring the stock up to a minimum required standard.
CCTV	Closed circuit television.
CHAIN	CHAINs are online Contact, Help, Advice and Information Networks for people working in health and social care. They are based around specific areas of interest, and give people a simple and informal way of contacting each other to exchange ideas and share knowledge. CHAINs are multi-professional and cross organisational.
Choice-Based Letting (CBL)	Schemes designed to give tenants (or prospective tenants) more choice about where they live and give social landlords the opportunity to test new ways of meeting housing need.
Commission for Architecture and the Built Environment (CABE)	An agency supported by Government to drive up design standards, including skills.
Commitments	Contractual commitments entered into, but payment not yet made.
Community Housing Task Force (CHTF)	A Government unit created in May 2001 to assist local authorities, tenants and acquiring housing associations through the process of stock transfer. Its role was later widened to assist local authorities and tenants through the Options Appraisal process, and the transition to ALMO or PFI.
Compulsory Purchase Order (CPO)	An order made by a private or public body usually a local authority or government department) with the relevant statutory powers which, after confirmation by the Confirming Minister gives the right to acquire specified land and buildings compulsorily.

Confederation of British Industry (CBI)	A trade association representing all sectors of business in the UK (covering a work force of 6 million) which lobbies to help UK businesses compete more effectively.
Contingencies	Money put aside to cover unforeseen costs or where the level of expenditure of a particular type is uncertain.
Contingent Major Repairs	An allowance to cover unexpected costs over and above the level provided for as future major repairs and catch up repairs.
Community Care Plan	The plan sets out how community care needs have been identified and how these services will be delivered by our Social Services department.
Community Cohesion Reports	The reports written as a result of the disturbances that took place in the North of England in Bradford, Oldham and Burnley in the summer of 2001.
Community Strategy	Under the Local Government Act 2000, all local authorities are required to work in partnership with the community, businesses, the voluntary sector and other public sector partners to develop a long-term strategy to promote the social, economic and environmental well being of their local communities. In Hammersmith and Fulham the strategy sets out a 10-year vision for the borough.
Construction Task Force	A Government Task Force chaired by Sir John Egan tasked with radically reforming the Construction Industry.
Consultation Board	Hammersmith & Fulham's internal committee concerned with ensuring research and surveys carried out use consistent methodology and are meeting cross Council information and data needs.
CPA: Comprehensive Performance Assessment	Comprehensive Performance Assessment is a Government inspection of the whole council and not just one service.
CPO	Compulsory Purchase Order ***or*** Crime Prevention Officer
CRE: Commission for Racial Equality	Commission for Racial Equality is a publicly funded, non-governmental body set up to tackle racial discrimination and promote racial equality.
Equality Standard for Local Government	A standard by which Councils can assess their progress in meeting equality and diversity requirements set out in a range of equality and diversity legislation including; Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and The Equality Act 2006.
Crime & Disorder Reduction Strategy	The Council is responsible for producing this in partnership with the Police. It provides the strategy for reducing crime after analysing the levels of crime based on our local audit of crime.
CSO	Customer Service Officer.
DCLG	Department of Communities and Local Government Formerly ODPM Government department set up in 2006 to take over regeneration, neighbourhood renewal, housing, planning and regional policy.
Debits	Costs
Deficit	Where spending exceeds the income available.

Decent Homes Standard	A national standard set to ensure social housing is fit, has modern facilities, is structurally sound and energy efficient.
Decent Homes Plus	The Decent Homes Standard is a minimum national standard. There is scope for local decisions to go beyond the minimum standard to reflect local needs and aspirations. For example the need for controlled access in inner-city locations or lifts servicing all blocks over (say) 5 storeys.
Department for Education and Skills (DfES)	The Government department with responsibility for education and skills training.
Department of Transport, Local Government and The Regions (DTLR)	The Government department that had responsibility for local government, transport and the regions until 2002.
Disability Adaptations Unit	A service run by HFHMS concerned with providing adaptations into homes for those council residents with disabilities.
DSD	Direct Services Dept
DWP	Department of Work and Pensions
EDI: Empty Dwelling Initiative	Empty Dwelling Initiative - schemes aimed at bringing back into use long term empty private sector homes
Eco-homes Standard	An authoritative rating system for new, converted or renovated homes. The standard assesses buildings in terms of energy, water, pollution, materials, transport, ecology, land use and health and well-being.
EDM	Electronic Document Management A system of using scanning technology to store and retrieve incoming post or other documents electronically.
EDMO	Empty Dwelling Management Order. There are two types of EDMO. An interim edmo is an order made to enable a local housing authority with consent of the relevant proprietor to take steps to secure and ensure a dwelling continues to be occupied. A final edmo is an order made in succession to an interim edmo for the purposes of ensuring a dwelling continues to be occupied.
Egan	Programme arising in response to the Rethinking Construction report of the Construction Task Force, chaired by Sir John Egan. Designed to reduce waste and defects, increase partnership working and efficiency, encourage cost savings and innovation, improve working conditions and Health and Safety and make more use of privatisation throughout the Construction industry.
EHHHA: Ealing, Hammersmith and Hounslow Health Authority	Ealing, Hammersmith and Hounslow Health Authority is our sub regional Health Authority.
eHM	Electronic Housing Management.
Empty Homes Agency (EHA)	A charitable organisation that advises local authorities, housing associations and property interests on bringing empty homes into use.

