You are encouraged to share your views with regard to the proposals contained within this framework at our consultation website: www.commissioning.csip.org.uk
# Commissioning framework for health and well-being

The Commissioning framework for health and well-being is published for consultation. It is aimed at commissioners and providers of services in health, social care and local authorities. It is part of the White Paper *Our health our care our say* implementation and we are consulting as part of the development of a final document to be published in Summer 2007.

**Cross Ref**

Health reform in England: update and commissioning framework (July 06)

**Superseded Docs**

White paper (2006) *Our health our care our say*


**Action Required**

feedback in consultation

**Timing**

Consultation closes 28 May

**Contact Details**

Anthony Kealy
Commissioning Policy Team
Room 603 Richmond House
Whitehall
London
113 2546081
www.commissioning.csip.org.uk

---

**Policy**

<table>
<thead>
<tr>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR / Workforce</td>
</tr>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>Management</td>
</tr>
<tr>
<td>IM &amp; T</td>
</tr>
<tr>
<td>Planning</td>
</tr>
<tr>
<td>Finance</td>
</tr>
<tr>
<td>Clinical</td>
</tr>
<tr>
<td>Partnership Working</td>
</tr>
</tbody>
</table>

**Document Purpose**

Consultation/Discussion

**ROCR Ref:**

<table>
<thead>
<tr>
<th>Gateway Ref:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7361</td>
</tr>
</tbody>
</table>

**Title**

Commissioning framework for health and well-being

**Author**

DH

**Publication Date**

06 Mar 2007

**Target Audience**

PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs

**Circulation List**

Voluntary Organisations/NDPBs
Contents

Foreword...........................................................................................................4

Executive summary...........................................................................................7

1. Introduction..................................................................................................10

2. Putting people at the centre of commissioning .......................................18

3. Understanding and planning for the needs of individuals and of the local population .................................................................24

4. Sharing and using information more effectively....................................33

5. Assuring high quality providers for all services......................................39

6. Recognising the interdependence between work, health and well-being ...............................................................................................45

7. Developing incentives for commissioning for health and well-being......50

8. Making it happen – local accountability ..................................................57

9. Making it happen – capability and leadership........................................60

Annex A – Joint Strategic Needs Assessment..............................................64

Annex B – Investing in prevention.................................................................71

Annex C – Tools and resources to support commissioning ......................75

Annex D – High impact changes to reduce health inequalities ............87

Annex E – Summary of consultation questions.........................................91

Glossary..........................................................................................................94
Foreword

This framework is about practical action. It is for everyone involved in commissioning local services – so they can work together to improve the health, well-being and independence of everyone living in their local area. We believe that local commissioners have the opportunity to make a real difference by focusing on the outcomes that people want for themselves and for their communities.

To help keep us all on the right track, here is a sample of what we would like people to be saying about health and well-being in five years’ time. Some of this is happening now, but in five years it should be happening everywhere, all the time:

Doris

My breathing gets bad every winter, and I often used to end up in hospital. I didn’t mind though, as my flat was cold and I got a bit lonely in the long, dark evenings. But a few years ago, the GP got this lady to come round to my flat and ask me how I was doing. I’m not sure who she works for – but she seems able to sort everything out.

For a start, she got double-glazing fitted for me, and help with my fuel bills. My flat is much warmer now, and that makes my breathing better. And then she got a nurse to teach me how to check my own breathing, by blowing into a tube. The nurse phones once a week to find out how I am, and if I’m getting wheezier then she comes and sees me, and sometimes changes my medicine. That helps a lot, too. And I feel I can ask her about other things – like getting my feet seen to, so that walking is easier. Between them, they’ve even got me involved in a lunch club once a week – I didn’t think I’d like it, but it is nice to meet new people and to have someone cook a proper lunch for me. I haven’t been in hospital at all for the last year.
Sunita

My daughter Sunita has multiple disabilities. She’s always going to need a lot of care, but we do want her to be as independent as possible. A few years ago we were struggling to get all the different things she needed – not just equipment like wheelchairs and bath hoists, but the right education, respite care that fitted in with our religious beliefs, all the things that made life easier. And Sunita ended up in hospital a lot, as we weren’t very confident about looking after her when she was even a bit poorly.

Then we were asked if we wanted to be in charge of the money that was spent on Sunita, and be able to choose what it was spent on. Since then, we’ve been able to make sure that we get regular breaks, knowing that Sunita is cared for by people who she really likes and who don’t just look after her physically, but really understand how important religion is to us as a family. We’ve also been able to get a wheelchair that fits her properly, so she can get out and about a lot more. Our GP helped us find some training on how to care for Sunita when she’s a bit poorly. I think he even paid for it. We know what to look for now, and feel confident about knowing when it’s safe to look after her at home and when the signs are bad and we need to take her to the hospital. It’s very reassuring.

Mark

I’ve played football in the park every Saturday morning for my local team since I came to live in London. A couple of years ago I found I wasn’t getting picked for games, and sometimes I didn’t even get to be a reserve. I knew I needed to get fitter, so I could keep up better, but I wasn’t sure where to start.

Then one evening, down the pub, I saw a beer mat with a stop smoking website on it. I thought stopping smoking would be a start, so I looked up a local group and went along. It worked a treat, but I did gain a bit of weight. Then on our final group meeting this GP turned up, and told us about how to be generally healthier – not just medical stuff like cholesterol, but useful stuff like getting fit for football, and which foods help you train better. And he gave vouchers to any of us who wanted them to get started at the local gym. I thought that it was worth a go, so I went along, and I got hooked. I go three times a week now, and I make sure I have a proper meal afterwards. And now I’m back starting every game.
Real improvements in people’s lives. That is what first-rate commissioning for health and well-being is all about. We hope every local commissioner – GP, Primary Care Trust and local council – will want to seize the opportunity.

Susan

My boyfriend used to hit me, and I put up with it until he started on the kids. My youngest was only two, and I knew I had to get out. A friend of mine told me about this refuge. When I got there, they gave me a lot of support. They helped me speak to the police and arrange things so that they’d come really quickly if I called. I didn’t want to get social services involved – I thought they might take my kids away – but the refuge said that they’d be able get us all some counselling, maybe sort out some childcare for me and so on. It’s true, they’ve helped me cope and the kids are a lot happier.

Once I felt ready, my key worker helped me find a council flat in a different area, somewhere my ex-boyfriend wouldn’t think to look for me. She also helped me find a GP, who’s sorted out my youngest’s asthma, which had got a lot worse with all the stress. My key worker also made sure my kids got a place in the local primary straightaway, and made sure I was getting all the right benefits. At the moment, she’s helping me to find some volunteering work, so I can get a bit of practice, and then maybe go for a part-time job. I’d really like that – it would mean I felt properly independent again, and it would set a good example for the kids.

Patricia Hewitt,
Secretary of State for Health

Ruth Kelly,
Secretary of State for Communities and Local Government
Executive summary

Commissioning for health and well-being means involving the local community to provide services that meet their needs, beyond just treating them when they are ill, but also keeping them healthy and independent.

This framework builds on the White Paper *Our health, our care, our say*, which promised to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home and to tackle inequalities.

This framework is about action, with a particular focus on partnership. It is for everyone who can contribute to promoting physical and mental health and well-being, including the business community, government regional offices and the third sector.

The case studies throughout this document illustrate how this type of commissioning is already bringing benefits to individuals and communities.

Where we are now

Current reform of public services rests on increased investment and on devolving power to local people so that they can make the choices that affect their communities.

Health reform and investment have put more staff into the NHS and drastically reduced waiting times. Clinical outcomes for the big killers, particularly cancer and cardiac disease, have improved. There is more choice among services, which are delivered closer to homes.

Nevertheless, our health service is still too focused on commissioning for volume and price, rather than for quality and outcomes. Too much long-term care is provided in institutional settings. Health inequalities still exist. There is too much of a focus on treating illness rather than preventing it. There are too few providers, and we need to do more to incentivise innovation and join up services. Excluding elective care, individual choice for many patients remains limited and we need to strengthen local voice.

Where we are moving towards

We now need to keep the focus on people – not just people who are ill, but everybody. And we need to look further than just physical health problems, to promote well-being, which includes social care, work, housing and all the other elements that build a sustainable community.
Commissioning framework for health and well-being

The aim of this document is to help commissioners do this by showing how they can provide personalised services, promote health and well-being, proactively prevent ill health, and work in partnership to reduce health inequalities by focusing on outcomes for children and adults.

How we can get there

This framework identifies eight steps to more effective commissioning:

1. Putting people at the centre of commissioning

   This involves giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices. Mechanisms will be developed to help the public get involved in shaping these services, with advocacy to support groups who find it hard to express views.

2. Understanding the needs of populations and individuals

   Joint strategic needs assessment by councils, PCTs and practice based commissioners will help them to better understand the needs of individuals, by using recognised assessment and care planning processes appropriately, and mitigating risks to the health and well-being of individuals.

3. Sharing and using information more effectively

   In order to make effective decisions for individuals and groups, we need to use and share information in an effective way. This includes clarifying what information can be shared under what circumstances, joining up the IT systems of front-line practitioners and encouraging individuals and communities to be co-producers of information.

4. Assuring high quality providers for all services

   Commissioners should develop effective, strong partnerships with providers and engage them in needs assessments. Procurement should be transparent and fair. Commissioning will be focused on outcomes, leading to more innovative provision, tailored to the needs of individuals and supplied by a wider range of providers.
5. Recognising the interdependence between work, health and well-being

Commissioners can facilitate collaborative approaches with businesses to improve advice and support for individuals. Additionally, all providers of NHS care will be incentivised to support and promote the health and well-being of their employees.

6. Developing incentives for commissioning for health and well-being

Bringing together local partners using Local Area Agreements will help to promote health, well-being and independence, by using contracts, pooling budgets and using the flexibilities of direct payments and practice based commissioning.

7. Making it happen – local accountability

The Department of Health and the Department for Communities and Local Government will develop a single health and social care vision and outcomes framework, including a set of outcomes metrics aligned with the framework.

8. Making it happen – capability and leadership

The Department of Health and other national stakeholders will provide support to all local commissioners to address their capability gaps, where these national organisations can add real value. This support will be tailored to different types of commissioners – PCTs, practice based commissioners and local authorities.

