



Report of LINK members' event on 29 September 2011



October 2011

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Introduction

At the LINK bi-annual event in March 2011 members expressed an interest in learning more about how the proposed reforms in the Health and Social Care Bill would be implemented locally. In particular, members were keen to find out about the new plans for commissioning healthcare and how the local authority would adopt the new roles and responsibilities outlined.

Primary care trusts that commission health services, will be disbanded as part of the government's White Paper 'Liberating the NHS'. In their place, GPs and other clinicians are to form groups which will commission services directly for their patients. In North Tyneside two clinical commissioning groups have been formed: CareFirst, led by Dr John Mathews and Engage Health led by Dr Jane Weatherstone. North Tyneside LINK invited Drs Mathews and Weatherstone to present to LINK members and the public the work they have been undertaking in North Tyneside in relation to the set up and functioning of clinical commissioning groups.

From October 2012 LINKs will cease to function and a new body, HealthWatch, will take over. HealthWatch will assume the responsibilities of LINK alongside additional functions of signposting and advocacy. North Tyneside LINK wanted to find out how members and the public would like HealthWatch to function locally.

As part of LINK's rolling work programme North Tyneside LINK wanted to find out what its priorities should be for 2012 and attendees were asked to rate a list of possible priorities or suggest their own.

Clinical commissioning groups

Dr John Mathews and Dr Jane Weatherstone

Some of the points made by Dr Mathews and Dr Weatherstone are summarised below. The full presentation is available in Appendix A.

Both groups are pathfinders, they are working closely together as well as with other partners such as:

- Northumbria Healthcare NHS Trust
Increasing community services and integrating ways of working.
- North Tyneside Primary Care Trust (PCT)
Creating new partnerships and ways of working with the clinical support team. The PCT is supporting with financial management, IT systems, contracts and planning.
- North Tyneside Council
Members of the clinical commissioning groups sit on the shadow Health and Wellbeing Board and all of North Tyneside Council's local commissioning boards.
- Local voluntary sector
Taking Part Workshops were commissioned to engage with patients to inform the local area forum events.
- Patients
All practices are represented on the Patient Board.

The clinical commissioning groups are planning more support in the community for those who are vulnerable or elderly and for those with long term conditions to reduce avoidable hospital admissions. Healthcare will be closer to where people live.

Local initiatives for the clinical commissioning groups are:

- Reducing emergency admissions
- Ensuring end of life care needs are identified early
- Extending care planning for long term conditions
- Improving planned referrals
- Reducing medicine waste

The timeline for the successful implementation of clinical commissioning groups is for all of England to be covered by established groups by April 2013.

Questions and answers

Members of the audience were then invited to ask questions which were answered by Drs Weatherstone and Matthews. This is not a verbatim account but is taken from notes taken on the day by North Tyneside LINK.

Q: How will the clinical commissioning groups (CCGs) manage PCT debt?

A: There is no PCT debt in North Tyneside.

Q: GPs are being asked to do too much. Can you clarify how CCGs will cope with commissioning?

A: The CCGs are not alone. A national commissioning board will oversee and be responsible for commissioning some services, for example maternity services. We will not lose the expertise of the PCT's staff; we will find that expertise and buy into it. CCGs can clinically inform but will be supported around technical and IT support etc, so will not be responsible for everything. We will work together as a group, for example we will need a director of finance and other experts.

Q: I am still not clear about how 'other' commissioning will work, that is, commissioning that is not 'bog standard', for example gender reassignment.

A: 'Other' commissioning will be done nationally but pathway stuff will be done locally.

Q: Time – how much time will be involved for you when you are still active as GPs?

A: Some GPs will be doing more work in commissioning. Some will be half-time GPs, half-time commissioners. In most CCGs there are GPs with specialist interests who will be interested in their field but the majority will not be doing what Drs Matthews and Weatherstone are doing. The vast majority of GPs will be listening to their patients' experiences of services etc and feeding up that information to influence commissioning.

This process has raised awareness of the patients' experience with GPs and what they are doing as clinicians, for example, prescribing. GPs now have a bigger influence; for example, if the patient tells of a poor service the GP can tell the CCG and the CCGs can hold that service to account.

Q: I am disappointed LINK has given over this space for propaganda for the GPs and the government. 60% of GPs are against the bill. The bill is not yet law. It is privatisation of the NHS and happening locally here in North Tyneside.