Enforcement action	Action taken by the council to ensure a private landlord complies with legislation
English Partnerships (EP)	A non-governmental organisation established in 1993 to promote (predominantly physical) urban regeneration. It has a role for regeneration issues that affect more than a single region.
EPS	Evening Patrol Service.
ERCF (Estate Renewal Challenge Fund)	Estate Renewal Challenge Fund - a central Government programme to bridge funding gaps arising from stock transfer of "negative value" estates. This funded the regeneration of Old Oak Estate in Hammersmith and Fulham.
ESM	Estates Services Manager.
Estate Warden	A new post/service created following H&F's Best Value Review. Based within the Anti-Social Behaviour Team the Estate Wardens monitor and report on incidents of anti-social behaviour on housing estates.
European Structural Funds	These funds support two main programmes aimed at benefiting London areas of severe disadvantage: Objective 2 is targeted geographically at 13 boroughs and Objective 3 is to tackle barriers to labour market participation.
Final Accounts	Statements on the completed financial year which show how much money has been spent, how much is still owed, how much has been received and how much is still due.
First Time Buyers Initiative (FTBI)	A Government programme announced in January 2005 to give first time buyers an affordable way to buy their first home on a shared ownership basis. In many cases, buyers will have the opportunity to buy further shares leading to full ownership over time.
Freedoms and flexibilities	The term used in the Government's Public Sector Agreements to describe a lesser level of scrutiny of particular aspects of service delivery that are discussed in detail and agreed directly with the ODPM.
Fuel Poverty Strategy	Sets out how Hammersmith and Fulham aims to reduce levels of fuel poverty with a long-term aim of eradicating it.
Full-year effect	When provision is made in a budget to introduce a new service or cost during a financial year, an extra provision is required in the following financial year to bring the budget up to the level needed to cover the full year's cost.
Generic Equalities Standard	The Equality standard for local government in services and employment in England is designed to ensure that local authorities consider gender, race and disability equality issues at all levels of council policy and practice.
General Needs Index (GNI)	A formula that combines indicators of housing needs and conditions into an overall index formerly used as a basis for allocating capital investment resources between regions and districts.

Getting London Moving (GLM)	Getting London Moving (GLM) is a choice-based letting scheme bringing a partnership of 11 landlords together to offer a scheme to existing council and housing association tenants in London. The partners are Hackney, Hammersmith and Fulham, Haringey, Islington and Lambeth Councils and Family, Metropolitan Housing Trust, New Islington and Hackney; Notting Hill Housing Trust; Shepherds Bush and Ujima Housing Associations.
GLA: Greater London Authority	The Mayor and the London Assembly constitute a new and unique form of citywide government for London.
GOL: Government Office for London	The regional arm of central government designed to co-ordinate the delivery of government programmes and thereby improve the delivery of services.
HA	Housing Association *(see also RSL)*
HAFFTRA	Hammersmith and Fulham Federation of Tenants and Residents Associations supports the work of all the Tenants and Residents Association in the borough.
HAFNEP	The Hammersmith and Fulham Non-Estate Properties TRA provides a residents association for people that are not based on council estates.
HALS: Housing Association Leasing Scheme	Housing Associations lease properties from private landlords to temporarily house people.
HBS	Head of Benefits Service.
HCSIT	Head of Communications Service Improvement Team
Health inequalities	Differences in people's health between geographical areas and between different groups of people. It is accepted now that the causes are not only differences in access to health services between areas, but also poverty, housing, education and lifestyle.
HECA: Home Energy Conservation Act	Home Energy Conservation Act 1995 - requiring local authorities to determine and implement energy improvement strategies.
HFHMS Hammersmith & Fulham Housing management Services	Hammersmith & Fulhams ALMO.
HHO	Head of Home Ownership.
HHR	Head of Human Resources.
HImP: Health Improvement Programme	A programme for improving local health and health care led by the health authority but involving the local authority and a wide range of other agencies. Over a period of three years, all health services are to be reviewed and targets set for improving health outcomes.
HIP: Housing Investment Programme	Housing Investment Programme - The annual submission to government of the local authority's housing strategy and programme of finances in housing.
HM	Housing Management.

