

ANNEXE 1

The draft response to the Health White Paper set out below are being considered by the Healthcare Special Interest Group on Monday 20 September 2010, and may be subject to further amendment.

Part A - Commissioning for Patients

Responsibilities – scope of GP commissioning

Waverley Borough Council (WBC) endorses the principle [para 3.1] that commissioning responsibilities and accompanying NHS resources should be devolved as close to the patient as possible.

Q1 In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

Maternity services should be commissioned locally by GP consortia rather than by the NHS Commissioning Board.

Q2 How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low-volume services?

Commissioning of low-volume services can be achieved through GP consortia developing their own partnerships locally to build optimum volumes for cost-effective commissioning. However, low-volume services must still be accessible for patients, and not centralised in too large a geographical area so that some patients are disadvantaged by transport costs/difficulties and travel time to reach the service.

It may be appropriate for a threshold of “frequency” and “typical cost of care” to be used to determine when extra central funding is appropriate to supplement practice-based budgets. This would acknowledge the hereditary or environmental causes of some illness which can produce localised hotspots.

Q3 Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

Maternity services and renal services could be commissioned by GP Consortia, particularly if they work in partnership to ensure patient choice.

Q4 How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

Primary dental and ophthalmic services will be commissioned by the NHS Commissioning Board, in much the same way as they will contract with GP practices to provide primary medical care.

It seems logical in terms of efficiencies and understanding the local population for these primary care contractors to be linked (as full members or otherwise) into the relevant GP-consortia for the purposes of commissioning specialist dental and ophthalmic services. There should be suitable controls to prevent cost-shifting from primary care budgets to consortia budgets, and vice versa.

Bringing dental and ophthalmic services into GP consortia also brings them within the purview of Health & Wellbeing Boards' oversight of coherent and co-ordinated commissioning strategies.

Responsibilities – duties and responsibilities of GP consortia

We note that the NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia [para 3.5].

Current per capita allocations give far too much weight to urban deprivation and do not recognise the effect of age demographic. Affluent people live longer and older people consume more health care than younger populations. This is evident to GPs who see that there is effectively more money in health care in cities, especially in the north, than there is in places such as Surrey.

We are concerned that the funding formula for calculating budgets should take account of:

Age – the funding formula needs to take account of the age profile of practice populations. GP practices that have a high proportion of elderly patients will have different and more expensive commissioning requirements than those that have a higher proportion of younger people, even taking into account deprivation measures. Allowance for this must be made in budget allocations in order to provide equality in access to healthcare.

Rurality – in a rural area, choice is meaningless and access is everything. Patients do not have the option of choosing treatment on the basis of quality; they must choose to receive treatment at locations that they can get to. The funding formula should include a rural premium based on Defra's Rural Definition or LA Classification, to take account of the additional cost of delivering services in rural areas and/or accessing services from rural areas to ensure quality of care meets NICE standards regardless of where the patient is based.

The Defra classification of Surrey PCT as Predominantly Urban does not reflect the fact that Waverley and Tandridge are classed as Rural 50, and Guildford as Significantly Rural; and around 70% of Waverley's population is classed as 'rural'. In the move to supporting local commissioning for local needs, budgets need to be rural-proofed, so that rural populations are not disadvantaged by poor access, e.g. do not assume "no car" urban solutions and guidelines work for rural areas; patient transport costs need to be funded.

There must be a clear distinction between responsibility (and corresponding budgets) for treatments and those for preventative health care. Money for preventative health care such as teenage pregnancy and obesity needs to be more evidence based. There is little evidence that either is responsive to intervention.

Responsibilities – relationship between consortia and individual GP practices

We welcome proposals to reform the Quality and Outcomes Framework so that it focuses on health outcomes of GPs rather than processes, and provides incentives for continuous improvement in quality of care.

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

There are already multiple layers by which this happens: prescribing reviews, appraisals, revalidation, NCQC from April 2012, PGEA & education, patients groups.

More bureaucracy will be a limiting factor as lack of GP time is the main constraint on quality.

GP consortia will need to work with Local Authorities at county and borough/district level to ensure effective preventative activity is commissioned, including the many services provided by the voluntary and community sector.

Q6 What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

See above - LEAN techniques.

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

Independent members of GP consortia boards – for example, elected representatives from local borough/district authority, or patient representatives - will help ensure transparency and fairness in the process of commissioning from consortium members.