A: There is no suggestion that the NHS will not remain publicly funded. The bill is a response to what has been happening over decades. It presents an opportunity for more providers on quality not cost. What is so wrong with trying to make things better and listening to people?

Q: Who is represented on CCGs?

A: There is a representative from each clinical group from practices as well as patient reps, practice managers, the foundation trust, local authority and PCT.

We are trying to have integrated care in all pathways in health from before birth to death; the best service – the total patient experience. We are aiming high and aspirational. There are lots of people influencing the pathways.

Q: Prevention and early diagnosis of chronic conditions – what are you doing?

Can you name services that you can't commission?

How many patient participation groups do you have?

A: We have had patient participation groups for ages – all practices have them.

Comment from questioner: Mine doesn't

As providers of healthcare the Quality Outcomes Framework says we must have patient participation groups for this year and there are rules on how they must function. Some individual practices are at present still organising theirs. Three patients from these groups sit on the CCG boards.

Comment from questioner: You are paid to do this through DES (direct enhanced services).

Q: Healthcare should be free and open for all. LINK has insufficient teeth and I am concerned how LINK will be involved in the commissioning process.

A: HealthWatch will hold CCGs accountable and a LINK rep will sit on the CCG board.

Health and wellbeing strategy

Anne Graney

Anne Graney, Health and Wellbeing Co-ordinator for North Tyneside explained the background to the government's health and wellbeing agenda and the new roles and responsibilities for local authorities. The full presentation is available in Appendix B.

A new Health and Wellbeing Board has been set up in shadow form until the bill passes into law and membership comprises:

1. Commissioners (primary care, GPs, local authority)
2. Providers (3 hospital and 1 local authority chief executive)
3. Elected Mayor (Chair) and 4 local councillors
4. 3 LINK representatives
5. Young representatives (Young Mayor, Young Cabinet Member)
6. Director of Public Health
7. Health and Wellbeing Co-ordinator
8. Administrator

Members of the audience were then invited to ask questions. These are not a verbatim account but are taken from notes taken on the day by North Tyneside LINK

Q: You have not mentioned alternative medicines – is this to be included?

A: We have a strong engagement plan and if this is an issue for people this will be fed up into the Health and Wellbeing Board which has a direct link to the commissioners.

Q: How can I get involved?

A: You can get involved through the Health and Wellbeing Board and the mechanisms through the clinical commissioning groups local representatives and community involvement.

The Health and Wellbeing Board has nine seats for community representation, including LINK. An engagement plan for the board

will strengthen this; we will make the plan visible to make sure you can engage.

Q: What is the composition of the Health and Wellbeing Board? Vast areas of the community are not represented, for example, older people, no disabled people, housing not represented. There is no way for direct input and not by total community. This would give the board more credibility.

A: There is a statutory requirement to have a community and engagement plan. The board is large already. Maybe a community reference group could work alongside the board. We need you to tell us what you want.

Q: You need to talk to people who need help, you need to get in touch with all people; you need to look at a new way of getting people on board. Look at the people you are serving not the politics.

A: Yes I agree.

Workshops

In the afternoon delegates attended workshops looking at how HealthWatch could work locally to be the consumer champion across health and social care and what priorities members may have for LINK for the future.

Shaping Local HealthWatch workshop

Members were given a briefing paper (see Appendix C) which summarised what is known about HealthWatch at present and how it would be similar and different to LINK.

HealthWatch's three main functions are to be:

- Collective engagement (LINK perform this function at present)
- Advice for individuals (this is a new role)
- NHS complaints advocacy for individuals (this will be new from 2013).

Members were then asked to look at four models of how HealthWatch could function locally and asked to consider the pros and cons of each; with a preferred option being decided.

Possible models for Local HealthWatch

- A local independent organisation could offer to provide all the HealthWatch services in its area as a natural extension of its existing remit.
- A group of local people could set up a local independent organisation to offer all HealthWatch services in their area. This could be a charity or a community interest company.
- The local authority could divide the HealthWatch functions into two or three contracts and commission each separately from independent suppliers, requiring each to operate a service under the HealthWatch brand, and each to collaborate with the other.
- A regional or national body could offer to provide HealthWatch services in a locality – they would need to have

A recurring theme across all four groups was the questioning of HealthWatch's independence if it is to be funded by the local authority and that this might be seen as a conflict of interests.