HMO: Houses in Multiple Occupation	Houses in Multiple Occupation - Properties with more than one household living there and sometimes using communal space, always sharing halls and staircases.
Homebuy	Schemes under which existing social tenants, those on housing waiting lists, and key workers can purchase a home on the open market with an interest-free equity loan. A planned extension to the Homebuy scheme will enable social tenants to buy a share in their existing home, with the possibility to move into full ownership in the future.
Homelessness duty	A local authority responsibility to re-house individuals when they are homeless.
Housing Association	Also known as Registered Social Landlords (RSLs). A not-for-profit organisation providing social housing and run by a voluntary committee registered with the Housing Corporation. They improve properties and build new homes, mainly for rent. Any surplus is ploughed back into the organisation to maintain existing homes and to help finance new ones.
Housing Corporation	The main government agency for supporting Registered Social Landlords (RSLs) in England. It makes grants available to RSLs and supervises and regulates their work.
Home Improvement Agencies	The agencies, which started in the 1970s, are small non-profit making bodies managed locally by local authorities, housing associations or charitable bodies to help older, disabled or vulnerable people remain independently in their homes. The agencies help with resources and funding for repairs and home improvements.
Home Improvement Trust (HIT)	A "not for profit" company limited by guarantee working on behalf of older homeowners and those with disabilities to make equity release more accessible in order to fund repairs, improvements or adaptations. HIT works with local authorities in London on the HouseProud scheme..
House Builders Federation (HBF)	The trade federation for private house builders in England and Wales. The HBF works with central, regional and local government and a wide range of third parties, including non-governmental organisations and the rest of the business community across a range of policy areas. These include: planning, housing, regeneration, design and economic and regional development.
HouseProud	A scheme that is promoted jointly by London boroughs and the GLA to release equity in owner occupied homes for improving the quality of life in the home.
Housing Health and Safety Rating System	A new framework of evidence based risk assessment introduced by the Housing Act 2004 which replaces the housing fitness standard.
Housing Needs Index	Information used by the Housing Corporation to allocate resources to RSLs through the Approved Development Programme.
Housing Needs Survey	The Housing Department collates the results of all surveys relevant to identifying the housing needs within the borough into one document on an annual basis. This includes population and household information such as census data as well as specific surveys commissioned by the Housing department such as the Housing Needs Assessment carried out by Fordham Research Consultancy.
HPSH	Head of Private Sector Housing.
HR	Human Resources.

HRA: Housing Revenue Account	Housing Revenue Account - a ringfenced account for managing and maintaining local authority council homes.
HRA Balances	The surpluses that arise where income exceeds expenditure in the Housing Revenue Account.
HRA Business Plan	The 30-year plan setting out the income & expenditure needs of the council owned homes, which all Local Authorities need to prepare.
HRA Credit Ceiling	The limits set on how much can be borrowed for housing purposes.
Housing Subsidy	Government grant toward the cost of managing and maintaining the council housing stock and Council Tenants Housing Benefit.
IEG	Implementing e-government
IiP: Investor in People	LBHF has the Investor in People award, a national standard that seeks to encourage good staff management and development practices.
Internal Component Renewal Scheme	Part of our Housing Capital programme concerned with renewing kitchens, bathrooms, rewiring etc. The majority of our homes failing the decent standard do so because of old kitchens & bathrooms. This programme will therefore contribute most to meeting the decent homes standard.
Intermediate housing	A collective term for all forms of both LCHO (e.g. shared ownership) and submarket rented housing (primarily for key workers), but excluding social rented housing. Prices will be above social rents, but substantially below open market levels.
Intermediate Market Housing	The term used to describe households who have a reasonable income, but cannot afford to be owner-occupiers in the borough. H&F are losing a large proportion of these households as people are forced to move away to find decent housing at a price they can afford.
IRRV	Institute of Revenue, Rating and Valuation.
ITS	Information Technology Section.
JCP: Joint Commissioning Partnership	A partnership between the Housing Corporation selected Housing Associations & London Borough of Hammersmith and Fulham to encourage closer working to develop new affordable homes and share good practice on management & development of social housing across the boroughs. Our selected partners are: Notting Hill Housing Trust (NHHT), Shepherds Bush Housing Association (SBHA), Acton HA, Ealing Family HA (EFHA), Family HA, Octavia Care & Trust, Threshold Trust.
Joint Venture Company	A local authority company set up to undertake a specific project.
Key Worker	Any worker who is key to the borough's strategic growth and the delivery of key services.
Key Worker Living Programme	A scheme helping key workers in London, the South East, and East of England to buy a home, upgrade to a family home or rent a home at an affordable price. Key workers who may get help in London are: nurses and other NHS staff; teachers in schools and in further education and sixth form colleges; police officers and some civilian staff in some police forces; prison service and probation service staff; and social workers, educational psychologists, planners , occupational therapists and speech and language therapists employed by local authorities.