Next steps

This document sets out a vision, a framework and practical proposals for the commissioning of health, care and well-being from 2008/09. There are a number of consultation questions throughout the document and these are summarised in Annex E. You are encouraged to share your views with regard to the proposals contained within this framework at our consultation website www.commissioning.csip.org.uk.
1. Introduction

1.1 The Commissioning framework for health and well-being is designed to enable commissioners to achieve:

> a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity
> a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs
> a stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

1.2 The policies that underpin these aims are described in Choosing health, in the White Paper Our health, our care, our say and in Every Child Matters and the Wanless reviews (see Annex C). All these documents placed a strong emphasis on closer working between health and local government.

1.3 Throughout, there are questions for consultation, and all the consultation points are summarised at Annex E.

1.4 The framework is for commissioners of health services and of social care services, and local government more broadly. It will also be of interest to those working in or through Local Strategic Partnerships who can contribute to promoting physical and mental health and well-being, including the business community, government regional offices and the third sector. This framework should be shared with current and potential providers of services commissioned by health and local authorities, as it signals a clear commitment to greater choice and innovation, delivered through new business relationships and partnerships. The framework covers commissioning for all of the population in a locality – adults and children, their family and carers, and all care groups. It includes the commissioning of primary care (with the exception of the national negotiations around the General Medical Services (GMS) contract), community healthcare, social care, public health, well-being, as well as other relevant services, support and interventions.
Commissioning framework for health and well-being

Key outcomes of, and requirements for, good local commissioning

Commissioning is the means to secure the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users which:

- deliver the best possible health and well-being outcomes, including promoting equality
- provide the best possible health and social care provision
- achieve this within the best use of available resources.

Commissioning for the health and well-being of individuals means helping local citizens to:

- look after themselves, and stay healthy and independent
- participate fully as active members of their communities
- choose and easily access the type of help they need, when they need it.

Commissioning for the health and well-being of a local population means:

- understanding and anticipating future need
- promoting health and inclusion and supporting independence
- identifying the groups or areas that are getting a raw deal and giving them a voice to influence improvements
- delivering the best and safest possible quality of care.

The essential principles and processes for good quality commissioning are set out in Health reform in England: update and commissioning framework (July 2006) and in Joint planning and commissioning framework for children, young people and maternity services (Annex C).

1.5 Our aspiration is for better health and increased well-being for everyone. This can only be achieved by local communities in every part of the country working together to tackle inequalities and promote equality. It also means working jointly to develop services that are more personal to individuals and provided closer to home; increasingly building on a closer integration of health, social care and other service providers, helping people to stay as healthy and as independent as possible.

1.6 This framework is about practical action. A core theme is partnership: partnership between communities and their commissioners, partnership
at the local level between health, particularly Primary Care Trusts (PCTs) and practice based commissioners, and local government, the third sector and other partners. This theme reinforces and starts to implement the direction set out in the Local Government White Paper Strong and prosperous communities, which proposes greater collaboration between health and local government through a health and well-being partnership (see Annex C). The framework describes the minimum data set required for such an assessment (see Annex A).

1.7 Building on the assessment of local needs, commissioning needs to include action to support the health and well-being of the population as a whole, especially groups at particular risk (e.g. a specific locality or people with a particular condition) and those who are economically or socially excluded, as well as the health and well-being of individuals.

1.8 We particularly wish to highlight the continued importance of effective commissioning for children and young people. A healthy start in life matters. There is good evidence that investment in the health of pregnant women, mothers and babies, and very young children leads to improved educational outcomes when the child reaches school age, and that healthier children achieve more at school. Children who thrive and achieve at school have a much greater chance of fulfilling their potential and of achieving stable relationships and economic security in adult life. Investing in services for children and young people therefore improves outcomes for individuals and society now and in the future.

1.9 The joint commissioning of services is not new in the area of children’s services. The Government’s ambition to maximise health, well-being and achievement for all children, as set out in Every Child Matters is now taking effect up and down the country through children’s trust arrangements. These are the key vehicle for the joint commissioning of services, including appropriate health services, for children and young people. They are underpinned by a statutory duty of co-operation, following the Children Act 2004 (see Annex C), that requires health, local authority and other commissioners to work together to improve the well-being of children, driven by and reflected in their Children and Young People’s Plan. Alongside these arrangements there is a strong set of service standards for children, young people and maternity care.

1.10 It is essential that momentum is maintained. The proposals in this Framework for Health and Well-being are consistent with all these recent developments for children and young people. Indeed, they are intended to give them further emphasis and reinforcement.

Vision

1.11 The following table sets out our vision. The good news is that nearly all of the characteristics of the new system already exist in one form or
another around the country. However, hardly anywhere is close to having all these features working together effectively. That is why it is so important to understand the barriers to change and to act to bring them down.

<table>
<thead>
<tr>
<th>Current practice</th>
<th>Vision for the future</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are moving from a system characterised by...</td>
<td>…to one where there is:</td>
</tr>
<tr>
<td>a focus on treating illness and ill health</td>
<td>promotion of health, well-being and independence and where this is seen to be as important as commissioning for ill health</td>
</tr>
<tr>
<td>doing things to/for people</td>
<td>a focus on enabling people to do things for themselves (e.g. homecare, re-enablement)</td>
</tr>
<tr>
<td>a focus on improving and reducing inequalities in access to services</td>
<td>an increasing focus on promoting equality, giving all children and adults the chance to live a healthy life</td>
</tr>
<tr>
<td>commissioning for volume and price</td>
<td>commissioning for quality, efficiency and value, where ‘health and well-being’ value is added at every possible point</td>
</tr>
<tr>
<td>reliance on historical information, struggling to tackle inequalities</td>
<td>use of real-time data and analysis to identify groups of people and/or areas that are getting a raw deal</td>
</tr>
<tr>
<td>a large amount of care for people with long-term needs provided in institutional settings</td>
<td>a greater focus on prevention, early intervention and support for self-care – this makes economic good sense. And, when support is needed, making it more convenient and closer to home</td>
</tr>
<tr>
<td>a limited range of providers in some markets</td>
<td>a wider range of providers and provision that is more innovative, offering services better tailored to people’s needs and building local social capital</td>
</tr>
<tr>
<td>weak management of transition points between services</td>
<td>seamless transition, with services configured around a person’s needs</td>
</tr>
<tr>
<td>commissioning mostly at local authority and PCT level</td>
<td>commissioning at practice (health) and individual level (social care) as well as by local authority and PCT, using direct payments and individual budgets, wherever possible, to give people more control of their own care and support arrangements</td>
</tr>
</tbody>
</table>
Current practice | Vision for the future
--- | ---
We are moving from a system characterised by... | ...to one where there is:
limited strategic planning across health, social care and other preventative services and relatively little flexibility about shifting resources between services | shared strategic needs assessment informing decisions across health, social care and local government, and greater flexibility in shifting resources to where investment can have greatest impact on current and future health and well-being needs
use of block contracts to finance health system | payment linked to work done, based on outcomes
focus on inputs and processes | focus on outputs and outcomes
limited specialist knowledge of commissioning | improving commissioning capability, with skilled and experienced commissioners
minimal individual choice | improvement in the commissioning and quality of many services that is driven by the choices that people make, with added support offered to excluded groups to ensure that they are able to exercise choice
looking upwards: national targets and central initiatives predominate; local voice minimal, incentives unaligned with commissioning priorities | an emphasis on looking outwards: engaging with people locally; focusing on addressing the needs of the local population; aligning incentives with commissioning priorities

How will this framework help?

1.12 We asked a cross-section of health and local authority commissioners to tell us about the blocks and what needs to change. Here’s what they told us:

> Local authorities, by virtue of their elected leadership, tend to have strong links to local people and community needs. Health partners’ links are often less systematic; they need to build upon local authority experience and networks to better engage with local people. This includes giving a voice to those who are seldom heard but frequently have the greatest need.
> Joint strategic needs assessment by health and local authority partners is happening – but in relatively few places. Local leaders and decision-makers need to develop an improved shared understanding of the health and social care needs of their local population, a joint vision and an integrated approach to improving health and well-being, reducing inequalities and promoting health equity.

> The sharing of information to support commissioning and care is often patchy. Health and local authority commissioners could have a greater overall impact if they planned from a shared data set with common understanding of their local population’s needs, delivering agreed measured outcomes and reporting progress against them to those whose needs have been assessed.

> Ensuring high-quality provision is a challenge. Even where commissioners want to secure innovative services, they can find that providers are unwilling or unable to provide these services. More could be done to develop the market for health, social care and well-being so that potential new providers can become established and choice can be increased.

> Being in work matters to the health and well-being of individuals and communities. Commissioners can have a much greater impact on this by working together with care providers, local employers and Jobcentre Plus.

> Incentives within commissioning systems do not yet fully support the delivery of better health and well-being. Funding routes, for example, can be real barriers to effective partnerships, service integration and innovative use of the health and social care estate. Clarification of rules and freedoms – particularly for practice based commissioning – would help.

> The accountability for joint commissioning can be weak, leading to misunderstandings and the breakdown of relationships. The developments in commissioning of children’s services, though, are showing how this can be overcome.

> Capability to commission well, particularly in terms of commissioning skills, is under-developed. This is partly historical, partly a function of being spread out over different organisations that do not always share skills and knowledge, and partly because competing immediate priorities can deter a long-term perspective. Commissioning needs to be more proactive, transformational and forward-looking, focusing on promoting good health, investing for prevention, independence and well-being. The skills to do this are relatively scarce and require systematic support and development.
> Health and local authorities are structurally complex and culturally different organisations. They have different histories, funding streams and charging policies, but this should not be a barrier to better joint investment. Effective investment in prevention requires both individual and whole-system solutions.

**What will help drive more effective commissioning?**

1.13 This framework proposes and consults on eight steps that, when put in place nationally and locally, will help to overcome these barriers and deliver improved health and well-being outcomes. These are:

> putting people at the centre of commissioning
> understanding the needs of populations and individuals
> sharing and using information more effectively
> assuring high-quality providers for all services
> recognising the interdependence between work, health and well-being
> developing incentives for commissioning for health and well-being
> making it happen – accountability
> making it happen – capability and leadership.

1.14 For each of the steps, we suggest how the proposed actions could lead to improvement: for the individual, for particular groups in the population, and for the population as a whole.

**Improving equality through more effective commissioning**

1.15 Alongside this framework we are publishing details of an initial assessment we have made of the impact of the policy on equality, and its potential to reduce health inequalities experienced by disadvantaged groups. This assessment suggests that in order for the policy to be successful, there should be:

> accurate ethnic monitoring, using widely accepted coding
> active seeking out of different groups and individuals
> a focus on addressing access issues
> differential application of policy to different groups and individuals to meet differing needs
> extra resources devoted to addressing differential need or hard-to-reach populations or individuals
> extra training for health and social care professionals and managers
> development of appropriate standards
> inspection and continuing evaluation.

