ADASS Response to the White Paper Equity and Excellence: Liberating the NHS

1. Executive Summary

ADASS welcomes the opportunity to comment on the proposals in the White Paper, "Equity and Excellence: Liberating the NHS". The proposals offer significant opportunities for people to be more closely involved in the health and social care they receive. In any reform of this scale there will inevitably be risks which our response will also address.

ADASS strongly supports:

- the focus on an agreed set of outcomes across the whole of the health and social care system
- the role given to local councils for health improvement and public health at a community level, aimed at prevention and reducing inequalities
- the establishment of statutory Health and Wellbeing Boards (HWBs) to strengthen the local democratic legitimacy of the NHS
- the underlying principle of the involvement of individuals in decisions concerning them and the proposals to bring commissioning decisions as close as possible to the people needing health or social care support
- new commissioning arrangements, based on Joint Strategic Needs Assessments (JSNAs) and health information held by GPs, with the opportunity to commission personalised health and social care
- councils commissioning on behalf of GP consortia a range of services where councils have considerable investment and expertise including mental health, learning disability , enablement, long term conditions, continuing health care, carers, drugs and alcohol services
- maximising the potential for health and social care integration to support people to stay healthy and independent and when health and care needs arise ensure that interventions enable people to receive care close to home.

Issues which will need careful consideration include:

- the risk of greater fragmentation between health and social care if the aspiration for integrated commissioning is not mainstreamed and the

potential loss of coterminosity between existing health and local government boundaries

- the transfer of knowledge to GPs in relation to whole system working and the nature of commissioning beyond individual clinical decisions and the need for the development of capacity and clinical leadership to support effective GP commissioning
- the links between HWBs and GP Consortia and the NHS Commissioning Board will need to be defined clearly in the development of transition plans and the creation of the new architecture as well as clarity about management of the whole system and where responsibility lies
- the role, resources and statutory powers allocated to HealthWatch to ensure that it can effectively represent the aggregated views of users and patients and hold both HWBs and GP consortia to account
- managing the transition from the existing system to the new one has major risks associated with a loss of organisational capacity at a time when local government will be subject to significant resource reduction and the NHS has to make productivity gains in the order of £20 billion. There is a major need to involve existing and new bodies, local authorities, citizens, local communities and providers in co-designing the changes at national, regional and local levels to achieve a different system that delivers different outcomes across health and social care rather than reinventing the system we have worked in to date.

2. Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in local authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their councils.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of their local communities and for the promotion of that well-being and protection through the use of direct services as well as the co-ordination of and liaison with the NHS, voluntary agencies, private companies and other public authorities. ADASS members have leadership responsibilities in local authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal Local Strategic Partnership arrangements.

ADASS offers this single response to the White Paper and the separate consultation documents.

3. Establishing a focus on outcomes

There is a huge opportunity in these proposals to ensure that the whole of the health and social care system is focused on delivering the same outcomes. It will be essential that the outcome frameworks setting the direction for the NHS, public health and social care are themselves completely integrated so that local commissioning arrangements are all driving towards the same goals. The proposal to create three outcomes frameworks for health, social care and public health must ensure that we do not see different parts of the system being pulled in different directions.

ADASS strongly supports the focus on commissioning for outcomes and a move away from looking at inputs and activity levels which has driven much commissioning activity to date. National outcomes need to provide a broad framework within which commissioners across social care and health can engage people and communities about priorities and local responses.

In the outcomes framework ADASS would like to see a stronger emphasis on prevention which is key to the successful use of resources.

Considerable progress has been made in integrating health and social care but the potential benefits are still to be fully realised. Once the outcomes and performance frameworks are aligned, joint commissioning and implementation locally will have a common and coherent context.