Key Worker Strategy	A strategy being developed to encourage the development of affordable homes for key workers and other middle income households in the borough.
KLOE	KLOEs, or Key Lines of Enquiry are questions which provide consistent criteria for assessing and measuring the effectiveness and efficiency of housing services. KLOEs are designed to provide inspectors, inspected bodies and others with a framework through which to view and assess services. Examples of excellent and fair services have also been provided that set out what inspectors would expect of services.
LA	Local Authority.
LA 21: Local Agenda 21	The local dimension of the programme for sustainable development. The local community, public bodies and businesses draw it up.
LASHG: Local Authority Social Housing Grant	A grant of capital money from Hammersmith and Fulham Housing Services Department to an RSL to assist with the funding of RSLs developments.
Land assembly	The process of bringing together more than one parcel of land for redevelopment
LAA	Local Area Agreement. LAAs are a new approach to the way local authorities and their partners can use government funding to support the implementation of national and local priorities in local areas. They are agreements struck between government, the local authority and its partners in an area (working through the local strategic partnerships) to improve public services.
LAWN	LAWN helps people move from one part of Britain to another. It works by linking councils and housing associations that have long waiting lists for housing with councils and housing associations that may have empty homes or shorter lists. This as with other mobility schemes is due to be replaced by Move UK intended as a single point of contact for those wishing to move outside the borough they currently live in.
LBH&F	London Borough of Hammersmith and Fulham
LDA: London Development Agency	London Development Agency is the regional body that co-ordinates the economic development of London. It now controls regeneration programmes such as SRB and NDC.
Leaseholder	Individuals who have taken out the Right to Buy (and those who have bought from them) on former Council property, but who do not own the freehold.
ESLG: Local Government Equalities Standard	The standard is a means to combat the institutional processes that lead to discrimination. The standard provides a common approach for dealing with equality for race, gender and disability.
Lifetime Homes Standard	The standard is designed to accommodate the changing needs of occupants of housing throughout their lives. There are 16 standards promoted in the Rowntree Foundation report 'Meeting Part M and Designing Lifetimes Homes' such as wider doorways, wheelchair access, downstairs toilet and provision for a future stair lift.
Local Development Framework (LDF)	The local development documents, set out in the form of a portfolio, which collectively deliver the spatial planning strategy for the local planning authority's area.

Local PSA: Local Public Service Agreement	A contract between Hammersmith and Fulham Council and central Government in which we agree to meet a specific target and for which the Council gets additional resources or greater flexibility from central Government.
Local Strategic Partnerships (LSPs)	Cross-sectoral, cross-agency umbrella partnerships matching local authority boundaries, which are focused on and committed to improving the quality of life and governance in a particular locality. They tackle multi-faceted problems, seeking to align services in a way that effectively meets needs and aspirations. They play a central role in delivering the Neighbourhood Renewal Unit's strategies.
LOCATA	LOCATA is a system helping LBH&F to deliver Choice Based Letting (CBL) Locata is a not-for-profit organisation, set up by a group of West London boroughs.
London First	A business-led not-for-profit campaign set up in the early 1990s to improve the promotion of London. It includes 330 private sector organisations and most of London's further and higher education institutions.)
London Housing Board	The Regional Housing Board for London. (see Regional Housing Board entry)
London Housing Federation (LHF)	The trade body of housing associations working with and in support of members and other partners to promote the values and strategic interests of the social housing sector in London.
London Housing Statement	Jointly published by the Government Office for London and the Housing Corporation. It sets out the key priorities for housing in London.
London Housing	A part of the Association of London Government. It provides research, analysis and information on housing and associated issues on behalf of its member boroughs.
London Plan	A new planning strategy for London. This replaces the previous strategic planning guidance for London (known as RPG3), issued by the Secretary of State. The London Plan is the Mayor's spatial development strategy.
LSP: Local Strategic Partnership	Established to involve local people and agencies in setting out a vision for local neighbourhood renewal and helping to improve the delivery of local services through better planning. They involve representatives from public, private, business community and voluntary sectors. They oversee the development and implementation of the Community Strategy. We call ours the Borough Partnership.
LSVT: Large Scale Voluntary Transfer	Transfer of the ownership and management of a large number of residential properties (over 500) from one landlord to another following a ballot. Usually the transfer of properties is from the Council to a Housing Association. See also Stock Transfer, below.
MEI	Minor Estates Improvements
MORI	Market and Opinion Research International - An independently owned market research company in the United Kingdom.
moveUK	A new on-line homes and jobs mobility service, bringing together information on access to social housing, job vacancies and a range of information on areas people want to move to across the country. Schemes such as HOMES and LAWN are being transferred to this new national scheme which will be launched in summer 2005.