In rural areas where access is the key issue, patient choice will be best served by commissioning services locally on “any willing provider” basis.

Responsibilities – role of the NHS Commissioning Board

Q8 How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?

Do not always hold consultations in cities without realising that the rural voice never gets heard. Make sure that representatives are geographically varied.

The national framework needs to take into account the population that is being served by the GP consortia, for example, age profile and rurality to ensure that patients receive quality treatment regardless of where they live. The combination of rurality and an aged population means more expensive healthcare needs.

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

Do not allow cherry picking of low risk work by independent providers.

Establishment of GP consortia – organisational form

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

GP consortia Boards need to have a majority of clinical representation – nurses, midwives, health visitors, physios, etc as well as GPs – but should also include independent representation from the local borough/district authority(ies) to ensure local democratic legitimacy; and from the local voluntary and community sector (e.g. via the Council for Voluntary Service) to ensure proper engagement with the VCS sector. It will be important to avoid distortion by special interest groups.

There should be a model protocol developed for collaboration between GP consortia, where commissioning of particular low-volume services needs to be undertaken by a larger commissioning unit with a lead commissioner.

Establishment of GP consortia – forming consortia

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

It is very important that GP consortia are formed around the catchment area of the acute hospital that they face, even if this crosses political and geographic boundaries.

Where GP consortia cross over county or unitary authority boundaries, guidance will be needed as to how they relate to Health & Wellbeing Boards and integrate with social care and public health commissioning

It is important that consortia are formed from similar types of practices - eg predominantly urban, or rural, reflecting different population needs.

We would not expect GP consortia to match current PCT boundaries in large county areas.

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

We expect that GP consortia in urban areas would support a higher population size than in rural areas. More important than meeting some arbitrary population size is ensuring the geographical coherence of each consortium. It is important that a GP consortium is constituted so that all the practices can relate to it, and engage with it, by virtue of natural geographical groupings; and also that the commissioning consortium covers an area that the local population can relate to.

This inevitably means that in order to preserve the principle of a local geographical identity for a consortium, in rural areas the population it includes will be less than in

urban areas. We would expect within a geographically large upper tier local authority, there to be a series of GP consortia, commissioning at a level below the current PCT geography.

This may mean that more services in rural consortia are 'low volume' than in urban consortia, and need to be commissioned in partnership with neighbouring consortia. Funding models will need to reflect this 'rurality' cost implication as overhead costs will be proportionally higher.

Freedoms, controls and accountabilities – Freedoms

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

Commissioning budgets will include a maximum allowance to cover management costs. It is inevitable that GP consortia will have to employ capacity/capability or out-source activities in order to obtain the required expertise to carry out commissioning and procurement responsibilities.

In the south-east, staff and premises costs are likely to be higher than elsewhere in the country. GP consortia should not be disadvantaged, by virtue of their location, with regard to the amount they can invest in developing capacity and capability in commissioning.

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

In reality, we expect that GP consortia will “develop their own capacity and capability in commissioning” by employing – sooner or later – PCT commissioning and procurement experts. We are concerned at the potential cost to the taxpayer of redundancy payments being made to PCT staff, only for them to be employed by publicly-funded GP consortia, both of which are part of the NHS. Provisions should be made to allow PCT staff to TUPE to GP consortia; and to prevent PCT staff from taking redundancy and then joining a GP consortium with only a minimal break in employment.

Freedoms, controls and accountabilities – Managing financial risk

Q15 Are [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; ensuring sufficient incentives and disciplines to manage financial risk properly, and service risk in particular, at the local consortium level] the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

These criteria appear to be reasonable.

Freedoms, controls and accountabilities – transparency and fairness in investment decisions

Q16 What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Independent members of GP consortia boards – for example, elected representatives from local authority, or patient representatives - will help ensure transparency and fairness in the process of commissioning from consortium members.

In rural areas where access is the key issue, patient choice will be best served by commissioning services locally on “any willing provider” basis.

Freedoms, controls and accountabilities –accountability to patients and public

Q17 What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

A commissioning outcomes framework needs to reflect clinical health outcomes and also patient-reported outcome measures and patient experience measures.

The commissioning outcome measures also need to take account of the way consortia work in partnership with their local authority(ies) via Health & Wellbeing Boards to integrate health commissioning with social care and public health improvement.