The groups felt that the remit of HealthWatch was too large for any one body and questioned how genuine representation of hard to reach groups could happen. Accountability of HealthWatch and the role of volunteers and existing membership was questioned.

Concerns were also expressed on a conflict of interests amongst the various strands which comprise HealthWatch; for example signposting of services and advocacy if a complaint arises concerning that service.

No single model was preferred but members were keen to stress that HealthWatch should be a local organisation representing local people.

LINK priorities for 2012 workshop

Workshop members were asked to rank a list of priorities for LINK in order of importance and to substitute any they felt should be included. (See Appendix D)

Many members felt that all priorities were important and this led to lively debates within the groups. However, the two main priorities were:

- Access to preventative health services and health improvement advice
- Availability of community health services

In addition to workshops LINK produced cards for members to write any comments, question or issues on. See Appendix E.

What happens now?

North Tyneside LINK will endeavour to make sure that there is user and carer representation within the new structures.

North Tyneside LINK will support members to inform commissioners how HealthWatch should look and operate locally in North Tyneside.

North Tyneside LINK will continue its role to support health and social care users and their carers to have a voice and act as a critical friend to providers of these services.

Next steps

North Tyneside LINK is in discussion with North Tyneside Council about operations after March 2012 until the introduction of HealthWatch in October 2012.

Evaluation

19 LINK organisational members and 43 individual LINK members and members of the public attended the event.

Most attendees felt that the meeting addressed the issues of what is happening in North Tyneside around commissioning, the Health and Wellbeing Board and Local HealthWatch. Those present said they welcomed the presentations and the opportunity to ask questions and discuss issues; although more time should have been allocated to ask questions.

‘All speakers were excellent and communicated well’

‘Very enthusiastic debate, which was excellent.’

‘It was useful to talk about normally ‘unspoken’ topics’

‘Very useful - getting up to date with new health bill’

The LINK team would like to thank all of the LINK members and members of the public who attended and contributed to the discussions.

If you would like to find out more or have a comment or experience you would like to share with us regarding any of the issues raised in this report please contact North Tyneside LINK on 0191 643 2623 or email link@voda.org.uk



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Who are the GP Clinical Commissioning Groups in North Tyneside?

Care First

Engage Health

Clinical Commissioning groups



Care First

- **18 GP practices**
- **North West, Wallsend, North Shields areas**

Engage Health

- **11 GP practices**
- **Whitley Bay area**

Working with partners on the
Shadow Health and Wellbeing Board

Background and politics



- Massive and radical changes
- Pause
- Hearing of Bill through to Lords
- What will Lords do
- Carry on regardless

Achievements so far



- We have become Pathfinders
- Working with new partners
- Started to understand some of the intricacies of healthcare system
- Pathways well on track
- Practice managers group
- Patient group

Working together



- Increased working across Care First and Engage Practices
- Sharing intelligence and information
- Working with local partners

Working with the PCT



- Completely new way of working
- Clinical support team
- Finance support
- Board membership
- Contracts and planning
- I.T.

Working with the Local Authority



- Sit on shadow Health and Wellbeing Board
- Members on all Local Authority Commissioning boards
- Joint initiatives- alternatives to hospital admissions
 - end of life and care planning
 - reablement

Working with Secondary care



- Community services
- Locality integrated network
- Increased integrated working
- Building up trust

Working with patients



nothing
about
you
without
you

Where is this happening



- Patient Board- all practices represented
- Patient engagement events
 - jointly commissioned 4 events
 - provided by Taking Part Workshops
 - results helped to inform Area Forum
 - Events

Current priorities



- Healthcare closer to where people live
- More support in the community for vulnerable and elderly and those with long term conditions to reduce avoidable hospital admissions

Local initiatives



- Reducing emergency admissions
- Ensuring end of life care needs are identified early
- Extending care planning for long term conditions
- Improving planned referrals
- Reducing medicine waste