Moving Out of London Scheme	A scheme that tenants can sign up to if they want to move out of London. We have arrangements with some northern council, such as Stoke to encourage tenants to move if they wish to do so. This as with other mobility schemes is due to be replaced by Move UK intended as a single point of contact for those wishing to move outside the borough they currently live in.
MRA: Major Repairs Allowance	A housing subsidy allocated to carryout Major Repairs to Council Housing.
Multi-tenure developments	Newly built developments containing a mixture of ownership.
National Asylum Support services (NASS)	The Government Agency supporting and accommodating asylum seekers around the country.
National Audit Office (NAO)	A statutory body that reports to Government on spending of central government money through financial audits and assessments of value for money. It is headed by the Comptroller and Auditor General who is an officer of the House of Commons.
National Framework for Older People	A series of documents giving specific government guidance to both health and local government in a number of key areas of joint working between the two.
NDC: New Deal for Communities	Major regeneration programme targeted at deprived communities. We have an NDC area based in North Fulham, which includes a number of our larger estates.
New Deal for Communities (NDC)	NDC Partnerships established in 10 neighbourhoods across London that bring local communities together with mainstream service providers and local stakeholders to tackle the problems in their neighbourhoods in an intensive and coordinated way.
NHHG	Notting Hill Housing Group
NOTIFY	A system developed by the GLA/ALG and administered by the GLA which aims to improve access to services for households in temporary accommodation by notifying relevant agencies (social services, health, education and housing) when statutorily homeless people move in and out of temporary accommodation and between London boroughs
Notional Housing Revenue Account	The Governments assessment of what a Council's Housing Revenue should be. This notional account is then used to calculate the amount of Housing Subsidy that is granted.
NRF: Neighbourhood Renewal Fund	A Government fund designed specifically to reduce deprivation. H&F has a small grant which is being used to tackle problems such as crime and housing.
NRS: Neighbourhood Renewal Strategy	Sets out how we will improve the most deprived areas of the borough. The strategy has highlighted a number of areas with high concentrations of social housing as priority areas for action. It will seek to bring together resources from across agencies to holistically tackle problems.
NTEC: New Technology Project	Providing IT support for elderly and disabled people

ODPM: Office of the Deputy Prime Minister	Government department set up in June 2002 to take over regeneration, neighbourhood renewal, housing, planning and regional policy. Previously known as DLTR.
PEDO	Principal Economic Development Officer
Peer review	An audit carried out for one local authority by another local authority.
Performance Assessment Boards	These are held in Hammersmith and Fulham every 3 months, with HAFFTRA representation to review the performance of housing management in detail.
Performance Plan	The statutory requirement on the council to produce an annual plan setting out our priorities on how we will deliver services at particular standards, show we are improving and how well we did in the last year.
Planning Policy Guidance Note 3: Housing	The guidance setting out the Government's policies for planning in relation to housing.
PFI: Private Finance Initiative	Arrangements where the private sector will finance capital work or construction up front and be repaid over a long period, (and may also take on some or all of the management services provided over the same period).
PIs: Performance Indicators	A way of measuring how a service is performing against its objectives. Performance Indicators may be collected for local or national purposes *(see BVPIs above)* and can be compared between service providers.
PPM	Planned preventative maintenance
Private Finance Initiative (PFI)	In a PFI transaction, a private sector service provider is given responsibility for designing, building, financing, and in some cases, managing assets, from which a public service is delivered
PSL: Private Sector Leasing scheme	The scheme whereby the Council (or RSLs) leases property from a private landlord to temporarily house families in housing need. Market rents are charged, but this is cheaper then using B&B and provides a higher standard of home for residents.
Private Sector Strategy	Aimed at providing, retaining and ensuring access to affordable private sector homes. Improving and maintaining the quality and condition of the private sector housing stock and delivering a customer orientated, best value service.
PSBR: Public Sector Borrowing Requirement	The amount of money that the Government needs to borrow to fund its' public spending plans.
PSA: Public Service Agreement	Since April 2001, local authorities have been able to bid for more money by agreeing to set local service improvement targets that go beyond best value performance indicators.
Public Sector Forum	Hammersmith and Fulham's sub group of the Local Strategic Partnership that includes all key, public sector partners.
Public sector stock	Homes that are owned by the Council or other public sector bodies.
Quality and Choice for Older People's Housing	Government document setting out housing priorities for older people.