Q18 Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

Initial feedback from GPs to the proposals for GP consortia commissioning has been very mixed. In order to engage all GP practices in the process, for the benefit of their patients, we support the proposal for a proportion of GP practice income to be linked to the outcomes that the practice achieves as part of its wider commissioning consortium.

Q19 What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

GP consortia Boards need to include in their membership independent members, from local HealthWatch and/or appointed by the local district/borough authority to ensure that there is oversight of local commissioning in relation to the Joint Strategic Needs Assessment.

The Joint Strategic Needs Assessment should identify the local commissioning requirements to address health needs inequalities at the GP consortia level.

Partnership – patients and the public

Q20 How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

General patient representatives may have little understanding or contact with specific patient groups. To inform commissioning decisions, GP consortia and the

NHS Commissioning Board need to engage directly with patient-user groups, eg Expert Patients for long-term chronic conditions and parent groups for paediatric services, or via voluntary sector and community support groups, operating in their local area to find out what the local needs are.

Q21 How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

Equitable commissioning decisions that meet local priorities may not necessarily reflect 'public voice'. The public do not always have a fair perception of what is common or rare or causes suffering. The media can unduly influence the public. It is important to trust GPs and clinical staff, working with relevant community partners, to reach equitable commissioning decisions based on the full range of intelligence available to them.

Q22 How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?

We have some concerns regarding the proposals – which have been presented as a 'given' – that LINKs be transformed into the Local Healthwatch.

Whilst we value the input of LINKs members, they are volunteers and often the reason for volunteering their time to LINKs is that they have a particular focus of interest which is not necessarily representative of patients' interests generally. For example, in a large county such as Surrey we would not reasonably expect volunteers from the east of the county to be as concerned about what is happening in the west as in their local area.

Therefore, we are concerned at a potential lack of geographical representation; the potential impact of vested interests skewing the official voice of the organisation; the potential lack of representation from 'hard to reach' groups; and the absence of accountability of "health watch" to the local population.

We suggest that "local healthwatch" is built on the model of the Community Health Councils, which included local democratic representation from the local authority and local voluntary groups and organisations. In order for these CHC/Healthwatch organisations to be effective, they would need to be organised on a borough/district basis, allowing for appointments to the CHC from the local council, who would also be able to provide an overview and scrutiny function.

Q23 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

Fair distribution of resources to the South East is the main way to eliminate disadvantage and poor access to health care in this area. Tariffs need to take into account of the local population.

Partnership – local government and public health

Q24 How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

It is important that as shadow GP consortia become established, they build lines of communication with the relevant local authority, including the local district/borough members. GP consortia should be required to have a local elected member representative on their Board.

Public health issues may be of national significance, or geographically focused. Responses and the role of the local authority needs to be adequately resourced. The skills of the local authorities will need to be developed to take on this increased role, and are not necessarily available currently in local authorities or PCTs. The role of Councillors is important, but will need to defer to public health experts.

Q25 Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

South West Surrey (Guildford and Waverley) has operated a tripartite grant funding arrangement with Surrey PCT and Surrey County Council to support voluntary and community sector organisations providing preventative and patient support services meeting shared health, social care and community well-being priorities of the statutory funding bodies.

This model has been commended by the Commission for Social Care Inspection CSCI (January 2009) as good practice in "micro-commissioning" and has worked particularly well for our rural communities with small organisations providing very local services in response to particular local need. It is an example of successful joint working to address common areas of inequality and service needs.

We suggest that a "healthwatch" service modeled on the widely popular and successful Community Health Councils would be more representative, accountable and effective than the proposed model based on LINKs.

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

Keep bureaucracy, monitoring and form filing to a minimum and maximise the sharing of data and intelligence.

Part B - Local Democratic Legitimacy in Health

Summary of Consultation Questions

Waverley Borough Council (WBC) welcomes the Government's commitment to local democracy. Councils are well placed to represent the views and interests of patients and the public at large, and they enjoy the benefit of advice from professional officers. It has been a defect of the NHS that it was set up without reference to the existing machinery of local democracy. We would only stress that this machinery involves borough and district councils as well as county and unitary authorities.

The Government would welcome views on the following questions:

Q1 Should Local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

No. Healthwatch – as proposed – will be unrepresentative, and have no reasonable means of robustly canvassing patients' views on any matter, including the NHS Constitution.

We propose that a “healthwatch” service is modeled on the Community Health Councils, with genuine democratic legitimacy, and the facility through the local borough/district council to consult and communicate with the local population.