1.16 We will develop this assessment further through the consultation period and would welcome comments on these points.
2. Putting people at the centre of commissioning

2.1 Our health, our care, our say (see Annex C) showed that when people get involved and use their voice, they can shape improvements in provision and contribute to greater fairness in service use. The challenge to commissioners is how to make greater local voice, choice and control a reality.

Where we are now

2.2 Too often, services are commissioned on a ‘one size fits all’ basis, insufficiently flexible to meet people’s needs and preferences. And the impact of local ‘voice’ is variable, with local people frequently involved only after a strategy or plan has been published, rather than being integral to its development. Poorly designed services as the consequence of a lack of engagement can mean that services are ultimately used inappropriately, or not at all, and can result in a poor experience for those using them. For example, at the moment, around half the people with long-term conditions are not aware of support or treatment options. They do not have a clear plan that lays out what they can do for themselves to manage their condition better. If people had stronger involvement in shaping services and were supported to understand and manage their own conditions, there would be a stronger likelihood of good outcomes.

Person-centred care – how commissioning can get care right for individuals

Choice and control

2.3 Commissioners should enable people to have greater control over their own health. They can do this by:

> offering individuals greater choice over the services and treatments available to them, including help with caring for themselves. Choice should become available across all services. The Department of Health will be publishing, in spring 2007, a set of proposals as to how this can be achieved. Commissioners will be expected to begin to implement the resulting new choice policy from 2008, with PCTs indicating their initial approach in their prospectus
> using local health profiles (see Annex C) and other relevant local data to inform the local community on how their health and well-being compares with that of people in other areas, helping people to influence commissioner priorities

> enabling any citizen – whether self-funding or paid for by the state – to obtain good information and advice about local health, social care and well-being services. This should include information about whether services meet a minimum level of quality, how services compare to others in the area and whether they deliver value for money. This applies to health services (e.g. physiotherapy) as much as it does to care services (e.g. domiciliary care) and preventative services (e.g. sexual health). The Department of Health’s recently announced national patient choice website will be an essential building block, which commissioners should supplement locally (see Annex C)

> encouraging people to use the HealthSpace facility (at www.healthspace.nhs.uk) to view their personal summary care record and obtain health information

> educating young people to understand the importance of the benefits of healthy choices, especially about food, alcohol, smoking, recreational drugs and sexual habits. Such education should be offered in a progressively universal way that is proportionate to need

> implementing the lessons from social care direct payments (and the individual budget pilots) to support and allow eligible service users to design their own tailored care and support package

> using practice based commissioning creatively, so that practice teams can work with patients, families and carers to design care packages better suited to their needs. This would support explicit discussions between GPs, social care practitioners, and individuals, together with their families and carers, about how health and social care resources are best deployed to better fit an individual’s needs and circumstances. For more information, see Section 7 on developing incentives for commissioning for health and well-being

> redesigning the pattern of local services, based on user needs, wants and daily lives. For example, co-locating relevant services on sites that children and young people already use, such as children’s centres and extended schools, to improve access and usage. Health visitors and community midwives are key front-line practitioners. If they are based in GP practices, extended schools or Sure Start children’s centres, families who need them can get to them more easily
> commissioning more easily accessible, extended self-care through the effective use of, among others:
  - community pharmacists, dentists, GPs, community nurses and care workers, helping people to reduce the future health risks presented by their current chosen lifestyles
  - Health Direct and local information services (such as Link Age Plus – see Annex C)
  - local third sector voluntary and community support groups
  - effective health information and promotion campaigns linked to social marketing techniques

> supporting the local roll-out of the Expert Patient Programme and Expert Carer Programme

> identifying and supporting the needs of carers

> commissioning appropriate shared care, for example piloting the ‘year of care’ approach for patients with long-term conditions. Work on this is already under way for people with diabetes (for further information see Annex C).

**Voice**

2.4 Commissioners should empower individuals to influence services and voice their concerns, recognising that some people can find it very difficult to make their voice heard when services are inadequate, or when something goes wrong. They can do this by:

> making it easy for users and patients to provide feedback on services, including how they could be improved, and identifying perceived gaps in provision

> developing mechanisms for patients and service users, as well as the general public, to get involved in shaping commissioning priorities and services. Effective community engagement is achieved through a variety of techniques: surveys, focus groups, large group events and newer approaches, such as blogs and internet discussion groups. Commissioners should also focus on those whose voice is not often heard (such as children and young people, socially excluded people, asylum-seekers) and use a variety of engagement, equity audit or social marketing approaches to ensure that they are able to have their views and needs recognised

> ensuring that there are effective advocacy services and complaints procedures in place, sensitive to the needs of more vulnerable members of the community, is essential. They should then be supported and enabled to secure the services required to meet their individual and community needs
informing local people about their rights to challenge poor service quality and gaps in services, for example through the mechanism of petitions.

**Team Around the Child**

Walsall PCT, in partnership with Walsall Metropolitan Council, has reduced waiting times and pressure on families by implementing a single, integrated assessment procedure.

Within the Team Around the Child (TAC) system, a referral panel receives a direct referral and within three weeks, members of the panel visit the child at home to complete a detailed multi-agency initial assessment (IA). The IA details all areas of the child's development, but also focuses on the family with regard to support networks, work issues, housing, benefits, siblings, etc. TAC agree with the family what services could be put in place for the child. In the past, services have included physiotherapy, early years education, a vision-impaired service, speech and language therapy, a health visitor, NCH and social services occupational therapy. As the IA identifies needs, it is easier to prioritise services and so reduces waiting times for individual disciplines.

For example, Jake’s mum said: “The TAC system has made all the difference to Jake and our family. We now know who to contact for all our problems and get early access to a particular professional when we need to.”

**Promoting health, well-being and independence for all**

**Choice**

2.5 Commissioners should seek to empower everyone to be able to make choices that promote their health and well-being. Socially excluded people have particular difficulty in making meaningful choices, and should be specifically supported to do this. Commissioners should:

> provide accessible, relevant information on how to improve health and stay healthy, and do so in a way that promotes greater equality and social inclusion. This needs to be provided in a variety of settings and using a range of media, recognising that different people access information in different ways and are influenced by different sources of information. Social marketing approaches can make a major contribution in helping to get the right messages to the right people in the right way
> support the local implementation of programmes designed to increase all types of physical activity, promote healthy eating and sensible drinking, encourage smoking cessation and support mental well-being.

**Voice and influence**

2.6 Commissioners should enable local people to exercise greater voice and influence. They can do this by:

> learning from those local authorities which have developed innovative methods to involve their local population on a variety of local issues. Further information is available from the IDeA website (see Annex C)

> engaging with Local Involvement Networks (LINks). LINks will provide a conduit for people and communities to engage with health and social care organisations, using flexible, innovative and inclusive ways to engage people from all sections of the community, including vulnerable groups suffering inequalities in health outcomes

> supporting advocacy approaches for groups who find it harder to express their views. Third sector organisations have an important role in this area, in helping commissioners to identify and access vulnerable groups, as well as providing advocacy where appropriate

> building on work that local authorities and children’s trust arrangements have under way to ensure that Children and Young People’s Plans reflect the views and needs of younger service users

> explaining, publicly and regularly, how they draw on the views of local people to shape priorities and service improvements

> PCTs, practice based commissioners and local authorities reporting progress against locally agreed priorities and targets in ways that promote debate and dialogue with those whose needs have been assessed.

**Consultation questions**

Qu.1 Are these measures sufficient to enable people to take greater control of decisions about their health and care? What further action could central government take?

Qu.2 What special arrangements might be needed to ensure that the views are heard of those who do not routinely use local services?
Local ‘health guides’

PCTs in North East London have improved access to health and social services and reduced isolation for minority ethnic communities, by training members of the communities to be ‘health guides’.

North East London Strategic Health Authority, PCTs and the third sector organisation Social Action for Health, have worked with boroughs across London to develop a pool of local ‘health guides’ from within three existing minority ethnic communities. Health guides are trained as advisors about how systems of public service work and how to maximise benefit from them. They can signpost and teach local people how to access services to meet their needs. In community sessions, relevant information is conveyed in ‘mother tongue’ language, concerns are addressed where possible and advice is provided.

More information is available from the National Strategic Partnership Forum.
www.dh.gov.uk/AboutUs/DeliveringHealthAndSocialCare/OrganisationsThatWorkWithDH/WorkingWithStakeholders/fs/en
3. Understanding and planning for the needs of individuals and of the local population

3.1 Assessing and understanding the needs of individuals as well as of the population as a whole is integral to helping them achieve good outcomes. This allows local partners to identify common priorities (for particular groups, services and areas) and to decide how best to work together to meet those needs – whether through joint commissioning, joint provision or other approaches. It is also important to understand the impact that meeting these needs will have on demand for health and social care services. Community-wide assessments of the needs of people who will self fund or seek self-care are as important as assessing the needs of people who already use services, or who may need them in the near future. Joint needs assessment is the only firm foundation for commissioning decisions and investment: it provides a solid justification, and ensures that decisions about resource use are fair.

Where we are now

3.2 Commissioners often refer to historic service use and investment, rather than to an assessment of current and future needs of their population and the individuals (users and carers) within it. Old style ‘cost and volume’ commissioning has limitations, especially in terms of value for money. A more transformational approach, built upon joint strategic needs assessment by health and local authority commissioners, is required. This already happens in places, but not in enough, and its absence is hindering the development of agreed common investments based on specified outcomes, as well as the commissioning of integrated care. Integrated needs assessment is used increasingly for people who are identified as having complex needs; however, more could be done to target individuals or communities whose needs are unrecognised, and who may be at risk of developing substantial health and social care needs in the future.

3.3 Greater progress has been made in assessing the needs of children and young people. Children’s trust arrangements increasingly ensure that services for children, including health, are centred on the needs of
individual children and young people based on an analysis of local needs, and are jointly planned and commissioned by the children’s trust partners.

**Person-centred care – getting care right for individuals**

3.4 Individual needs assessment means working with a person to identify their care and treatment requirements and then, where appropriate, co-producing a care or treatment plan or assisting the person in directing their own care and support. This may range from advice or a single intervention to planning for longer term, more complex and ongoing needs. Aggregated, anonymised data from the record of the individual needs assessments and any associated care plans can also improve understanding of the local population’s needs and aspirations, and form part of a joint strategic needs assessment.