Race and Housing Inquiry Challenge Report	Joint inquiry by the CRE, Housing Corporation, National Housing Federation and Federation of Black Housing Organisations conducted in 2001 which looked at what could be expected of the RSL sector and to identify how it can achieve long-term change.
Race Equality Scheme	A race equality scheme is a statement of how a listed public authority plans to meet both its general and specific duties to promote equality under the amended Race Relations Act. It is part of our equalities strategy in Hammersmith and Fulham.
Race Relations (Amendment) Act	Act of Parliament that makes it unlawful to discriminate against anyone on grounds of race, colour, nationality (including citizenship), or ethnic or national origin. The amended Act also imposes general duties on many public authorities to promote racial equality.
Regenasis	The Hammersmith and Fulham local regeneration partnership, which brings together the wide number of existing partnerships delivering regeneration programmes.
Renewal grants	Grants provided by the council to help residents/landlords to refurbish their homes to an agreed standard
Regional Housing Board (RHB)	ODPM's Sustainable Communities Plan introduced new regional arrangements to help deliver sustainable communities, including the creation of a Regional Housing Board in each of the nine English regions. The Board is responsible for drawing up the Regional Housing Strategy (i.e. in London, the London Housing Strategy) and making recommendations to Ministers about Regional Housing Pot funding.
Regional Housing Pot (RHP)	A new single pot for housing investment that replaces and combines the resources formerly allocated to each region through the Housing Corporation's Approved Development Programme (ADP) and the local authority Housing Investment Programme (HIP).
Regional Planning Guidance (RPG)	This sets out the Government's policies on different aspects of planning specific to different areas of the country. They include the framework under which Unitary Development Plans are to be prepared.
Rent restructuring	Government plan to simplify and converge RSL and council rents so that they are set at about the same level. Uses a formula based upon the capital value of the property, regional average earnings and adjusted for bedroom size.
Repairs Hub	Repairs hubs are centres through which tenants can order repairs either in person of over the telephone. There are two repairs hubs, one in the north of the borough and one in the south
Reserves	Money put on one side, for no intended specific (current) purpose
Responsive Repairs	Day to day repairs, including broken glass & leaking pipes
Rethinking Construction	The report of the Construction Task Force chaired by Sir John Egan, aiming to improve the way the construction industry operates with a customer-led focus concentrating on continuous improvement through innovation, partnering, benchmarking, supply-chain management, and driving out waste.
Ring Fence	Government rules to keep HRA finances (raised from rents) separate from the General Fund (raised from Council Taxes).
Rough sleeper	An individual who sleeps on the streets, who is homeless.

RSL: Registered Social Landlord	The technical name for social landlords that are registered with the Housing Corporation. Housing Associations are all RSLs, but there are also some trusts, co-operatives and private companies who are RSLs.
RSU: Rough Sleepers Unit	Central Government department section.
RTB	Right to Buy.
RTL	Regeneration Team Leader.
SAP rating	Standard Assessment Procedure, standard national measure of energy efficiency with the aim of encouraging improved energy efficiency in residential homes.
SBHA	Shepherds Bush Housing Association.
Scrutiny Committee	Hammersmith & Fulham committee of Councillors (who do not hold executive positions within the council) and specialist co-optees who examine the work of particular services or decisions made by the executive committee. Councillor Gavin Donovan is the Chair of the Housing Scrutiny Committee.
SCP: Single Capital Pot	System where Councils are given approval to borrow money to invest in a range of services. The HIP is a part of the SCP.
Special Cleaning Services	Specialist Cleaning Services
Section 106	An agreement made, under section 106 of the Town and Country Planning Act, between a local planning authority and developers specifying, for example that a proportion of a development site will be reserved for affordable housing.
Secure Tenant	Tenant of a local authority where an Act of Parliament secures tenancy conditions.
Service Charges	Charges made to cover the costs of particular services to a dwelling; these may include caretaking, lift servicing, grounds maintenance etc.
Shared ownership housing	This is a form of housing which is part mortgaged and part rented - so the occupiers owns a percentage and rents a percentage. Occupiers can gradually take on more of the ownership and could buy the property completely when they can afford it.
Sheltered Housing Forum	A Hammersmith and Fulham consultative body for sheltered housing tenants.
Sheltered housing	A wide range of supported housing for older people. Generally it provides specially designed self-contained housing, communal facilities and a warden service.
Social housing	Housing which is rented from a Housing Association, local authority or trust.
Social Housing Grant (SHG)	Capital grant provided by the HC to fund housing associations to develop social housing.
SIT	Service Improvement Team
Small Landlords Association (SLA)	A national membership body for landlords of private housing offering advice and lobbying services.

