



The Moore Adamson Craig Partnership's 10 Point Plan For the NHS Future Forum on Amendments to the HSC Bill focusing on Public Accountability and Patient Involvement.

Open

1. The NHS Commissioning Board and its regional offices, all Commissioning Consortia and Foundation Trust Boards must meet in public and be open to the public under the Public Bodies (Admission to Meetings) Act 1960 and their activities must be subject to the Freedom of Information Act. The same provisions must apply to Health Watch England and all Local Health Watch meetings and business.

Patient Focus Evidence Needed to be GP Commissioner

2. GP practices must earn the right to be part of commissioning consortia by demonstrating their compliance with the new DES for patient participation, the aim of which is to promote the proactive engagement of patients through the use of effective Patient Reference Groups, to seek views from practice patients through the use of local patient experience surveys, agree priorities with their patients and show how patient views have been incorporated into practice decision making . This compliance must be validated annually in order for a practice to remain in membership of the consortium.

No to Health and Well Being Boards

3. Integrated health and social care commissioning organisations, spanning specific geographical areas such as whole boroughs and districts, must be created with public health at their core and utilising service user, carer and public views and experiences in their commissioning intelligence. Their remit must be to improve health and well-being and reduce health inequalities. Separate Health and Well Being Boards are therefore not necessary and should not be created.

Role for Lay Members and Local Councillors

4. Integrated commissioning organisations must be seen to be clinically led and chaired, but be democratically accountable. As well as clinical representatives from the participating practices, their top level governance arrangements must include elected local councillors as well as independent lay members chosen through an open selection process on the basis of specified competencies and experience and rewarded on a parity basis with others at that level the basis of their commitment and levels of responsibility.

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Patient Reference Groups Integrated into Consortium Governance

5. Commissioners must be responsive to the needs and recommendations of the populations they serve. Each commissioning organisation must create and support and be seen to work collaboratively with a patient and public reference group comprised of patient representatives from local practices and lay leaders from local 3rd sector bodies and community networks. This reference group must be part of the governance arrangements of the consortium at all levels and have rights to make inputs to the decision making process of major consortium committees and particularly around strategic commissioning plans. It would exercise oversight of the consortium's patient and public involvement activities and comment on their adequacy to the local authority and Local Health Watch. The patient and public reference group must include people from communities and groups who can help the commissioners understand how to overcome their health inequalities and comment on the effectiveness of efforts to do so.
6. Local Health Watch as a statutory body (and before they are created the Local Involvement Network) relating to the area covered by the commissioning consortium, must have a seat on the top level governance group – whether or not it is called a “board” - of the consortium. The LINK/LHW representative must be supported from consortium resources to enable reports to be produced and disseminated to the wider community following each meeting.
7. Commissioning consortia must be subject to a duty to involve, engage and consult with their local populations and must demonstrate to the satisfaction of their patient and public reference group (see 5 above) that they have both listened and responded to the views and recommendations from local people before their commissioning plans are finalised.

Hands Off for Two Years after Agreement between Local Partners

8. Reflecting the duty of partnership between local government and the NHS, the local authority relating to each commissioning consortium must, through its health and social care overview and scrutiny arrangements, have the power to sign off the strategic commissioning plans of the consortium and, in exceptional circumstances to veto commissioning plans and refer them to the Secretary of State, Monitor, Health Watch England or the Care Quality Commission as appropriate. As a safeguard against politically-based interference with legitimate commissioning changes including decommissioning of services, once a plan is agreed it would not be changed by the local authority for at least two years.

Feedback on Decisions

9. The commissioners must have a duty to be open about decision making and acknowledge when and how involvement, engagement and consultation has been responsible for change. When resources or other restrictions mean that well-

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informed views for alternative approaches cannot be implemented, the commissioners must explain to those who have given their views why it is not possible to implement them and make clear the rationale and implications for whatever investment, service development or other changes have been agreed by the consortium instead.

More Money for Patient-Responsive Commissioners

10. In its oversight of the consortia, the NHS National Commissioning Board should introduce a “responsiveness premium” – like the current CQUIN scheme where payment to providers is linked to quality performance - comprising funding that rewards responsive commissioners. This would be top-sliced initially and returned to commissioners if they demonstrated commissioning that is responsive to the expressed needs of the local population and if this is confirmed by the consortium’s patient and public reference group and by Local Health Watch.

A Moore Adamson Craig Partnership Public Policy Paper

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This paper has been prepared as a contribution to current public policy debate. Its focus is on Patient Engagement.

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