4. Local Authority Leadership

4.1 Public Health

ADASS has a particular interest in the focus on “improving public health, tackling health inequalities and reforming adult social care”. ADASS supports the transfer of public health responsibilities to local authorities, who have a history of joint working with public health colleagues, in relation to strategic needs analyses, which is a critical underpinning of commissioning activity. Most councils have some form of joint appointment and all have histories of joint working. The transfer of public health to local government provides an opportunity to ensure all activities of the council and its partners contribute to health improvement and seek to narrow the gaps in health outcomes.

The relationship between the role of councils and the National Public Health Service will be explored further in the White Paper on public health but ADASS believes that as much scope and capacity as possible must be devolved to local priorities and action to deliver against the emerging national outcomes framework. We must also ensure that public health expertise around evidence based interventions for whole populations continues to inform the thinking and priorities of the new GP consortia.

The role and function of the Director of Public Health (DPH) will need to relate, in part, to the requirements of the National Public Health Service. How they are deployed and where they sit within local authority structures needs to be

left to local decisions. It is critical that the resources that are deployed in the area of public health are transferred to support the new functions local government will take on. What will be critical is local engagement with people, communities and partners to be clear about what improvements are the priorities for local places. We need to be held accountable for delivery and the use of any transferred funds to local citizens.

The current model of public health is not delivering the reduction in health inequalities that all communities want to see. Local authorities can use the JSNA to support agreed public health priorities to change community level outcomes. Devolving public health funding will enable commissioning for place as well as for people.

The terms of the ring-fence for the public health monies should be as broad as possible to allow any investment that supports an identified public health gain. Public health funding should be able to be used as flexibly as possible against agreed local priorities.

The importance of the inter relationship between GP commissioning and the role of Public Health can not be underestimated. It needs to be transparently included in the remit of the Health and Wellbeing Boards in order to ensure that the prevention aspects of disease management are included in GP commissioning decisions.

ADASS looks forward to the public health White Paper later this year including clarity on the DPH role and funding.

4.2 Local Health and Wellbeing Boards

The creation of Health and Wellbeing Boards (HWBs) will provide the infrastructure to bring together the key local commissioners for health, social care and public health in each locality. It will be important to allow flexibility in the way these are set up and developed locally, building on current partnership arrangements. Depending upon the way in which GP consortia emerge and how this corresponds with council geographical boundaries, Boards will have to find ways of working across local government boundaries and of collaborating with others on a sub national and more local footprint depending on the commissioning and service models for more specialised services.

In order to be effective they must be capable of, and empowered to, discharge statutory responsibilities and duties of the council. Legislation should ensure that the necessary powers of delegation from statutory bodies to the HWBs exist with sufficient force.

ADASS supports the key functions proposed for HWBs and agrees that JSNAs should be the core information base about what needs are present within local populations. This will inform the commissioning priorities. Commissioning or re-commissioning should be evidence based and built on effective intelligence at a population, area or neighbourhood level. All commissioning should be driven by the JSNA or shared assessments across

local authority boundaries, whether these are GP commissioning, council commissioning or joint commissioning. HWBs should hold commissioners to account to ensure that this takes place. ADASS accepts that for this to be the case the quality and capacity of JSNAs will need to be built and developed. This also provides a major opportunity to build further integrated models of commissioning. We also think that the reduction of local health inequalities should be a function of the Boards.

ADASS believes that membership of the HWBs should substantially be left to local discretion. There will be key people who will form the core membership and are likely to include: senior lead members, chief officers (Directors of Adult Social Services, Directors of Children's Services, Directors of Public Health), lead representatives of GP consortia, HealthWatch and patient and user representatives. ADASS would though recommend that there should be a statutory requirement for the leads of the GP consortia to be members of the HWBs to ensure effective joint commissioning arrangements. One of the opportunities in the White Paper is the drive towards greater integration, but one of the risks is that integration to date has been patchy, often effectively driven by the quality of local leaders and a shared commitment to align resources and effort to deliver shared outcomes. In some places additional support will be needed to support the ambitions within the White Paper.