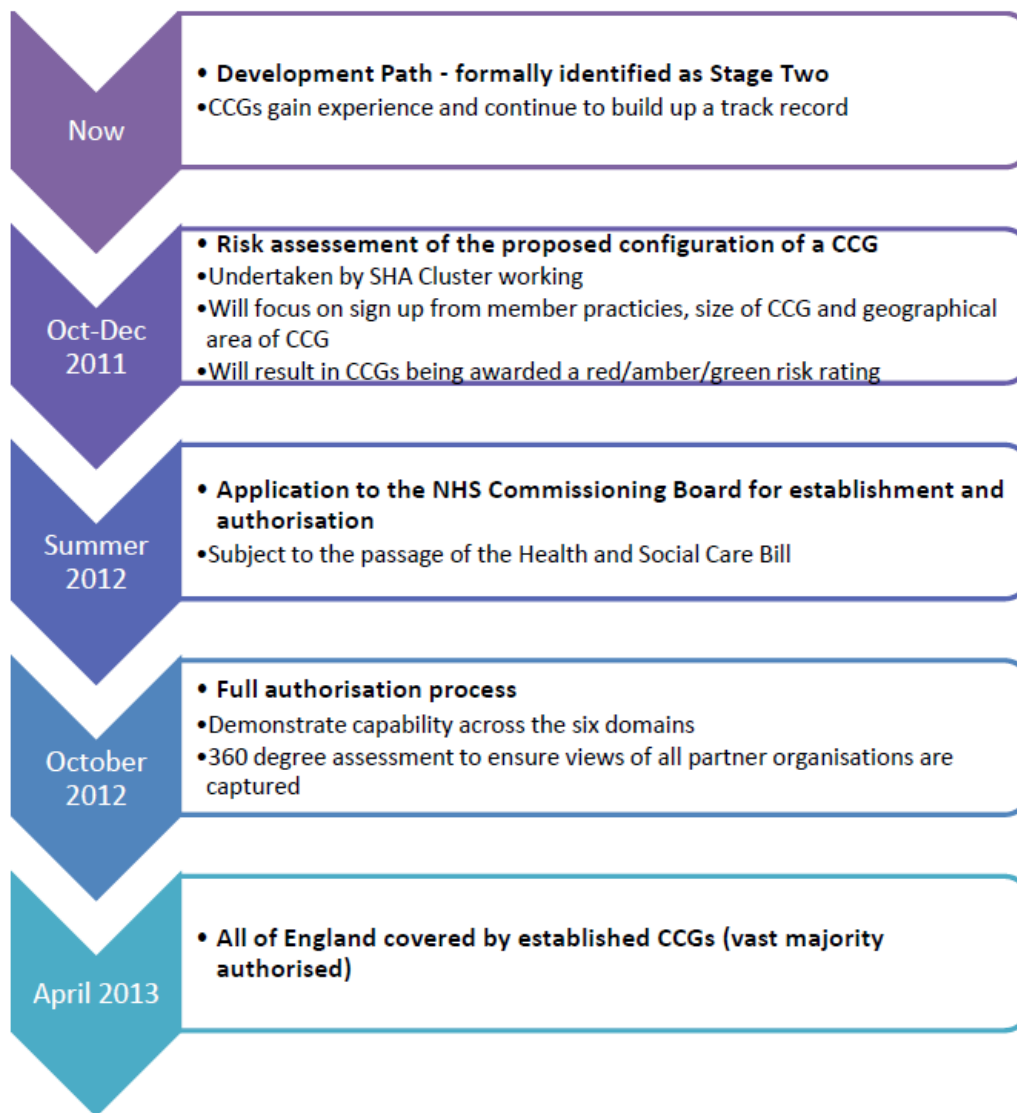
Authorisation



Six key domains

- A strong clinical and professional focus which brings real added value;
- Meaningful engagement with patients, carers and their communities;
- Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national outcome standards and local joint health and wellbeing strategies;
- Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control as well as effectively commission all the services for which they are responsible;
- Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and
- Great leaders who individually and collectively can make a real difference.