3.5 Improving the commissioners’ understanding of an individual’s needs can be achieved by:

- using recognised assessment and care planning processes appropriately, in partnership with current and potential users
- understanding the risks to the health and well-being of individuals and communities and mitigating them through medical, environmental, educational and social interventions and opportunities
- involving individuals and communities in the design of processes that assess individual needs, especially of those who are disadvantaged or excluded from mainstream services.

**Assessment and care planning**

3.6 Considerable progress has already been made to develop assessment and care planning processes that support proactive, co-ordinated, person-centred care provided by multi-disciplinary, cross-agency health and social care teams. This is already the norm for people with serious mental health problems – improvements to the Care Programme Approach (CPA) are currently out to consultation. For children and young people, there is already a well-developed common assessment framework which also takes account of a range of other needs, such as education.

3.7 The Single Assessment Process (SAP) for older people provides an integrated framework for assessment of health and social care needs. The implementation of SAP with shared electronic care records will support joint commissioning, by enabling commissioners to access all relevant data about care needs. Work is under way to develop a Common Assessment Framework for adults drawing on the lessons from the existing SAP.
3.8 We will publish guidance on person-centred and integrated care planning later this year to help meet our expectation that by 2008 everyone with both long-term health and social care needs will have a care plan if they want one, and our expectation that by 2010 everyone with a long-term condition will be offered a personal care plan.

Understanding and mitigating the risks to individuals’ health and well-being

3.9 Each person has a set of risk factors that make it more or less likely that they will need future support from the NHS or social services. Front-line practitioners should identify people who might be at high risk, and offer support before the risks become an established condition or vulnerability. This requires:

> the use of tools and information systems to assess individual risk, whether it is of developing a disease or of unnecessary and unplanned admission to hospital. The Quality and Outcomes Framework (QOF) already provides incentives for practices to ‘case-find’ diseases. In some areas, however, significant numbers of patients with long-term needs are still not being identified. Although QOF rewards practices for managing some of the most significant risk factors, such as smoking and hypertension, it does not yet incentivise the systematic identification and management of those at risk of developing diseases such as cardiovascular disease. However, Local Delivery Plans do cover primary care registers for the ‘at risk’ population and, from 2007/08, will also highlight the gap between QOF performance on the management of hypertension and cholesterol, and expected local prevalence – providing valuable information to help commissioners to fill that gap.
The PARR Tool and the Combined Predictive Model

The Patients At Risk of Re-hospitalisation (PARR) tool can be used to identify patients in the community who are at risk of re-hospitalisation.

The Combined Predictive Model is more broad-based and can help predict the risk of admission to hospital across an entire population. As it combines data sources, it can identify individuals along the whole continuum of risk, as opposed to just those who have already experienced a recent admission. Identifying this larger group and helping them by commissioning good disease management programmes, or support to self-care, should have a great impact on their daily lives and prevent unnecessary hospital re-admissions. For further information, see Annex C.

> at a simpler level, local authorities, PCTs and GP practices have noted that the death of a spouse can be a significant trigger for ill health and decreasing independence, especially in older people. Action to identify and follow up in those situations might include increased support, treatment for depression, or practical care in the home.

> local availability of preventative interventions, so that once an individual at risk has been identified, they can be helped to reduce their risk through help and advice with, for example, smoking cessation, falls prevention, daily activity, weight reduction, and/or more equitable prescribing (e.g. of statins). PCTs should ensure that the use of local interventions matches estimated prevalence, especially in relation to the QOF. In 2007/08, PCTs are able to use the chronic heart disease, diabetes and hypertension models on the Association of Public Health Observatories (APHO) website (see Annex C) to support local planning. This will highlight the gap between recorded and expected/actual prevalence and will help practices to ‘case-find’.
North Prospect Community School, Plymouth

Joint working between the school, the local PCT and GPs to understand the needs of the local community culminated last year with the opening of a GP surgery on the school site. There has been a significant improvement in the behaviour of pupils.

A door-to-door consultation exercise focused on identifying those health-related issues that most concerned families: smoking cessation and teenage pregnancy. There was also a problem with access to GP services, which was felt to be having a negative impact on the health of local families.

Having a GP surgery at the school allows quicker and earlier intervention when young people require support from health services. Both the school and families have benefited from quicker and more effective referrals.

Promoting health, well-being and independence for the population as a whole

Joint Strategic Needs Assessment

3.10 A good strategic needs assessment, which many areas are already doing, is based on a joint analysis of current and predicted health and well-being outcomes, an account of what people in the local community want from their services (those provided by the statutory sector and the wider market), and a view of the future, predicting and anticipating potential new or unmet need. It could include opportunities for disinvestment and resource transfer. And it should incorporate views of the local population, not just existing users of services, and include and be informed by equality impact assessments. We see the proposed new statutory Joint Strategic Needs Assessment as a critical tool to inform the development of Sustainable Community Strategies (these set out the vision for the sustainable improvement of the economic, social and environmental well-being of each area) and Local Area Agreements (the delivery agreement for the Sustainable Community Strategy).

3.11 The Joint Strategic Needs Assessment should be used to inform planning over a range of timescales – annual, medium and long-term, and be conducted by upper tier local authorities (in consultation with district authorities where appropriate). The Joint Strategic Needs Assessment will then provide a key basis for agreeing the longer-term priorities in the Sustainable Community Strategy via the Local Strategic Partnership (see paragraph 3.19 for more details of the legal duty proposed). These priorities will then flow through to the joint objectives in the Local Area Agreement and Children and Young People’s Plans. For
PCTs these joint objectives will become part of the broader health agenda on which they are held to account by their Strategic Health Authority.

3.12 Strategic needs assessments should help to answer the following questions about the current situation:
But also more importantly about the future:

3.13 It is crucial that there is a strong focus on neighbourhoods and groups of people who are getting a raw deal. People at high risk of future illness or disability and people with the lowest levels of well-being often have poor access to services and may have poorly developed advocacy skills. Segmentation and mapping of need can make an important contribution to identifying localities or groups of people that have high levels of serious illness, poor diet, or where there is a risk of these in future. Improving health outcomes over the longer term also requires a particular focus on children and young people now.

3.14 Good strategic needs assessments should include an analysis of the current and future wider determinants of health such as physical activity and access to green open spaces, local air quality, fuel poverty and access to fruit and vegetables – all of which impact on the health and well-being of individuals.

3.15 It should also take account of those groups or individuals for whom special arrangements may be necessary, such as those in prisons or hostels. This will necessitate sharing work and information with a wider group of partners, including the police, offender management services and the courts.

3.16 For children and young people, commissioners should use the Joint planning and commissioning framework for children, young people and maternity services (see Annex C) to help provide a clear and comprehensive picture of what they need, and then join up services so they provide better outcomes than they could on their own.

3.17 The Care Services Efficiency Delivery (CSED) programme is developing a database forecasting system that can be accessed via the internet. This will provide local commissioners with population projections to district level with characteristics and prevalence assumptions from research. It will also include care services data returns with national
comparators and thus offer a consistent, easily accessed view of centrally available data as a starting point for needs assessment. For further information, (see Annex C).

3.18 Outputs from the strategic needs assessment will help commissioners to prepare to tackle health inequalities and to commission for equity. Tools such as the APHO’s Inequalities Intervention Tool allow local authorities and PCTs to take an evidence-based approach to achieving specific inequalities reductions (see Annex C).

3.19 We are proposing to establish a duty on PCTs and local authorities to produce a Joint Strategic Needs Assessment. We are consulting on a proposed minimum data set and list of stakeholders who should be given the opportunity to be involved (see Annex A), and we would welcome views on these. We expect all local commissioners to undertake joint strategic needs assessments as a matter of good practice. We expect PCTs and local authorities to do so in a way that is in line with the proposed duty and that, at the least, meets the minimum requirements of, and is in line with, the principles we set out following the consultation on this framework (the draft requirements are set out in Annex A).

3.20 PCT Directors of Commissioning should work together with the Director of Public Health, the Director of Adult Social Services and the Director of Children’s Services to manage this process across commissioner and provider organisations in order to collate and pool knowledge. This should then be fed into the Local Area Agreement, or (where this is not suitable) other processes should be used to ensure that the Joint Strategic Needs Assessment has an impact on commissioner priorities and actions. Practice based commissioners will have an important role in informing the PCT perspective. Consequent commissioning strategies and planning cycles should also describe how success will be measured and reported back to those whose needs have been assessed.

3.21 We are proposing that Joint Strategic Needs Assessments should be made available to current or potential providers, who may have additional relevant information or innovative proposals for meeting needs. Strategic Health Authorities and Government Offices will have a key role to play in helping to build the capability to undertake such assessments, including sharing scarce analytical and support skills, and providing appropriate leadership and support.

**Using appropriate analytical techniques**

3.22 Health and social care commissioners can benefit from analytical techniques used in other industries (e.g. actuarial forecasting, market segmentation and cost-benefit analysis) to refine predictions and identify those communities which have, or are likely to develop, significant health problems. Use of the Combined Predictive Model (see paragraph 3.9)
will also help. These techniques can require skills not readily available in every local authority and PCT, so commissioners may wish to buy in expertise, or pool their resources in order to train staff who can then share expertise between several commissioners.

3.23 The Department of Health is making a variety of analytical tools available to support commissioners in assessing the demand for services and how this can be met (see Annex C for details).

Consultation questions

Qu.3 Will the approach set out here and in the supporting Annex A help commissioners to undertake (a) an assessment of an individual’s needs, (b) an assessment of the needs of particular groups or communities and (c) Joint Strategic Needs Assessments?

Qu.4 How can we shape the duty of Joint Strategic Needs Assessment to have the greatest impact on health and well-being?

Qu.5 Will this approach be suitable for children and young people, for whom services are commissioned through children’s trust arrangements?

Action Diabetes

Slough PCT has developed a scheme to take early testing services for diabetes directly to their ‘at-risk’ population, to help avoid costly hospital admissions.

They used a health needs mapping tool to identify postcodes that had a 49% higher-than-average risk of diabetes. Focus groups were carried out among the most at-risk group in the community to provide an understanding of the experience of contracting diabetes and the related emotional issues.

Because the at-risk areas were a long way from the diabetes clinic, the PCT needed a way to take specialists to the people at risk. The solution was a double-decker bus for the nursing team, who were then able to test over 2,000 people close to their homes.

More information on Action Diabetes is available at: www.drfoster.co.uk
4. Sharing and using information more effectively

4.1 Commissioners can be more effective in delivering integrated care when they pool relevant information and analysis. We expect commissioners to work flexibly and innovatively, to do what is necessary to share information, taking proper account of confidentiality. This may include identifying information held by other organisations (including providers) that would be useful in commissioning care, as well as sharing information between local commissioners as appropriate.