ADASS would welcome further clarity regarding the role of children's services on the HWBs and the relationship between them, Children's Trusts and Local Safeguarding Children's Boards. It will be important for children's services to be involved in the HWBs to inform commissioning decisions for children's health and the public health priorities which affect the local population of children and young people.

We believe that the remit for the HWBs should cover key areas of commissioning across the whole health and social care pathway. Most importantly, such Boards must simplify accountability and be able to address the strategic and key commissioning and delivery decisions across the whole of health and social care, and wider social systems.

HWBs will also have a crucial interface with health providers so will develop partnerships with those delivering primary care as well as acute trusts and foundation trusts.

4.3 NHS Commissioning Board

ADASS considers that more guidance is needed on the way in which the NHS Commissioning Board will engage locally where relevant issues are being discussed. In a context where government is wanting to shift the balance of accountability from the centre to localities we must ensure the NHS Commissioning Board does not reproduce "old behaviours" and continue a top down approach. HWBs will need to have as much influence in holding commissioners to account for the delivery of outcomes set at a national level but negotiated and owned at the local level, as the NHS Commissioning Board.

In line with the aspiration to bring commissioning decisions and money as close as possible to the clinical practitioner, patient or user, ADASS would expect to see commissioning decisions made at a local rather than a national level, unless there are clear reasons not to. The rationale for commissioning at a national level would need to be made explicit. There may need to be some acute, secondary and specialist services commissioned nationally but where possible there should be flexibility to devolve these to regional or local levels. Local authorities will want to consider options for collaboration at a sub regional level also.

4.4 Scrutiny functions and HealthWatch

There needs to be local determination and flexibility to decide the best possible arrangements for scrutiny functions. There should be close working arrangements between scrutiny and HealthWatch to ensure that user concerns and issues are fully addressed. Scrutiny and HealthWatch should come together to undertake a wide range of scrutiny functions as together they are charged with representing the interests of individuals and communities who rely upon these services.

A combined scrutiny and HealthWatch function should be able to refer matters which are not resolved locally if they impact on a wider cross section of the community or a particular community of interest, which relies on the service in question. ADASS would like to see firmer proposals on the alternatives to the current statutory powers of referral that are vested in the scrutiny committee.

The establishment of HealthWatch is completely in line with the intention to ensure that patients and users have choice, control and involvement in the commissioning of health and social care services that best meet their needs. HealthWatch will have a vital role as a strong champion organisation for patients and users with clear powers to challenge decisions and provision. It will need sufficient resources and an appropriately qualified workforce to deliver its key roles. The wider functions that HealthWatch will be adopting have some similarities to those exercised by Citizens Advice Bureaux (CAB). Consideration might be given to whether it could be linked to CAB which has a recognisable and trusted branding. It will also need to engage with harder to reach communities and reflect their needs within the HWBs.

In many places Local Involvement Networks (LINKS) have struggled to build their capacity and influence. The current structures of LINKS and host arrangements have meant that they have spent effort on internal governance rather than focusing outwards on better services. Building quickly on the experience of LINKS will be important if the new organisations are to effectively carry out the function of lobbying on behalf of citizens who use health and social care services and calling commissioners and providers to account against national standards and quality concerns.

While respecting the independence of HealthWatch, the local authority should be able to measure HealthWatch performance against their contribution to the shared outcomes for an area, as well as responding to the issues raised by HealthWatch. We agree that the new organisations should be commissioned

by councils and it is important that the funding arrangements for these are clarified as a matter of urgency or there is a significant risk in some areas of losing the positive work that LINKS are now bringing to fruition.

5. Commissioning

5.1 GP Consortia and the offer from local authorities

The key ADASS issues in relation to the proposals around commissioning are:

- integration of a whole system of health and social care
- the engagement of the public, patients and carers
- ensuring that the services, supports and pathways commissioned improve outcomes for people, are personal and safeguard the rights and wellbeing of individuals
- the interface with the health and wellbeing of local populations and the role of the local authority and public health
- tackling inequalities and ensuring that the needs of more vulnerable individuals, families, carers and those with specialist needs are addressed
- the significant interfaces with other public and community systems
- the effective use of resources in a challenging economic and demographic environment.