SLA	Service level Agreement
SMT	Senior Management Team
Special Development Strategy.	The policy that will shape London over the next 20 years. It was published by the Mayor as the London Plan in February 2004.
Socio-economic survey	The survey carried out alongside the stock condition survey to establish data about the economic and social circumstances of our tenants which is used to consider how future policies and strategies can be developed to best meet their needs.
Social Homebuy	This is a new scheme that gives tenants the opportunity to become home owners, by purchasing their existing, rented homes. The scheme allows tenantsa to buy their home on an outright basis (100%) or on a part-buy, part-rent basis. Under the part-buy, part-rent arrangement they could buy either 50% or 75% of their home and rent the remaining part from the Council.
SP: Supporting People	The Supporting People programme is a programme administered by the Department for Communities and Local Government that funds housing support services including those provided to older people living in some sheltered accommodation schemes, housing support schemes for those with mental health problems and temporary supported housing schemes for single homeless.
SRT: Service Review Teams	Hammersmith & Fulham's teams for carrying out Best Value reviews of services provided to residents.
Stock condition	The state of repair/disrepair of property.
Stock Condition Survey	The survey carried out between November 2000 and February 2001 to establish the current condition of the council stock and to measure how many homes are decent or not. The report was received in June 2001 and has formed the basis for our work to establish the investment strategy.
Stock Transfer	Where the ownership and management an estate, or the whole stock is transferred from one landlord to another. Usually from the local authority to an RSL. This can only occur following a ballot and vote in favour of transfer by tenants.
Supplementary Credit Approval	A power for a local authority to borrow money for particular capital projects that the Government has a strong wish to promote. For housing, an SCA may be given to support Single Regeneration Budget schemes.
Sustainable Communities	Places where people want to live and work, now and in the future. They meet the diverse needs of existing and future residents, are sensitive to their environment, and contribute to a high quality of life. They are safe and inclusive, well planned, built and run, and offer equality of opportunity and good services for all.
Temporary accommodation	Homes occupied by households on a short-term basis.
Tenanted Market Value	Valuation used in calculating the sale price of housing stock to be transferred to a new landlord.
Tenant Participation Compacts	Written agreements between the local authority and its tenants setting out how tenants will be involved, what can be delivered locally and how delivery can be monitored.

Tenure	In housing, the legal terms on which a property is occupied e.g. as owner occupier, private tenant, Council tenant, Housing Association tenant, leaseholder
Thames Gateway	Identified by Government as one of the four growth areas for new housing, this is an area extending for 40 miles along both sides of the River Thames from London docklands to Southend in Essex and Sheerness in Kent.
TMO: Tenant Management Organisation	A tenant led organisation that has taken on the management of some or all the housing services in their area or estate.
TRA: Tenants and Residents Association	Tenants and Residents Association is an elected group of tenants and/or leaseholders who live in a particular area of Hammersmith and Fulham. The TRA represent the views of their residents to the council.
Transfer Scheme	A scheme whereby tenants who are living in homes that do not meet their needs can be registered to await a more suitable alternative.
UDP: Unitary Development Plan	The document drawn up by local authority planning departments to set out the plans for using land. It is used to determine planning decisions and physical regeneration schemes.
Unfit housing	The housing unfit standard is a set of basic requirements that homes should meet to be acceptable places to live. The standard is set down in Section 604 of the Housing Act 1985 as amended by Schedule 9 to the Local Government and Housing Act 1989.
Urban renaissance	Improving the quality of life for all those who live in urban areas
VFM	Value for Money (VfM) is the term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it acquires and/or provides, within the resources available to it. It not only measures the cost of goods and services, but also takes account of the mix of quality, cost, resource use, fitness for purpose, timeliness and convenience, to judge whether or not, when taken together, they constitute good value. Achieving VfM may be described in terms of the 'three Es' - economy, efficiency and effectiveness: a. **Economy.** Doing less with fewer resources, i.e. making savings. b. **Efficiency.** Doing the same as before, but with fewer resources (money, staff, space). c. **Effectiveness.** Doing more than before with the same resources as now (or less).
Voids Maintenance	Works that need to be done before an empty property can be re-let.
Voluntary Sector Hostels	Hostels owned or managed by not for profit sector organisations
WLA: West London Alliance	The six west London Boroughs of Hammersmith and Fulham, Hounslow, Ealing, Brent, Hillingdon and Harrow. Determines sub regional priorities affecting economic, social and environmental wellbeing.
West London Housing Partnership	The West London Housing Partnership consists of 7 West London boroughs, covering the same area as the Housing Corporation's West London Sub region: Hammersmith & Fulham; Kensington & Chelsea; Ealing; Hounslow; Brent; Harrow and Hillingdon. The partnership actively lobbies for housing resources to meet West London's housing