Where we are now

4.2 Commissioners do not necessarily share between them information that could help improve outcomes for individuals or the population as a whole, and there is often a lack of understanding about what is legally permissible. We need to work towards an environment of trust and partnership, which gives people reassurance that the confidential nature of information will be respected while enabling commissioners to make appropriate use of it for them and the wider public interest within existing legal and ethical constraints.

Person-centred care – getting care right for individuals

4.3 Improving the use of information at individual level can be achieved by:

> clarifying what information can be shared, and in what circumstances
> joining up the IT systems of front-line practitioners
> consolidating informatics, analytical skills and capability across public sector partners.

Clarification of the legal requirements

4.4 The effective sharing of appropriate information about individuals is crucial to more integrated commissioning and care, but it is also a complex challenge. The role of the Patient Information Advisory Group and local Caldicott Guardians are important in this context and the
recently announced National Information Governance Board will strengthen arrangements.

4.5 Many local organisations have indicated that they find it difficult to know what information they are allowed to share about individuals and for what purposes. Generally it is understood that information can be shared with the explicit consent of the individual concerned or where there is a statutory requirement to share but, in the absence of these, organisations are often uncertain. In such circumstances, the NHS Confidentiality Code of Practice makes it clear that an overriding public interest is required or approval under Section 60 of the Health and Social Care Act 2001. The NHS Care Record Guarantee also commits to using information about an individual’s health care, to improve services or to support research, in a way that doesn't reveal their identity.

4.6 Some interpretations of the Data Protection Act have led to it being wrongly seen as a barrier to information sharing, whereas in reality it provides a vehicle for ensuring that sharing meets appropriate standards. Where health information is used for commissioning purposes however, the common law of confidentiality will also need to be satisfied.

4.7 Guidance on data sharing has been produced by a number of government departments (for further information see Annex C). The NHS Confidentiality Code of Practice explains the differing constraints on confidential data, non-confidential personal data and anonymised data, and advises that anonymised data sets should be used for commissioning (see Annex C). However, it may be helpful to provide specific additional guidance to support the commissioning process. The Department of Health is consulting on whether commissioners would find it helpful if the Department worked with other government departments and key stakeholders to develop a set of common principles to help underpin local agreements, building on the requirements set out in paragraph 4.5 above. These could draw on the experiences of children’s services, especially in child protection, and of mental health services and adult abuse procedures, to share information effectively to develop more joined-up services.

Joining up the IT systems of local front-line practitioners

4.8 The White Paper Our health, our care, our say has set objectives for integrated health and social care records by 2010 and, while this is a challenging target, some useful initial work has been done. NHS Connecting for Health has established an electronic social care record board (ESCRB) with responsibility for overseeing national implementation of the electronic social care record, ensuring consistency of its implementation by local authorities with social services responsibilities and integration with other information systems. The
board is overseeing a number of national initiatives to support local action. A scoping study of closer integration between health and social care systems, covering all client groups, is due to be completed by May 2007. This will address issues about information sharing between health and social care and will take account of the recently published NHS Care Record Guarantee, which emphasises the rights of individuals to consent to information about them being shared. This study is also looking into how the technical architecture recommended in the SAP project can be implemented.

4.9 In the near term, however, commissioners should work with their providers to develop appropriate local methods of ensuring that information about individuals is shared where this has a clear basis of patient consent and will lead to better outcomes. Encouraging joint working between health and social services staff and a sensible and pragmatic approach to the governance that supports information sharing should lead to improvements.

4.10 The information sharing index ‘Contact Point’ (see Annex C) will support the sharing of contact details among practitioners working with children to allow them to share information between them, based on their clinical judgement to deliver more integrated support.
Durham IT

With the consent of those involved, Durham County Council has developed a single assessment system to provide seamless care to the elderly and people with physical disabilities across Durham.

The computer system means that district nurses visiting clients in their homes do not have to ask clients the same questions twice. Social workers can check that patients leaving hospital receive the aftercare they need, such as bandages or removal of stitches.

Social work assistant Jane Hughes says: “I was called to see a lady with complex needs and I noticed she had mobility problems. I was able to flag this via the computer system so the nurse, who goes more regularly, could check the lady’s foot care, which turned out to be the source of the problem. The IT system helps us break down role barriers and put the users first.”

Promoting health, well-being and independence for the population

4.11 Improving the sharing and use of data at population level can be achieved by:

> sharing data sets and population level information
> joining up the IT systems of local commissioners
> encouraging individuals and communities, including the third sector and voluntary and community organisations, to work together to produce and use good quality information.

Shared data sets and population level information

4.12 Commissioners should work together to identify the data sets and information infrastructure required to support effective commissioning, and help current and potential service providers understand the contribution they can make to outcomes and to improving the services they deliver.

4.13 Sharing information or data at population or group level is acceptable if this information is sufficiently anonymised to prevent the identification of individuals. (This usually means information grouped in a pool of at least 10.) However, it is important to ensure that individuals cannot be identified using another source of data accessible by a third party.
4.14 Much of the nationally collected data on health, healthcare and social care is freely available. Annex A contains a minimum dataset for Joint Strategic Needs Assessment, for consultation. Commissioners should use these sources as a minimum when undertaking their Joint Strategic Needs Assessments.

4.15 The use of data collected at service user level from operational systems, can be regarded as secondary uses of that data. Additional guidance on the secondary uses of health and social care data will be provided by the Care Record Development Board in the near future, following a report from a working group on this subject.

4.16 The Secondary Uses Service (SUS), being developed by NHS Connecting For Health and the Information Centre for health and social care, is the national source for patient level datasets of healthcare activity. SUS will also provide, in the near future, indicators on the commissioning of health services down to practice level.

**Joining up the IT systems of local commissioners**

4.17 Alignment of information systems used to gather local information is important to support the Joint Strategic Needs Assessment. This can be done at aggregate level by bringing together summary statistics for neighbourhoods, using available information from the full range of local services, the neighbourhood statistics service, local survey data or data from local general practices.

4.18 SUS will, as it develops, provide support for this for NHS commissioners in terms of data, indicators, tools and facilities, such as pseudonymisation and record linkage.

4.19 It is also possible to set up databases linked at the level of households (see Annex C). These databases can draw data from multiple agencies such as police, social services and health. Although this does not require new, expensive IT infrastructure or software, it must be done in a secure environment. Considerable leadership effort may be needed locally to secure the necessary permissions and good will to share identifiable data in this way within the principles set out in paragraph 4.5. However, the benefits are considerable in providing a clearer view of health needs and determinants, and in supporting combined approaches to addressing them. We expect Directors of Public Health to lead this work jointly with Directors of Adult Social Services and Directors of Children’s Services and ensure it provides data that is fit for purpose. Further guidance is being developed as part of the Department’s Informing Healthier Choices strategy.
Get Fit, Avoid Falls

Bucks South PCT has used statistical information effectively to improve health and well-being, and save money, by investing in falls prevention services. Initial data shows that A&E attendance for falls has reduced.

Bucks South PCT worked with Bucks County Council Social Care and a local leisure organisation to provide Get Fit, Avoid Falls – an education and exercise programme with strength and balance training. Get Fit, Avoid Falls is positively evaluated in terms of patient satisfaction, and a range of tests also indicates substantial physical outcomes.

Evidence shows that various falls prevention initiatives can reduce falls by 15–30%. It costs the health service more than £12,000 to treat each broken hip, and there are huge personal and social care costs as well. Each hip fracture results in more than eight extra consultations with a GP in the year following the injury. Hip fracture patients occupy more than one in five orthopaedic beds.

More information is available at: www.buckinghamshirefallsprevention.co.uk

Consultation questions

Qu.6 Are the main information requirements for effective commissioning identified here? Are there any obstacles or gaps that need to be addressed?

Qu.7 Is the legal position with regard to information and data sharing for the purposes of commissioning clearly set out here? Is there any need to review the current rules (including primary and secondary legislation, audit processes, etc.) in order to facilitate information and data sharing?

Qu.8 Are there any specific issues around sharing information on children and young people that should be addressed at national level?

Qu.9 Would it be helpful for the Department of Health to work with other government departments and national stakeholders to develop a set of common principles to help underpin local agreements?
5. Assuring high quality providers for all services

5.1 Our vision is for a wider range of more innovative providers that work with commissioners to offer services better tailored to the changing needs of individuals and make a reality our commitment to shift care closer to home and towards a greater emphasis on prevention and early intervention. Commissioners have a key role to play in shaping the market through dialogue and procurement to stimulate providers to produce innovative solutions and create an environment where these can be sustained. This includes more strategic, earlier discussion with provider communities about need (e.g. by making available the Joint Strategic Needs Assessment and the Prospectus), transparent fair procurement, and introducing or increasing contestability by addressing potential barriers to entry. We also believe it essential, and entirely consistent with good procurement practice, for commissioners to develop effective and strong partnerships with current and potential providers.

Where we are now

5.2 Commissioners can find that existing providers are unwilling or unable to provide appropriate and innovative services. Providers may feel that their scope to innovate is restricted by overly prescriptive approaches to commissioning, focused on inputs. Traditionally, health commissioners have been wary of using community and voluntary groups to deliver services. Potential new providers, particularly third sector providers, may find it difficult to enter new areas without active support because the barriers to entry may be too high. Grants and contracts are often conflated, resulting in issues about full cost recovery.

5.3 These issues were highlighted during 2006 in the recommendations of the Department of Health’s Third Sector Commissioning Task Force (see Annex C). Reinforcing this, a report published in August 2006 by the Department for Education and Skills on markets for children’s services and a recent review published by the Department for Communities and Local Government concluded that a key gap in developing the local government services market was the need for a more proactive approach to market shaping and development by both commissioners and central government (for further information, see Annex C). We believe that this is equally true of health services.
Person-centred care – getting care right for individuals

5.4 Systematic involvement of service users in assessing need and designing services will be crucial in developing innovative and responsive services and self-directed care. Certain types of organisation (e.g. some community-based third sector providers and user-led organisations) may be more effective at advocacy and engagement (thereby informing needs assessment) and providing responsive personalised services. Commissioners need to be proactive in engaging such providers in needs assessment, as well as in developing the right providers to serve their communities best.

Weight management support

Dudley PCT has developed a scheme to help its population access high quality weight loss programmes.

The Obesity Strategy and the Weight Management Pathway were developed via a multi-agency group made up of key organisations within the local health economy. A contract has been set up with Weight Watchers UK to deliver a 12-week programme of community-based group weight management support. Referrals will be available across primary care via GPs and Allied Health Professionals.