Directors of Adult Social Services have a long history of working with health authorities, NHS Trusts, GP total fund holders, PCGs, PCTs and practice based commissioners. We know that structure and process for commissioning are important but we also know that the interaction, behaviours, knowledge and skills of partners are essential to make things happen locally.

ADASS members are already engaging in a range of discussions to ensure that integrated commissioning is made a reality in their localities and a core function of the new consortia. We believe that there is significant potential for the Royal College of GPs, ADASS, the Association of Directors of Children's Services, the Association of Directors of Public Health and the NHS Confederation to work together as professional organisations to deliver the agenda.

ADASS is concerned that the transition planning for achieving the transfer of commissioning from PCTs to new consortia is undertaken with full engagement of local councils as one of the critical partners. ADASS is clear we need to build on what has worked in different places, particularly around the opportunities that co-terminosity has brought to integrate functions and pool resources. New consortia will have to be able to flex wider into discussions at a sub regional and regional level and also flex down to a practice level. Local authorities will also need to collaborate together to influence a range of commissioning beyond the geographical boundary. It is important that local, regional and national level NHS planning processes are fully engaged with local government. Without effective engagement there is a

risk of fragmentation and the opportunity to change how we work together for the benefit of local people and places being lost.

The scale and speed of the transition arrangements also poses some risks. It will be vital that lessons from early adopters are disseminated and good practice shared before the reforms are implemented across the country.

We have identified the following key issues for Directors of Adult Social Services to bring to the table for discussion with GP consortia:

- **Resource agreements:** such as continuing care, reablement and rehabilitation, equipment and telecare investments and joint commissioning.

- **Risks and rights activities:** such as Mental Health and Mental Capacity Act work, safeguarding children and vulnerable adults, interfaces with the Criminal Justice system and complaints, inquiries and CQC investigations

- **Population based programmes:** such as Joint Strategic Needs Assessments, emergency and civil contingencies, prevention, public engagement, and public and school health

- **Development and reform programmes:** including personal budgets, social capital and volunteering, carers, dementia and autism

- **Infrastructure:** such as assets, commissioning, procurement, HR and information management

Another offer that local authorities can make to GP consortia is to increase efficiency by sharing overheads and infrastructure, knowledge and skills. These might include back office functions like HR, payroll and IT which may be more efficiently procured from local authorities than from the private sector, which could draw money out of the NHS to support profitability. Other expertise which local authorities could offer to GP consortia would be consultation with user groups, risk management and best practice re safeguarding.

5.2 Integrated Commissioning

There is considerable experience of successful joint commissioning between councils and PCTs with pooled budgets and other arrangements in place. Holistic thinking about how best to respond to health and social care needs of patients, service users and the carers who so often support them, will need development.

There are some services which rely on contributions from both health and social care to be effective and it will be essential for local authorities and GP consortia to commission these together. Decisions will need to be informed by shared data from JSNAs and local health needs. Examples of services where commissioning should be aligned, are those for people with mental health

problems, with learning disabilities and with long-term conditions; reablement, rapid response, intermediate care, services for carers, dementia care, stroke care, telecare, end of life care and Continuing Healthcare. If the local health and social care system is seen as a whole, interventions in one part of the system will produce efficiencies in another part, which can in turn be reinvested in prevention. Confidence and trust will be built as budgets are aligned and efficiencies unlocked. Costs and risks will be need to be shared and the benefits for the whole system can then be properly realised. Crucially the experience of patients and users will be greatly improved. The joint commissioning plans for these services should be signed off by the HWB.