Timeline to authorisation



Appendix B

Health and Well Being

Anne Graney
Health and Well Being Co-ordinator

September 2011



North Tyneside Council

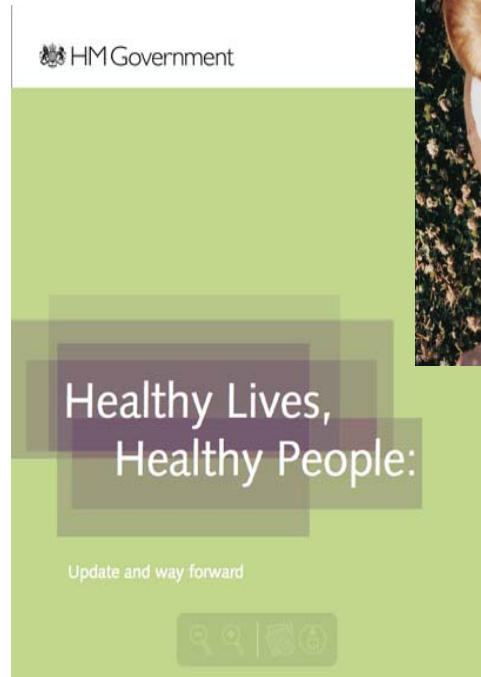
widening
horizons

Overview

- Background
- Health and Social Care Bill
- New responsibilities and expectations
- Next Steps for North Tyneside



Key documents



Fair Society, Healthy Lives (2010)

Marmot Review - Six Inequality Recommendations:

A: Give every child the best start in life

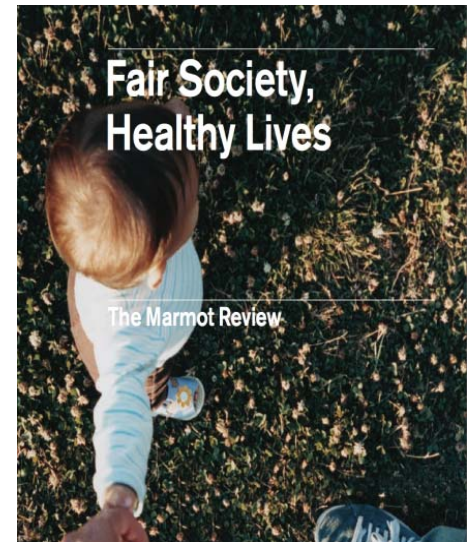
B: Enable all children, young people and adults to maximise their capabilities and have control over their lives

C: Create fair employment and good work for all

D: Ensure a healthy standard of living for all

E: Create and develop healthy and sustainable places and communities

F: Strengthen the role and impact of ill-health prevention



Healthy Lives, Healthy People (2010)

- Health and Well Being to become everyone's business
- Focus on health improvement, across the life course
- Aim to close the gap in health inequalities
- Ambitious Reform of the Public Health System
- New responsibilities for Local Authorities



Local Authorities

- Focus on wider determinants of Health and Well Being i.e. Employment, Housing, Education, Leisure etc
- Greater opportunity for community engagement
- Development of integrated solutions with partners
- Public health budget
- Director of Public Health will lead this work as principal adviser on health to the Local Authority



Health and Social Care Bill

- Put these proposals into Law
- Health and Well Being Board
- Health and Well Being Strategy (2013)
- Public Health Workforce Strategy
- Engage partners (including community)
- Agree set of commissioning priorities
- New system for assessing health (Joint Needs Assessment)
- New Health Watch



Health and Well Being Board

1. Commissioners (Primary Care, GPs, LA)
2. Providers (3 Hospital and 1 Local Authority Chief Exec.)
3. Elected Mayor (Chair) and 4 local Councillors
4. 3 LINK representatives
5. Young representatives (Young Mayor, Young Cabinet Member)
6. Director of Public Health
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8. Administrator



Next Steps

- Health and Well Being Board 'time out' – Autumn
- Development of the Health and Well Being Board
- Key work priorities for 2012/13
- Process for consultation and engagement
- Guiding principles
- Interim health and well being priorities/baseline



Developing Strengths

- Coast, River, Port, Country side
- People
- Leisure and Tourism
- Rich heritage and history
- Local services/partnerships



Local HealthWatch Briefing Paper

This paper summarises what we know so far about Local HealthWatch. The picture is not entirely clear, as ideas are developing in a very changeable situation, and much is open to debate! However, this paper attempts to explain some of our guesses about what Local HealthWatch is intended to look like. It also asks some of the questions that still remain unanswered. Most of the information in this paper is based on information in the Health & Social Care bill that is currently going through parliament – and our best guesses!