A monitoring and evaluation framework has been established which includes the monitoring of weight loss in relation to 5% and 10% initial body weight targets.

More information is available at: www.dudley.nhs.uk

Promoting health, well-being and independence for the population through high quality provision

5.5 Commissioners are more likely to secure cost-effective high quality provision if they:
> commission for outcomes and outputs. This means judging success by the tangible benefits achieved by the people that services are designed to serve. That means moving away from counting services given (treatment episodes, prescriptions) to counting outcomes achieved (back in work, significant weight loss). For people with diabetes this would mean commissioning for both improvement in key output indicators (e.g. reduction in BMI, participation in physical activity, reduction in blood glucose levels) and outcomes such as a reduction in the proportion of the population who, having been diagnosed, subsequently develop adverse outcomes or complications of diabetes. This has to be the right way forward, but we recognise that it will take time. It will require changes in financial and auditing systems to provide greater flexibility, and systems of care management and assessment which enable people at individual level to consider and express the outcomes they wish to gain.

> involve current and potential providers (including the voluntary and community sector) appropriately in needs assessment (at both population and individual level) and in how to address need. Joint Strategic Needs Assessments should be made available to the provider community, and the PCT Prospectus and Local Area Agreement used to clearly signal commissioners’ strategic intentions and priorities.

> engage the provider community constructively and transparently about priorities and issues for market shaping and development. All commissioners should establish a local provider forum to support this.

> develop better market intelligence and greater understanding of the role of all providers, including the third sector and user-led organisations and, within those, small providers, and how best to commission from them – see A Guide on how to commission from third sector organisations, Third Sector Market Mapping and Compact on relations between government and the voluntary and community sector (VCS) in England (see Annex C). The SHAPE (Strategic Health Asset Planning and Evaluation) tool can also be used to inform and support the strategic planning of services and physical assets across a whole health economy (see Annex C).

> provide easily accessible information and guidance, to help people – whether self-funded or state funded – choose between providers. This could be done through recognised community information channels such as public libraries.

> following needs assessment, systematically review the range of providers available to meet the needs of the community and consider how best to incentivise providers to improve their services or meet gaps in provision.

> build a market and develop enough opportunities for different providers to ensure genuine choices for users.
> adopt procurement practices that are fair and open – meaning neutral between different types of providers and transparent on pricing – minimising transaction costs and allowing providers to frame realistic economic tenders. We believe this is the most straightforward way to deal with the issue of ‘full cost recovery’

> are clear about the distinction between grants and legally binding contracts, and the role each has to play in service and market development

> adopt appropriate and proportionate contractual mechanisms

---

**Mushkil Aasaan**

Wandsworth Borough Council ensures it meets the needs of the entire population, including Muslim women, by commissioning a range of services from Mushkil Aasaan through a mix of block funding and spot purchasing.

About 10 years ago, the council realised that different parts of their population wanted their needs met in different ways. Mushkil Aasaan is one of a number of organisations that the council encouraged and supported to develop the services that were needed. It was set up by a group of Asian women who got together to help each other cope, in what was for them an unfamiliar environment. Mushkil Aasaan provides services for Asian families in crisis or need. These include crisis intervention, advocacy, counselling, and family and child care support. It is now an approved provider for Home Care Services in Wandsworth, which include personal care, household tasks and emotional support for older and disabled people and their carers, children and families. Terminal illness support and bereavement counselling is offered, and Islamic burials. All services are provided with appropriate language support.


---

> actively encourage a strong provider market, based on a diverse supply community from all sectors. Encourage entry by new participants and growth from under-developed sources of supply, including social enterprises and the third sector. Health reform in England: update and commissioning framework – annex: the commissioning framework (paragraphs 2.20 to 2.24, 3.19) sets out a range of steps to facilitate this (see Annex C). These include using additional incentives to make the provision of new services more attractive to existing providers or new entrants by:
– paying a supplement to the tariff, only where this is necessary to secure new provision and meets the criteria set out in Health reform in England: update and commissioning framework – annex: the commissioning framework (paragraphs 2.19 to 2.27)
– providing guarantees within the contract
– reducing the capital investment required from the provider
– for suitable primary care providers, considering providing pump-priming loans to start up a service (subject to affordability).

5.6 Other important considerations in commissioning from a wider range of providers are likely to be contract length, enshrining the principles of ‘fair and reasonable trading’ and the proportionate assignment of risk between commissioner and provider. Both may vary by market segment. Providers will be expected to demonstrate that their work does not worsen health inequalities, and that they will support the socially excluded. Commissioners may also wish to take into account any ‘social dividend’ when considering bids from providers.

5.7 The Department will facilitate this by:
> developing and consulting on a contract template for out-of-hospital services for use from 2008/09. The contract(s) will implement relevant recommendations from the Third Sector Commissioning Task Force to help lower barriers to entry, including contract length. This will build on the Task Force’s work on a ‘model contract’
> working with other government departments and the Office of the Third Sector to align, over time, approaches to commissioning
> collaborating with the Office of the Third Sector in commissioner development programmes designed to raise awareness of issues relating to market entry and third sector provision
> ‘unbundling’ appropriate NHS tariffs, or developing local tariffs, where this will support changes in care pathways and makes sense locally. In time, such local tariffs may form the basis of a future national tariff (see Annex C)
> introducing, subject to legislation, a requirement that both public and private providers of health and social care are registered by the new health and social care regulator as safe and fit for purpose.

Consultation questions

Qu.10 Will these proposals support commissioners to assure a range of high quality providers for all services?
Qu.11 Should the Department develop one contract template for out-of-hospital services (except GMS and PMS) or one for each of the main service segments (e.g. mental health, long-term conditions, etc.)?

**Bromley by Bow children’s centre**

The Bromley by Bow children’s centre is allowing integrated working in Tower Hamlets by offering a range of services in one place based around the needs of children and families.

The centre offers a range of activities broadly grouped around enterprise, education, environment, health and the arts. There is a GP surgery based in the centre with a list of over 5,000 patients. Patients attending appointments are also exposed to a diverse range of opportunities, such as an IT facility with free public access and scheduled lessons, courses ranging from basic skills to higher education diplomas, and arts activities for babies, young children, young people and adults. The children’s centre staff and health teams can easily attend each other’s meetings and also, where appropriate, attend some home visits to families together.

More information is available at: [www.bbbc.org.uk](http://www.bbbc.org.uk)
6. Recognising the interdependence between work, health and well-being

6.1 Work matters: it can help improve health, reduce health inequalities, improve social inclusion and offer individuals improved opportunities. Health, work and well-being - Caring for our future (see Annex C) sets out a clear vision for improving the health and well-being of people in employment. Commissioners, working through Local Strategic Partnerships and directly with providers, have a key role to play in helping to deliver that vision.

Where we are now

6.2 Good work is already going on in some organisations to support and improve employee health and well-being (more information is available from Investors in People – see Annex C), but there needs to be effective co-ordination of all key stakeholders and better support for individuals to protect and improve their own health. The challenge is considerable: absence due to sickness costs the economy an estimated £12.7 billion each year. Sickness absence rates in the health and social care workforce are the highest of all sectors at 4.1% (the UK average is 3.1%). The NHS Institute for Innovation and Improvement’s report Delivering quality and value: focus on productivity and efficiency states that sickness absence costs can cost an average Trust £5.4 million per annum. It can also place an additional workload on staff.

6.3 Delays in accessing diagnosis and treatment, or poor co-ordination with employers and, for example, Jobcentre Plus services, can increase the likelihood of loss of work, or lengthened sickness absence.

6.4 There are three main ways in which health and social care organisations can have a positive impact on the health and well-being of people in employment:

> by delivering services that improve health and well-being, and so support people to remain in, or get back to, work
as employers, by recruiting from the communities they serve and helping individuals who have manageable health problems associated with ageing, long-term conditions or a disability to maintain or regain work. This can also benefit employers by improving the quality and efficiency of the services provided. In the late 1990s the Department of Health encouraged NHS organisations to provide occupational health services to staff. Employers were also encouraged to offer re-deployment opportunities to staff unable to do their own jobs through ill health. The number of ill health retirement pensions awarded to NHS staff each year fell from 5,098 in 2000 to 3,137 in 2005, a decrease of around 40%. Early access to physiotherapy and other services may bring some benefits to a wider population.

by using the power of commissioning to influence the health and well-being of people employed by local health and social care providers.

For those who are not in or who are unable to gain paid employment, support to enable involvement with their community, e.g. volunteering, can provide benefits to people’s health and well-being.

Carers make a major contribution to supporting individuals; they also need support to help maintain their health and well-being.

**Person-centred care and support – helping individuals to improve their well-being through employment**

Commissioners can make a significant contribution to helping people to retain, gain or return to employment. They can do this by:

- redesigning local health service delivery for people in employment to ensure speedy access to investigation, diagnosis and treatment. For example, providing GPs with rapid access to back-up occupational health advice and increasing the availability of physiotherapy and psychological therapy services can help reduce the length of sickness absence and the potential for job loss

- ensuring there is effective local collaboration between health services (especially in primary care) and agencies supporting employment, e.g. Jobcentre Plus and other employment services and the Department for Work and Pensions Pathway to Work Programme, helping GPs in supporting patients experiencing long-term sickness to return to the workplace

- working with small and medium-sized businesses to improve the availability of occupational health services, including advice and support provided to individuals experiencing illness or injury
> encouraging service providers to recruit locally and provide structured opportunities for individuals who have experienced long-term illness or disability to regain work. Other things being equal, commissioners should give preference to providers (including ‘social firms’) who are willing to accept their broader community responsibilities (for further information see Annex C). Local authority commissioners may be able to influence local employers to adopt similar initiatives

> encouraging and facilitating volunteering

> raising expectations of local employers to be supportive of people with caring responsibilities, e.g. by encouraging more flexible work options

> encouraging providers to distribute health and well-being information through community resources such as public libraries.

---

**Improving Access to Psychological Therapies**

Doncaster PCT and Newham PCT have improved the health and well-being of people suffering from anxiety and depression, and helped them stay in or return to work, through the Improving Access to Psychological Therapies (IAPT) project.

IAPT provides evidence-based psychological therapies in primary and other community settings for adults of working age suffering from anxiety and depression. Employment support and advice is also available.

Mrs Patel, a service user at the Newham site, said: “I joined the service in August, when I thought I’d never work again. The therapist really helped me with my thinking and the practical help that I got from employment support means I start work this week.” In January, Mrs Patel successfully returned to work as a school secretary.