Two examples illustrate the interdependency of health and social care. First, rapid response and reablement services can prevent unnecessary hospital admissions in conjunction with rehabilitation services that are commissioned currently via PCTs. People can recover at home or as close as possible to home and be diverted away from more costly health and social care interventions. They are also linked in to wider universal services and health improvement initiatives so that their independence and continuing contribution to their community can be sustained. Secondly, in partnership with the Princess Royal Trust for Carers, ADASS produced a joint paper "Supporting Carers – Early Interventions and Better Outcomes". This adopts a holistic approach to the support of carers and patients and shows how this can generate better outcomes.

This is a significant re-organisation of both the NHS and Local Government and it is taking place at a time when both have key financial and quality issues to focus on. As well as potential benefits there are therefore considerable risks. High among these is increasing fragmentation between health and social care if the aspiration for integrated commissioning is not mainstreamed.

5.3 Engaging Public, Patients and Carers in different levels of commissioning

ADASS is strongly in favour of increasing the patient and public voice. Much work has been done to support people being in control of their social care through the implementation of Putting People First. We also believe that systemically involving people in commissioning decisions at an individual level will ultimately lead to an increase in quality, as users choose services which they feel will meet their needs. The proposals in the White Paper, with regards to increasing user choice and voice, mirror the national direction that social care has taken.

The White Paper argues that NHS commissioning through PCTs has become too remote from patients and that it is not shaped effectively by the clinical insight of GPs. The proposals for the involvement of people in decisions about their health care mirror the developments that are already becoming widespread in social care. Enabling patients to shape the NHS, through their close relationship with their GP follows this pathway. Social care has much to offer on individual planning and design of services and is in line with the intention of the government to put "more power and control in the hands of

people". It is not clear from the White Paper whether this will extend as far as developing proposals for personal health budgets.

Directors of Adult Social Services have experience in engaging people in a range of contexts, both strategically and operationally. We believe that commissioning needs to operate on a number of levels.

Commissioning for Individuals:
At an individual level, much has been done to support people to be in control of their social care through work on personalisation. Adult social care has supported the use of personal budgets, developed universal information and advice and supported brokerage services to enable people to organise what they need. This individual commissioning resonates with the concept that "the headquarters of the NHS is in the consulting room". Individual commissioning and information about outcomes and people's experiences are critical means of driving up quality. Given real choices, people will not choose the service with a high mortality, infection or pressure sore rate or where there are low levels of dignity, safety or safeguarding. There will however need to be structures in place which allow patients to access information about services which allows them to make informed decisions. There will also need to be analysis of aggregated outcomes to look at gaps in the market.

Individual commissioning is also dependent on developing markets to respond to personalised service and support needs and on developing community capacity. Much of this has been most effective where people's views, preferences and needs have been put at the heart of commissioning. Unless there are suppliers of a range of individually responsive services that meet the needs of the individual, then real choice cannot be exercised. Delivering individualised services is dependent upon the development of a workforce with the necessary skills and aptitudes who are able to respond to need.

Commissioning for Carers:
Integral to individual commissioning also are families and carers who often provide support that both prevents increasing dependency and promotes health and wellbeing. When commissioning services, GP consortia will need to be aware of the needs of carers as this could influence commissioning decisions and raise questions regarding the health and support of carers themselves. Commissioning services for carers should be an integral part of commissioning for patients.

Whilst there has been encouraging joint work with the Royal College of General Practitioners, for example, issues of recognition, referral, assessment and support of carers at practice level can be problematic and need encouragement. To this end, we would propose that at 6.8 of the document a responsibility should be included to: "support improvements in local understanding of the needs of carers and in their recognition and support by health and social care".

Commissioning for Practice Populations:
Alongside individual commissioning is commissioning for practice populations and communities. Local authorities are key leaders both in terms of their democratic accountability and in terms of their leadership of a range of partnerships focussed on improving outcomes for their populations and places Consortia will need to engage with communities to support neighbourhood based approaches to meeting needs. Increasingly communities should be fully engaged in commissioning and commissioners should be looking to support community networks, peer support and mutual partners who can provide different responses to needs.