“ **Local HealthWatch organisations will be the local consumer champion across health and social care.** * ”

** according to the (not-quite-ready) Health & Social Care Bill, Schedule 16A Section 220A (1)*

The things we do: What will stay the same?

Local HealthWatch will retain all involvement and scrutiny functions of the LINK, including:

- ✓ promoting involvement
- ✓ obtaining views
- ✓ monitoring health and care services
- ✓ making reports and recommendations
- ✓ carrying out Enter & View visits

The things we do: What will be new or different?

- ✓ **Local HealthWatch will provide information to support patient choice:** Responding to questions about information – similar to the role which the PCT PALS teams currently do.
- ✓ **There will be a HealthWatch representative on Local Health & Wellbeing boards:** These boards will be made up of local councillors, council officers and GP commissioners and will be responsible for the Joint Strategic Needs Assessment (JSNA) and also for developing a Health and Wellbeing Strategy based on the evidence in the JSNA.
- ✓ **(From 2013) Local HealthWatch will point members of the public in the direction of NHS complaints advocacy:** Currently, this service is commissioned nationally but it will be the responsibility of local authorities from April 2013. Local authorities will be required to contract organisations to carry out this work, and Local HealthWatch can either run the service, or work closely with whoever is running the service.

When will this happen?

LINKS will come to an end when Local HealthWatch will begin in October 2012.

2012			
January	February	March	April
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September	October	November	December
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What sort of organisation will Local HealthWatch be?

Local HealthWatch will not be a ‘network’ like the LINK. It will be a “body corporate”.

This is a legal term that means something that has "a legal personality distinct from that of its members". This would include companies with limited or unlimited liability, companies limited by guarantee, charter companies and bodies created by statute.

So at some point, Local HealthWatch may need to be set up as its own charity, company or similar. As a ‘body’, that means that Local HealthWatch:

- ✓ ... will be an organisation in its own right, and no longer ‘just’ a network overseen by volunteer groups.
- ✓ ... may appoint its own staff.
- ✓ ... will have to produce its own annual accounts.
- ✓ ... will have standards provided by a national HealthWatch organisation, HealthWatch England, against which Local HealthWatches can be measured.
- ✓ ... will be subject to the Equality Act 2010.

It appears that Local HealthWatch will be led by local members or volunteers, as are LINKs, and that paid staff will be there to support volunteers, as is the current situation with LINKs.

Local HealthWatch ‘Members’:

The Bill talks about Local HealthWatch ‘members’. It isn’t clear exactly how HealthWatch will define ‘members’, but it is possible that the Department of Health considers that Local HealthWatches will be run and ‘owned’ by a board of members, similar to charity trustees or health board non-executive directors. Some parts of the bill suggest that Local HealthWatch members might be paid. Perhaps this suggests that Local HealthWatches will have a paid board, similar to some health boards at the moment. However, it also says that Local HealthWatch members must be “representative of local communities”. Some people have raised concerns that this might be difficult to achieve, as volunteers from hard-to-reach sections of the community may not always put themselves forward for these sorts of roles.



Unanswered questions....

What is a HealthWatch ‘member’? What will happen to current LINK volunteers?

Will Local HealthWatch have a paid board? Who will select the members of the board?

Will volunteers be expected to do the signposting work of Local HealthWatch?

Will volunteers be responsible for the HR and legal work of running an organisation?

How will Local HealthWatch’s ‘members’ be representative of the whole community?

How will volunteers be supported to be public representatives on Health & Wellbeing Boards?