Q2 Should local HealthWatch take on the wider role [outlined in paragraph 17,] with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

Whilst we recognise the need for these wider services to be provided, we have some concerns about the capacity and capability of Local HealthWatch – as it is currently described in the White Paper - to fulfill these roles. LINKs are made up of volunteers. The roles proposed for Local HealthWatch go beyond a purely voluntary role – they will need management, training for advocates, monitoring of advice given to ensure quality of service, etc.

Will the commissioning local authority be given sufficient funding to resource the service adequately, particularly the patient advocacy services in a large county, and to ensure a comparable standard of service across the country? What help will be given to LINKs to enable them to build capacity, to be able to bid for the contract to provide Local HealthWatch services?

Community Health Councils were staffed to provide, inter alia, information about local NHS services, advice on rights as a patient, and advice and support for those patients who wished to make a complaint. A “healthwatch” service modeled on the widely popular and successful Community Health Councils would be able to take on the roles of complaints advocacy and supporting individuals to exercise choice and control.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

To be effective commissioners of local Healthwatch, the local authority (assumed to be upper tier) needs to recognise:

- the need for local healthwatch to be genuinely, locally representative – geographically and in respect of the different types of patients and carers, minority or hard to reach groups, etc. This will not happen if local healthwatch is made up of volunteers.
- that in a large county, such as Surrey, the composition of a locally representative healthwatch will be very different in different parts of the county, and the concerns of patients will also be very different, reflecting local health needs and inequalities. In Waverley, issues relating to patient transport services and access to services for complex elderly patients may be of greater significance than elsewhere in the county.
- that local healthwatch needs to be accountable to the local population which it represents.
- that local healthwatch needs to be resourced to carry out the roles designated, particularly the advice, guidance and advocacy roles.

We suggest that the most appropriate model for local healthwatch is the Community Health Council model, made up of elected representatives appointed from the local authority, and elected representatives from the local voluntary and community sector. This would provide a locally representative, and accountable body, which would engage with the local population, based upon a model that has been tried and trusted in the past.

This process needs to take account of local democratic structures (e.g. Boroughs and districts in two-tier areas) to ensure that Local HealthWatch has a genuinely local reach, and volunteers feel able to engage with and influence the organisation.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Integrated working and joined up services around the needs of, for example, older people or children and families, goes beyond joint commissioning of health and social care. It must include the roles and responsibilities provided by boroughs/districts in two-tier areas, including housing, benefits assessments, provision of leisure facilities, crime and disorder reduction partnerships, etc. It is imperative that district/borough authorities are full partners, along with the county local authority, on Health & Wellbeing Boards.

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

Further freedoms and flexibilities that would support and incentivise integrated working could include: dedicated budgets; the freedom to investigate and pursue any health-oriented matters affecting residents within the area.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Yes. Without statutory powers it will be a toothless and meaningless exercise, and likely to be a waste of resources.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Yes. If Health & Wellbeing Boards are to take on the functions designated below, including the statutory functions for producing the JSNA and undertaking health scrutiny functions, then they must be statutory bodies.

We suggest that Health & Wellbeing Boards are established along similar lines as Crime & Disorder Reduction Partnerships, with a core membership of statutorily prescribed partners (which must include representatives of districts/boroughs in two-tier areas) and encouragement to engage with whatever additional local agencies are necessary from time to time to achieve the objectives.

There should be sufficient flexibility in the prescription such that where existing strong and effective partnerships are in place, these can be designated as the Health & Wellbeing Boards provided they include statutory partners.

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30*?

No. We agree that the Health & Wellbeing Board should be responsible for assessing the needs of the local population.

However, the responsibility for joining up commissioning plans may lead to commissioning a one-size fits all approach which will not take account the differing needs of the various populations in a large two-tier local authority area – in Surrey the north of the county is predominantly urban, whilst the south is rural which brings differing challenges and may result in unequal service provision.

We have serious concerns over the Health & Wellbeing Board having a scrutiny role which in reality will be a self-scrutinising role, with expertise on the Board being provided by those who have made the commissioning decisions.

[*The Government proposes that statutory health and wellbeing boards would have four main functions:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment;
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- to undertake a scrutiny role in relation to major service redesign.]

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Yes, the proposed Health & Wellbeing Boards would benefit from further support.

This would include:

- Support for two-tier areas to ensure fair district/borough engagement;
- Details as to how the scrutiny role will be undertaken given the board will include those who are undertaking the commissioning, and
- Ensuring HealthWatch is commissioned to ensure true local representation in large county areas.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

These would work alongside the duties of children's trusts.