5.4 Commissioning Purpose
Commissioning led through GP consortia and councils should have as its purpose to shift patterns of care and support to achieve both better outcomes and more effective and efficient services. There are key opportunities for closer integration of primary care and other services and more flexible, preventive and streamlined services for people with long term conditions.

There is much work to do to build shared models for commissioning starting with clear and shared definitions about what commissioning involves and how it is best delivered. Commissioning is much more than aggregating up individual interventions and has to address the whole life issues of people from care and support in their home through to primary and secondary interventions.

Local authorities will be very aware of the needs of those with specialist needs and groups in the local population who may be less vocal, visible or marginalised. They have consistently championed the needs of children, those with mental health, drug and alcohol problems, those with learning disabilities or who need safeguarding, both children and vulnerable adults. There is a concern that smaller specialist services, for example hearing and sight loss services, could be decommissioned by GP consortia. We would want to guard against the risk that community health and social care services could be driven back towards a medical model of care by GP consortia in areas such as physical disabilities and sensory impairment.

Investment is needed in joint approaches to prevention and public health interventions which support people to take responsibility for their own health and wellbeing and ensure they are supported to maintain and regain independence. This should help to reduce the need for costly acute and residential care. These services should support people to stay where they generally want to be, which is at home. ADASS and the Department of Health published “Commissioning Care Closer to Home” this year. It addressed the commissioning of services that move away from an acute hospital focus and encompass a broader approach to people than treating a condition and which include community wellbeing, social inclusion and health inequalities. As critical as commissioning new services is the de-commissioning of less effective or inappropriate services.

The report suggests elements of a commissioning framework which begins with people living relatively independent lives in their communities. It addresses the risks to continuing health and wellbeing in specific places and circumstances and it then ends with individuals (back) in their communities having been re-enabled (where necessary) to live as independently and participate as fully as possible in the life of their communities.

6. Continuing Healthcare

ADASS believes that future arrangements for the delivery and governance of NHS Continuing Healthcare must be robust. Since the early 1990s eligibility for NHS continuing healthcare has been a source of confusion, controversy, ombudsman investigations, litigation, media attention and ministerial concern. In 2007 a national framework was introduced which provided a single national process for determining eligibility and did much to improve fairness and consistency across England. In 2009 the framework and the associated tools were updated and under this framework the PCTs, SHAs and local authorities have clear statutory responsibilities. ADASS believes there is an urgent need for the risks and challenges inherent in NHS continuing healthcare to be fully understood and considered in discussions between PCTs, emerging GP consortia and local authorities in order to ensure that transitional arrangements run smoothly, and that the statutory functions are assigned to new organisations once the PCTs and SHAs are abolished.

ADASS proposes that the following arrangements could be put in place to mitigate the risks:

- The NHS Commissioning Board is given powers and responsibilities in relation to ensuring the fair application of the National Framework for NHS Continuing Healthcare in England and that the Department of Health retains policy responsibility for the Framework

- NHS Commissioning Board should have powers to hold GP consortia to account in relation to the fair application of the Framework

- Clear plans are made to ensure that the Independent Review Panel arrangements (required by Directions) continue to operate as joint local authority and NHS arrangements at a regional level, ensuring independent arbitration where an individual appeals against a decision not to provide them with NHS funded care. This could be a responsibility of the NHS Commissioning Board delegated to regional arrangements.

- Health and Wellbeing Boards/partnership arrangements between local authorities and GP consortia are established in such a way that facilitates/requires:

    - A joint approach to assessment for NHS CHC eligibility
    - Governance and system management of NHS CHC processes across local authorities and clusters of GP consortia

- A joint approach (across local authorities and GP consortia) to commissioning care for people in receipt of NHS CHC and for people who have high levels of need but do not necessarily meet the criteria for fully funded NHS care.