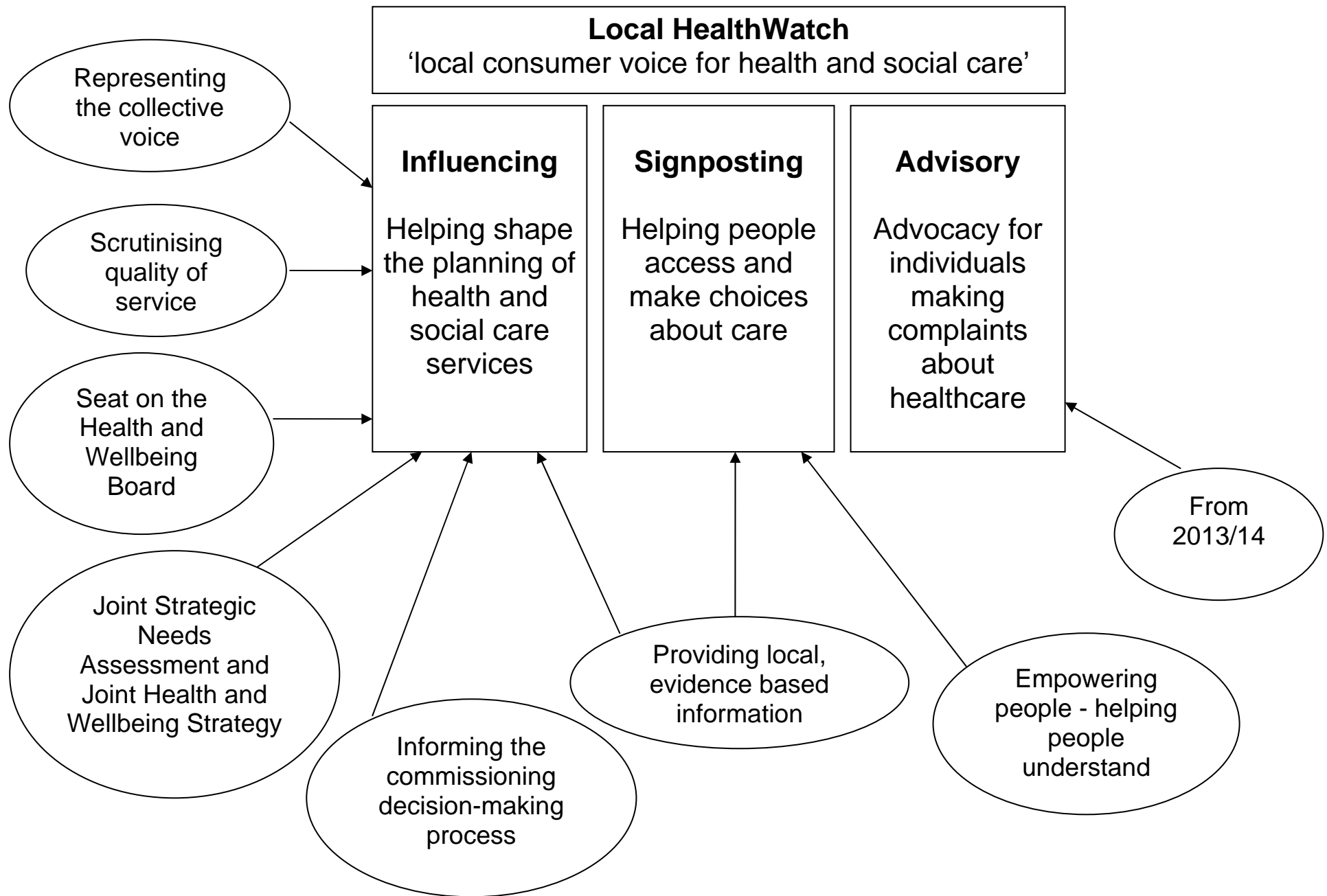
How will a HealthWatch Representative truly represent the public?

How will Local HealthWatch be truly independent when it is funded by the Local Authority?

How much will each Local Authority decide to put towards Local HealthWatch?

When the Independent Complaints Advisory Service is commissioned, who will support the public to complain about social services, as well as health services?

Appendix C



Appendix D
Workshop exercise 2
North Tyneside LINK priorities September 2011

Please score the following topics in order of importance, with 12 points for the most important and then point by point in descending order of importance to you.

If there are any topics missing please substitute the least important to you with the topics you feel should be included and then complete the exercise.

Topic	Score
Community support services for carers	
Respite services	
Access to secondary care for older people	
Being involved in decision making	
Dignity and respect in hospital care	
Availability of community health services	
Availability of community care support services	
Services for those with a learning disability	
Services for those with an addiction	
Services for those with mental health difficulties	
Hospital discharge	
Access to preventative health services and health improvement advise	

Possible priorities for LINK in 2012

Previous topics to consider

Counselling
Urgent care
Information
Respite care/short breaks
Very elderly
Transgender people
Mental Health
Young people
Hospital discharge
Access to GPs
Lesbian gay and bisexual people
Home care
Transition
Black and ethnic minority communities
North Tyneside General Hospital