More information is available at: [www.mhchoice.csip.org.uk](http://www.mhchoice.csip.org.uk)
Promoting health and well-being for all people in employment

6.8 Commissioners working through Local Strategic Partnerships should actively promote the health and well-being of all people in employment. They can do this by:

> encouraging and incentivising all providers of state-funded care, through contracts, to actively support and promote the health and well-being of their employees. An appropriate benchmark could be implementation of the relevant recommendations of Health, work and well-being - Caring for our future; a key metric could be sickness absence rates in state-funded provider organisations

> encouraging all local employers to use workplaces as settings for health improvement. Circumstances and needs will vary, but opportunities for health improvement include accessible and responsive occupational health services that help individuals to manage their own health, facilitate early diagnosis and treatment and provide effective return-to-work support. Health-promoting programmes, focusing for example on smoking cessation, reduction of excessive drinking, physical activity and healthy food choices can make a significant contribution to health and well-being. With employers’ active support, workplaces may also provide appropriate settings for targeted programmes (such as the NHS 'Life Check') designed to help individuals assess lifestyle-associated health risks

> working effectively with Strategic Health Authorities, Government Offices and Regional Development Agencies to ensure that health and well-being issues are taken into account when decisions about broader economic development are made

> encouraging community groups, such as those for young or older people or black and minority ethnic groups, and carer support groups or networks, to become involved in health promoting programmes.

Consultation question

Qu.12 Are there sufficient levers and incentives for commissioners and employers to improve health and well-being?
Parcelforce Worldwide

By following a business plan to improve workforce health and well-being, Parcelforce Worldwide have reduced staff absence by a third, reduced the number of accidents happening at work and increased employee satisfaction.

This included raising the awareness of health and well-being and providing new management information, enabling local managers to make decisions on how to take the programme forward. Head office provided the appropriate incentives and support, which included on-site health screening clinics, a 24/7 health and well-being contact centre, two days annual health and well-being training for every manager, and health education programmes covering stress, smoking and nutrition delivered personally by the managers.

In addition to reduced absence and accidents and increased employee satisfaction, numbers and values of compensation claims were reduced, and there was a 12.5% productivity gain and a 50% customer service improvement. Overall, Parcelforce estimate savings of £6 million in direct costs through an investment of £2.25 million.

More information is available on the Business in the Community website at: www.bitc.org.uk
7. Developing incentives for commissioning for health and well-being

7.1 We want commissioners to work together to deliver better health and well-being outcomes for their populations. They need appropriate financial and other incentives to help achieve this. We also believe that greater alignment of accountability mechanisms should form an important part of an incentive framework, creating both greater transparency and strong drivers to collaborate. Many of the vehicles for doing this (e.g. the PCT Prospectus, greater user and community engagement, etc.) have been set out earlier (see paragraphs 2.3–2.6). This section therefore focuses principally on financial and contractual incentives. Issues relating specifically to accountability are addressed in the next chapter, ‘Making it happen – local accountability’.

Where we are now

7.2 Commissioners often work separately, leading to inefficiencies, gaps and overlaps, and increase the potential for conflict. Accountability for delivering agreed outcomes is not always clear, and even where there is clarity, incentives to deliver these outcomes may be weak.

7.3 Planning, contracting and financial structures focus on services rather than outcomes, and often make integrated working harder; resources rarely shift between different services as people move or earlier intervention reduces downstream demand.

Person-centred care – getting care right for individuals

7.4 Delivering services that are better integrated around the needs of individuals can be achieved through:

> enabling people (including young people) to tailor their own care package through individual budget pilots, direct payments, year of care pilots, etc. (see paragraph 2.3)
> PCTs and practice based commissioners spending NHS funds on non-health interventions and supporting better self-care
> agreement of personalised joint health and social care plans
> establishment of multi-disciplinary teams across health and social care.

**Flexible use of NHS resources through practice based commissioning**

7.5 Practice based commissioners are well placed to make referrals for interventions that support self-care and continued independence. This can be undertaken as part of a care package for patients who have been objectively assessed to be at high risk of needing NHS services, or where there would be a clear improvement in their health. Preventative measures, such as installing grab rails in the homes of older people who are at significant risk of falling, can have a positive impact on independence, health and well-being. It reduces the risk of pain and discomfort, as well as making good sense financially. We have been told that uncertainty as to how ‘health funding’ may be used can get in the way of such ‘common sense’ solutions.

7.6 We would therefore encourage PCTs and practice based commissioners to be more flexible in using NHS funds, where by doing so they can:

> provide a more appropriate alternative to hospital admission, for example by providing carer support or a ‘sitter service’, or

> avoid more expensive interventions which may also reduce independence, for example action to reduce a person’s risk of becoming unwell (such as supporting weight reduction, greater activity, etc.).

7.7 The legal position regarding using NHS funds in this way is set out at Annex C. The following specific examples illustrate what the Department considers to be reasonable flexibility in the use of NHS funds by PCTs and practice based commissioners. We would, however, welcome suggestions or proposed additions to these.
Commissioning framework for health and well-being

- **Purchase of respite care** – This allows carers to take a break, particularly families of children with a disability, or when patients with a terminal illness need more intensive nursing for a fixed period of time. This significantly reduces unnecessary hospice and acute hospital admissions.

- **Supporting carers of terminally ill patients so that people with a terminal illness can choose to stay and die at home.**

- **Crisis avoidance and intervention** – This could include urgent aids or adaptations such as installing grab rails for people at risk of falls.

- **Supporting healthy lifestyles** – Provision of dietary advice and access to weight reduction and exercise programmes through GP practices.

- **Supporting greater independence for people with long-term conditions** – This could include provision of self-monitoring equipment (e.g. to measure blood pressure) and self-care educational programmes.

- **Provision of Citizens Advice, other advocacy and return to work advisor sessions at practices** – Patients with situational disturbance often seek medical advice, and sometimes inappropriately receive medical treatment, when their need is through social interventions.

- **Support to parents** – This could include initiatives such as the Community Mothers programme, which uses trained volunteers with mothering experience to support local parents. Parents with poor parenting skills are likely to raise children who have a significantly higher call on medical services both in childhood and later life.

- **Developing practice-based multi-disciplinary mental health resources** – The quality of care for people with mental health problems can be made much better – and out-patient attendances and re-admission rates reduced – by having occupational therapists, community psychiatric nurses, approved social workers, and other services such as pharmacy, clinical psychology and counselling available at the practice.

- **Purchase of anger management support for children and young people** – This helps prevent situations arising of self-harm or harm to others which would otherwise require medical treatment and so reduces calls on practice-based or acute health services.

- **Developing social and practical support for isolated older people** – There may be substantial benefits from building community capacity to support isolated older people to maintain their independence.
7.8 Where practice based commissioners are unsure as to whether a particular non-health intervention is appropriate, or wish to go beyond the above flexibilities, they should seek advice from their PCT.

7.9 If practice based commissioners wish to pursue such flexibilities, they should submit a business case to the PCT for a decision, in line with current PBC guidance (Practice based commissioning: practical implementation, Department of Health 2006). Such business cases should clearly demonstrate how the proposed use of funding would benefit the NHS and individual patients.

7.10 Practice based commissioners can play a key role in shaping services to better address the unmet needs of population groups that have been significantly under-served in the past (as identified through the strategic needs assessment). For these groups in particular, PCTs should actively encourage practice based commissioners, through favourable consideration of business cases, to experiment with new models of care and explore more innovative use of funds.

7.11 In deciding such matters, PCTs should regard the prime consideration as being whether the proposed use of such funds would:

- be consistent with the legal requirements regarding the use of NHS funds (see Annex C)
- be of demonstrable benefit to the NHS and better value for money (both in terms of health improvement and promoting equality)
- not breach acceptable procurement practice
- not create any liability or problems in relation to non-NHS services which are means-tested
- not exacerbate healthcare inequalities.

7.12 PCTs would clearly need to seek the views of local authority partners in reviewing such proposals to ensure there is an appropriate fit with the overall local commissioning strategy. One option may be for PCTs to procure, potentially with local authority partners, appropriate ‘call-off’ service contracts or grants.

7.13 The legal position is as follows: it is not normally reasonable for PCTs, and therefore practice based commissioners, to use NHS funds and resources on community care services that fall within the legal remit of local authorities. Such community care services are defined in Section 46(3) of the NHS and Community Care Act 1990 and include the provision of residential accommodation and domiciliary care services. However, PCTs (and therefore practice based commissioners) can spend money in this way where they are satisfied that the provision of
such services is necessary to meet a health need, or where the PCT has entered into a formal partnership arrangement with a local authority under Section 31 of the Health Act 1999. This agreement allows the NHS and local authorities to pool resources and work together as a single entity, providing both NHS and health-related local authority services.

Creating local financial incentives

7.14 Commissioning organisations can create local financial incentives to encourage early action for those at risk and the development of person-centred care. These could include local Quality and Outcomes Frameworks or other local incentive schemes for front-line teams in health and social care. Local authorities already have the power to establish such schemes, if they believe they are appropriate and will improve local services.

7.15 In response to Department of Health guidance on practice based commissioning, PCTs are developing local incentive schemes for practice based commissioners to incentivise them to achieve agreed commissioning objectives. Any payments are dependent on practices not overspending their indicative budget. This will incentivise practices to explore clinically appropriate preventative measures and care packages to reduce the likelihood of high-risk patients requiring more expensive treatments at a later date. We expect all PBC incentive schemes in 2008/09 to include incentivising practice based commissioners to reduce people’s lifestyle risks.

East Riding Council

East Riding Council and the PCT have reduced waiting lists for child and adolescent mental health services, and saved headteachers’ time, by using a pooled budget to support integrated working between schools, health services and social services.

The appointment of primary mental health workers has reduced waiting lists and improved the quality of referrals. Providing access to health services through schools has helped to ‘de-medicalise’ the services and improve accessibility. A move towards early information, support and intervention through locality-based commissioning has reduced the number of referrals to social care services and almost halved the number of re-registrations on the Child Protection Register.