In order to ensure fairness, transparency and to maximise personalisation, ADASS proposes that arrangements should be made for reporting nationally on the number of individuals in receipt of NHS CHC who are supported to live at home as a percentage of those in receipt of NHS CHC in the local population.

7. Outcomes: The NHS Outcomes Framework

ADASS welcomes the NHS Outcomes Framework and the recognition that health and social care will need to work together in partnership.

ADASS also supports the domains of quality which will be used to inform commissioning outcomes namely, the focus on clinical and patient outcomes and safety and treatment provided and that these criteria are used to inform a commissioning outcomes framework for GP consortia.

We also support the need for a transition phase in order to allow for changes to take place. The NHS Outcomes Framework appears to attempt to 'de-limit' the scope of NHS activity. We understand the rationale for this. The NHS cannot be responsible for everything and there are a number of partners who might be better placed to work on, for example, prevention strategies ranging from training and employment schemes to fitness schemes. The Adult Social Care sector is a strong contributor in this continuum so that we ensure people can be independent and enjoy a sense of well-being in their lives. Developing a separate Outcomes Framework for Adult Social Care will promote continued focus on the importance of these issues to complement the NHS Outcomes Framework.

The interdependence between domains and the need to measure outcomes along and across a number of care pathways for patients and carers has to be recognised. Unless this happens and unless resources can move along care pathways then the risk remains that systems wide thinking, action and outcomes for patients and carers will not be developed. Also, that the full benefits of self-care management and care closer to home are not fully realised. A silo based approach based on single outcomes will not address the many individuals with complex needs for whom multiple interventions are required. We need an outcomes framework which recognises the need for coordination and consistency across all elements of care. This could be represented in new duties of 'care coordination/navigation' for GPs to ensure and/or agree the most appropriate part of the system to undertake this in order to achieve the best outcomes. The approach to this could be overseen by Healthwatch and the HWBs.

We do not however think that the theme of "choice" is strongly represented through the NHS Outcomes Framework. We had expected that it might have

been linked to the issue of patient experience and some expression in outcome indicators. However, we are assuming that further thought will be given to the theme in relation to the Quality Standards work that will be further developed.

In respect of equality considerations, we believe that the danger of an over-arching framework is that it may overlook issues that are specific to certain groups in our society. It is heartening that questions are asked about this in the individual consultation document on outcomes, but we would also encourage that more specific attention be given to this issue within the Quality Standards work that is to be developed and published.

Finally, given the enhanced role for General Practitioners envisaged by the NHS White Paper, we believe it is vital that they 'sign-up' to the NHS Outcomes Framework as an agreed approach upon which to proceed in the context of overall reforms. The Adult Social Care Sector seeks to work very closely with GPs in our localities and it will be important that there is shared sense of confidence that the approach set out in the NHS Outcomes Framework is owned and promoted throughout the whole system. If there is any danger of one group not playing its part, then the wider approach will become unworkable. ADASS believes that it will be vital that incentives are created through the implementation of this NHS Outcomes Framework for GPs to work collaboratively with the social care sector and Local Authorities so that we maximize effort in promoting the well-being of our communities through improved health and care services. We see this as particularly significant in the context of the proposed development of statutory HWBs where the NHS Outcomes Framework will very much need to support the aspirations of establishing such a Board on a statutory basis with responsibilities for local health improvement.

8. Resource Implications

There are a number of financial and resource implications for councils which flow from the White Paper proposals. Key concerns for us are:

- the level and nature of public health budgets transferred and staffing transfer arrangements
- the costs of Boards and local HealthWatch and the short-term implications for LINKS as existing contracts expire
- arrangements for joint commissioning and pooled budgets
- financial accountability arrangements for GP consortia and practices, including any overspending
- the NHS, flexibilities and place based budgeting
- the future funding of reablement services
- stability of the funding of Continuing Healthcare.

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