Current topics to consider

Personal budgets
Young people and mental health
Home care
Adults with autism
Reablement
Black and ethnic minority communities
Medicines
Personalisation
Dementia

Other topics to consider

Community support services for carers
Respite services
Access to secondary care for older people
Dignity and respect in hospital care
Availability of Community health services
Availability of Community care support services
Services supporting those with a learning disability
Services supporting those with mental health difficulties
Services supporting those with addiction
Hospital discharge
Involvement in decision making

Appendix E

29 September LINK bi-annual event

Clinical commissioning groups session - questions, issues and comments

You asked:

“Equality for all patients from all GP’s”

For example, patients can visit a different GP practice for a special treatment e.g. facial moles etc.

Clinical commissioning group (CCG) replied:

In North Tyneside patients will have access to the same services whichever practice they are registered with although not all practices provide the same services in their own premises.

In this example, some GPs have additional training to undertake more complicated minor surgery procedures such as removal of facial moles. A patient may therefore be referred to a GP in a different practice to carry this out. This is the arrangement that exists at present and we don’t foresee a change.

You asked:

“Why has there not been mention of specialised clinics for chronic illnesses like fibromyalgia?”

CCG replied:

Most chronic illnesses including fibromyalgia are looked after by their GP although they may be seen by a specialist to make the initial diagnosis. A few more complicated and progressive diseases such as multiple sclerosis and Parkinson’s disease remain under the care of a specialist

You asked:

“There is an urgent need for more information about Clinical Commissioning Group. Most don’t even know which group their own practice is in, let alone the governance and management structures. Who is making the decisions and what are their decisions? There is currently a major need for transparency.”

CCG replied:

Clinical Commissioning Groups are still in the process of being formed and setting up their organisational structure. The formal governance and management arrangements will be determined by the health bill once it is finalised. At present commissioning of health is still the responsibility of Primary Care Trusts although clinicians are becoming more involved.

We are very keen to ensure a high level of public awareness about the role of Clinical Commissioning Groups and as we develop further we will provide more information for local people.

You asked:

“Patient participation – panels should be statutory and meet not just get a newsletter about what is happening in one practice.”

CCG replied:

We expect all of our member practices will have a patient reference group but it is not currently a legal (statutory) requirement. There is likely to be a legal requirement for patient representation on the CCG Board.

Similar to the PCTs, we will be required to ensure that there is appropriate and robust patient engagement and consultation in all commissioning decisions. CCGs need to be able to demonstrate effective patient engagement in order to be authorised as a statutory organisation and take on commissioning responsibilities.

You asked:

“How will the North Tyneside Clinical Commissioning Groups influence the decision to be taken about location of midwife/consultant led maternity care at the new emergency care hospital, when maternity services are commissioned nationally?”

CCG replied:

We understand that at present the commissioning of maternity services will be a matter for the Clinical Commissioning Groups. The proposal for the new emergency care hospital included an obstetric-led maternity unit. When considering feedback to the consultation, NHS North of Tyne said that there would be further consultation on the future configuration of midwifery led services. We would expect to be involved in the consultation and decision making process.

You asked:

“How will GP Commissioning determine priorities when there is clearly difference between patient’s priorities and funding? Or when other clinicians of other trust challenge priorities?”

For example, the proposed emergency hospital near Cramlington for Northumbria Healthcare Trust and Newcastle Consultants challenge this”.

CCG replied:

GP Commissioners, like all commissioners, should commission services on the basis of an assessment of health needs and the resources available. Sometimes the needs of the whole population need to be balanced against the needs of local groups. The services commissioned must be of high quality which means that

they must be safe, cost effective and meet patients' satisfaction. Sometimes there will be conflicts of interest between providers of health care and commissioners need to take a decision in the best interest of patients.

You asked:

“We are paying a heavy price for democracy, so it is fortunate that LINK members are engaging with the process – to what end remains to be seen. I didn't fully understand how services were administered before and those pronouncements enshrined in PowerPoint have not revealed the future”.

CCG replied:

We will be very pleased to continue working with the LINK and in the future with HealthWatch. The changes that are currently being proposed for the NHS are as a result of national policy. We are not here to defend or to comment on national policy. Our role in the future will be to take on our new responsibilities to make sure that we provide local people with the best possible healthcare.