	need and is developing partnership working in order to deliver better, more cost effective services to residents living in the sub region. The West London Housing Strategy sets out a 10 year vision for housing in West London and identifies the overarching aims of the seven boroughs by 2012. The 7 member boroughs jointly fund a sub regional post to co-ordinate delivery of the West London Housing Strategy
West London Housing Strategy	Housing Strategy being developed with the other west London local authorities of Brent, Ealing, Harrow, Hillingdon and Hounslow.
WLL: West London Partnership	West London Leadership - A private sector led strategic partnership between the private and public sectors leading economic development in west London.
"windfall" site	A site unexpectedly made available for housing development.

GLOSSARY: HEALTH AND ADULT SOCIAL CARE

Clinician
A general term to describe doctors, nurses, radiotherapists and all professional staff who are directly involved in the treatment and care of patients.

Commissioning
The process of assessing the needs of a local population and putting in place services to meet those needs.

FAST test
Stroke recognition test:
Face weakness?
Arm weakness?
Speech problems?
Time to call 999.

Foundation Trusts
NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control, enabling them to be more responsive to the needs of local populations.

Individual Budget
A predetermined allocation of funding based on assessed need. Money can be used to design and purchase support from public, private and voluntary sectors. This budget can be taken via services arranged by the council or as a direct payment, or a mix of both.

HASU - Hyper-acute stroke unit

Local Area Agreements
Local Area Agreements are a new way of working to build a more flexible and responsive relationship between central government and localities on the priority outcomes needing to be achieved at a local level.

Local Involvement Networks (LINks) – LINks are local organisations in each local authority area set up to represent views of local people and social care services. These will become Local Health Watch.

Monitor
Monitor regulates NHS foundation trusts, making sure that they are well-managed and financially strong so that they can deliver excellent healthcare for patients.

MTC - Major Trauma Centre

National Institute of Health and Clinical Excellence (NICE)
An independent organisation which provides advice and guidelines on the cost and effectiveness of drugs and treatments.

NHS Constitution
The NHS Constitution describes the principles and values of the NHS in England, and the rights and responsibilities of patients, the public and staff.

Patient Reported Outcome Measures (PROMs)
PROMs provide information on how patients feel about their own health, and the impact of the treatment or care they receive.

Personal health budget
An extension of personalised care planning, which gives people more choice and control over the services they receive by giving them more control over the money which is spent on their care.

Primary Care Trusts (PCTs)
The NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services.

Provider
Organisations which provide services directly to patients.

Putting People First
This is the national vision to ensure that every person who receives support, whether provided by statutory services or funded by them, will have choice and control over the support they need.

Self Directed Support
This describes the over-all principle that people should be able to choose, organise and control the support they receive, to meet their needs in a way that best suits them.

Social Enterprise
Organisations are run along business lines, but where any profits are reinvested into the community or into service developments.

Support Plan
A plan developed by service users to describe how they will use all the resources available to them to achieve what is important to them.

Supporting Your Choice
This is the name adopted in Hammersmith & Fulham to describe the programme of work which responds to the national aims described in Putting People First. A key part of the Supporting Your Choice programme is the introduction of individual budgets, which we are trying with the “100 Club”

Third Sector
The non-profit or voluntary sector is known by this name (government and the private sector being the first two sectors).

Transient ischaemic attack (TIA)
A stroke-like event that fully recovers within 24 hours of the start of symptoms.