Health and Well-being Boards would need to also work with Crime and Disorder Reduction Partnerships associated with the duties and provision of Drug and Alcohol Teams.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

These arrangements are effectively the same as may come into being in two-tier areas, i.e. the health & wellbeing board is designated at county level (which will hold social care and public health responsibilities) but will work across district and borough areas. Health & Wellbeing Boards should be required – within statutory responsibilities – to recognise the input of districts and boroughs within 2-tier areas, which is where true local democratic legitimacy lies.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 – 41*?

* [Leader/Directly elected Mayor, social care, NHS Commissioners (GP consortia & NHS Commissioning Board), local government, patient champions (local HealthWatch), Director of Public Health, LA directors for social care, public health, children's services, representatives of voluntary sector, other public service officials].

We are concerned that the Health & Wellbeing Board has **real** local democratic legitimacy and representation. In a large two-tier area such as Surrey, which has marked differences in geography between a predominantly urban north/west and rural south/east, it is important that there is representation from elected members of all local districts/borough councils, genuinely 'local' "Local Healthwatch" and local voluntary sector.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

There would need to be a mechanism for resolving local disputes. It could be a joint panel, or a panel drawing on representatives from a number of appropriate local bodies; or the ability to call on an external and independent facilitator/mediator.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Health & Wellbeing Boards will be statutory bodies within the local authority (upper tier) which is the same body that will have responsibility for providing social care and public health improvement services. The Health & Wellbeing Board will have a responsibility for the integration of NHS commissioning with social care and public health commissioning and delivery.

There needs to be a very clear definition of what a Health & Wellbeing Board has scrutiny and referral powers over, given that the Health & Wellbeing Board has membership of those who are making the decisions that will be subject to scrutiny and is itself responsible for assessing the needs of the local population, so that there is no conflict of interest; and to distinguish between powers of scrutiny over health and well-being held by the local authority.

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

By ensuring that the arrangements allow for local voices to be heard fully; by having different stages of dispute resolution, eg [1] purely at grass-roots level, with mediation; [2] if not successful, then referred up, etc etc. Naturally, mediation needs resources and personnel, as do full and proper scrutiny and other processes.

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

To scrutinise a board's functions effectively, the local Borough or District Council needs the power, the authority and the means to fully access all the business of the Board and relevant information from its constituent members e.g. full information on commissioning decisions. Full local authority representation on the Board could help ensure this on a day-to-day basis, but there could be occasions when a situation requires further processes. This should be written into the constitution, allowing for a wide remit of scrutiny, NOT anything narrow or restrictive.

Q17 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, the public and, where appropriate, staff?

District and borough elected representatives are best placed to ensure that the needs of their local communities are taken into account in relation to GP commissioning, social care commissioning and public health improvement.

Make it easy for any member of the public to make an approach without any fear of 'awkwardness', especially if making a representation on behalf of in-patients as in-patients frequently do not want a fuss to be made for fear of being unpopular with staff; help staff to understand the patient's viewpoint and help them not to feel threatened by ideas for improvement; provide 'advocates' for any individual [staff,

patients or patients' representatives] who may want that kind of help; ensure a listening ear at all times for individuals.

Beware of 'equality' that can so easily lead to dumbing-down: strive at all times for excellence.

Q18 Do you have any other comments on this document?

It is essential that the problems of rural areas are taken into account, just as much as major conurbations. Rural areas, with their tiny scattered communities, have problems which are just as real as in cities, but which are more easily hidden, ie harder to detect. Problems in city areas, because of their concentration, attract major publicity, while the reverse is true for rural areas. It is most likely that the structure of the proposed Boards and Local Authority involvement should not be identical but should be tailored to the type of area. In rural areas, it is vital that local authority involvement is as close as possible to local communities, and there may well be a role for Town and Parish Councils in some areas, as well as Boroughs and Districts.

It is important to remember that in two-tier areas, real democratic legitimacy is derived from the involvement of district/borough elected members. The proposals barely acknowledge the existence of two-tier areas, and districts and boroughs. Whilst they do not have direct responsibility to provide social care and public health improvement services, districts and boroughs are best placed to ensure that services meet local needs and address local inequalities. It is vital that proposals for the governance of GP-consortia and Health & Wellbeing Boards provide for representation at the local level.