More information is available at: www.eastriding.gov.uk
Promoting health and well-being for all

7.16 Commissioners can incentivise the promotion of health, well-being, dignity and independence for all. They can do this by:

> creating an investment vehicle for delivering the vision. Experience shows that pooled budgets – especially budgets with one lead commissioner, rather than a committee structure – can be very effective in delivering joined-up services for populations. However, pooled budget arrangements often create multiple audit requirements, despite legislation that enables one audit arrangement for pooled budgets which is valid for the auditors of all the organisations involved (see Annex C for specific legislation). We would welcome any other suggestions as to how pooled budget arrangements could be made more effective

> using contracts and putting in place a contractual regime (including national contract templates) that encourages providers to incorporate a health and well-being element in all that they do, to deliver health, well-being and independence. Local commissioners should use contracts to improve the health and well-being of the wider population, especially those who are directly employed by partners and commissioned providers. For example, commissioners may choose to award preferred status, or pay a premium to providers that deliver continuous quality improvement as shown by improving outcomes for service users and that contribute to reducing social exclusion. This might be, for example by taking part in ‘back to work’ schemes that help people with mental health problems enter paid employment. Contracts can also be used to improve access, ensure that equality legislation is implemented and promote the well-being of employees. The Department is developing a national contract template for out-of-hospital services to give practical effect to this type of approach (see paragraph 5.6).

Consultation questions

Qu.13 What practical, legal and financial issues need to be considered in enabling PCTs and practice based commissioners to spend effectively on non-health interventions?

Qu.14 What further changes would make it easier for resources to follow individual service users?

Qu.15 What considerations do you see in increasing the use of single audit arrangements for pooled budgets?
Qu.16 How can we ensure that practice based commissioning and children’s trust arrangements work effectively together to improve outcomes for children?

<table>
<thead>
<tr>
<th>Reducing delayed discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Kent PCT has reduced delayed discharges from 50 per week to 4 per week.</td>
</tr>
<tr>
<td>Healthcare assistants in Livingstone Community Hospital were skilled up to enable nurses to extend their practice and specialise in areas such as nutrition, falls, and pain control. This was complemented by the introduction of a team of therapists, pharmacists, social workers, and a local GP specialising in geriatric medicine. Teams focus on early transfer from A&amp;E and, where appropriate, on supporting patients in their own homes.</td>
</tr>
<tr>
<td>More information is available at: <a href="http://www.kentandmedway.nhs.uk">www.kentandmedway.nhs.uk</a></td>
</tr>
</tbody>
</table>
8. Making it happen – local accountability

8.1 We believe that clear local accountability for improving health and well-being is a prerequisite for effective delivery. Appropriate channels of accountability, consistent with those in the Local Government White Paper, will be developed to hold each public body to account for its individual commissioning responsibilities and those which are delivered in partnership.

Active, Warm and Well training workshops

Gloucestershire PCT and Severn Wye Energy Agency developed a project to improve knowledge and understanding of energy efficiency and affordable warmth issues among health professionals and those working with older people in the community and voluntary sectors.

Gloucestershire Warm and Well is a successful scheme that has been running in the county since 2001. It offers advice, home visits and energy efficiency measures to home owners at risk of cold-related illness. Active Warm and Well was a project that provided materials and training sessions that covered the health effects of cold, damp homes along with information on physical activity, falls prevention and nutrition with the aim of increasing the number and quality of referrals to the scheme.

The project was funded by the PCTs and delivered by Severn Wye Energy Agency. It could be adapted to all types of settings and groups dependent on their requirements. The benefits of the scheme include improved energy efficiency that can reduce the burden on healthcare professionals and public health workers and reduce the length of hospital stays.

Where we are now

8.2 Commissioners often work separately, leading to inefficiencies, gaps, and overlaps. Business planning cycles and processes are often complex and can conflict as organisations are held to account using different criteria and to different timetables – though we are currently working on a new NHS performance framework which will link better with the local government framework. The different systems can frustrate the genuine desire of local organisations to work together. Accountability for
delivering agreed joint outcomes is not always clear, resulting in little real change on the ground. Sometimes plans based on the results of local needs assessments are over-ridden by national targets, which by their nature are not applicable to every area and have, in the past, focused too much on inputs and processes, and not enough on outcomes. The number of national targets and linked performance management have focused commissioners’ attention ‘up’ to central government, rather than ‘out’ to the needs of their local populations. This means that it can be very difficult for users and the public to get engaged, and even once they are involved it is very hard for them to know whom they can hold to account.

**Holding local commissioners to account**

8.3 In developing arrangements for holding NHS commissioners individually and jointly to account we will incorporate the following:

- empowering individuals through effective powers of complaint, petitions and other ‘voice’ mechanisms
- empowering communities through new methods of engagement and innovative consultation methods
- requiring commissioners to undertake and publish Joint Strategic Needs Assessments
- requiring PCTs to publish Prospectuses, which will set out unmet needs, perceived gaps in service, priorities and proposals for addressing these
- requiring practice based commissioners’ business plans to state how they are going to contribute to the key goals set out in the Prospectus and Local Area Agreement
- Local Area Agreements will take account of the outcomes of Joint Strategic Needs Assessment, and be reflected in the PCT Prospectus
- Local Strategic Partnerships will be underpinned by a legal framework (see Annex C) that ensures that all of the relevant statutory local partners are participating in the production of Sustainable Community Strategies and co-operate to agree targets in Local Area Agreements
- the Sustainable Community Strategy and Joint Strategic Needs Assessment should be consistent with one another, and each should be drawn up with regard to the other
- thematic partnerships, including children’s trust arrangements, will continue to inform and be informed by the Local Strategic Partnership
- establishing the new, independent health and social care regulator (for further information see Annex C)
> developing a new type of performance framework focused on local priorities and based on outcomes
> creating a single performance framework for everything done by local authorities on their own and in partnership with health bodies, and committing to NHS co-operation in ensuring the complete alignment of accountability and performance regimes
> Overview and Scrutiny Committees
> co-operation on capital spend to ensure that the benefits of co-location (both of staff and of services) are maximised and that capital resources are spent in the most cost-effective way.

**Consultation questions**

Qu.17 What further measures might be required to clarify accountabilities for commissioners?

Qu.18 Should a local authority have some say in the capital investment plans of a PCT (and vice versa) to ensure they support more integrated service delivery, where appropriate?

Qu.19 What metrics would best support a single health and social care outcomes framework?

**Integrated Best Value reviews**

Newham PCT has saved £3 million by becoming more accountable, which allowed joint working and ultimately improved services.

The PCT and children’s services jointly funded an Integrated Commissioning Team with joint management arrangements and pooled budgets. A programme of Best Value reviews were undertaken, concluding in an analysis of need for each service area. Commissioners worked with operational staff to describe the service needed in terms of quantity and quality – a process that improved transparency and accountability, clarifying links between services and creating opportunities for joined-up working.

Newham has saved £3 million by increasing efficiency in preventative work, procurement and market management of placements and packages for vulnerable children and young people. They hope to save a further £2 million through their commissioning approach over the next five years in fostering and adoption, care packages for disabled children, preventative services, parenting programmes and integration with youth services and health professionals.
9. Making it happen – capability and leadership

9.1 Building the organisational capability, skills and working relationships to undertake effective commissioning is a key challenge for the next phase of development for commissioning organisations.

Commissioning capability

9.2 The skills needed to commission well – both for populations and individuals – need to be developed. Commissioning organisations and front-line practitioners need to identify their skill and capability gaps, and take the lead in addressing them, drawing on accredited sources of education, training and support. The Department of Health and other national stakeholders will help facilitate this where they can add real value.

Where we are now

9.3 For PCTs, the Fitness for Purpose Programme (FfP) provides a foundation on which to build (see Annex C). All PCTs are now creating development plans to address areas highlighted by the Fitness for Purpose process as requiring attention. The Commission for Social Care Inspection’s (CSCI) report, The State of Social Care 2005/06, lays out how far local authorities have met the challenges of strategic commissioning (see Annex C). Although there are examples of strong and effective commissioning to improve health and well-being, practice remains highly variable and is often not focused on those interventions that would have the biggest impact. Many commissioners (whether NHS or local authority) may find it hard to bring together the capacity, capability and leadership necessary to commission health and well-being effectively. Although there is already a wide range of development initiatives and resources nationwide, these are of varying quality and appropriateness and lack effective co-ordination. Many are not joint initiatives, when they should be.

Building commissioning leadership and capability

9.4 It is the responsibility of local commissioners to ensure that they and their teams have, or develop, the necessary skills to commission for health and well-being. We believe that taking the following steps should deliver a significant improvement in commissioning capability.
9.5 PCTs

> Their starting point should be the Fitness for Purpose Programme.
> They should prepare Development Plans to address key needs arising from the Fitness for Purpose assessments.
> Reflecting the importance the Department attaches to effective commissioning, we will ask the Healthcare Commission to assess, during 2007/08, PCTs’ progress in building capability. In doing so, it will take their development plans into account.
> PCTs can choose to meet those development needs by drawing on a range of national or local sources of education, training and support.
> These include those providers available under the nationally procured Framework for procuring External Support for Commissioners (FESC).
> To help ensure the consistency and quality of other nationally endorsed development programmes for PCTs: (a) we expect that they should be designed using the model of the Commissioning Cycle set out in Health reform in England: update and commissioning framework – annex: the commissioning framework (see Annex C) and (b) they should be accredited. The NHS Institute will lead the accreditation process.
> PCTs may wish to take other steps to increase their commissioning capability, possibly with practice based commissioners and/or local authorities. For example, exploring options for co-locating or sharing relevant infrastructure (e.g. information and analysis), skills and expertise, or commissioning learning sets, peer-to-peer support, and other local initiatives building on the learning from the Fitness for Purpose programme.
> The Department of Health publishing practical advice and guidance, for example on potential high-impact changes for health and well-being (see Annex B), or ‘toolkits’ to help inform commissioning for specific conditions (e.g. diabetes, mental health well-being), issues, or groups (e.g. the homeless). For further information, see Annex C.

9.6 Practice based commissioners

> Practice based commissioning is at the heart of good commissioning. Practice based commissioners should review their development needs and work out how best to meet these.
> There are already a range of nationally available development programmes, tailored to the needs of practice based commissioners, led by the Improvement Foundation.

> Through their PCTs, commissioners can access services and support from the FESC (see above).

9.7 **Commissioners of social care**

> The CSCI report The State of Social Care 2005/06 sets out the key areas for improvement.

> Commissioners of social care can access services and support from the FESC (see above) through their PCT.

> There are already a range of nationally available development programmes, tailored to the needs of commissioners of social care (see Annex C).

> We will look to provide further, focused support for social care commissioning, leadership and management.

9.8 **Broader commissioning development**

> We recognise that commissioning partners may have generic development needs, which may be best served through the Department of Health working collaboratively with other government departments and national stakeholders. For example, on effective commissioning from third sector providers and other, broader aspects of ‘market development’. We will also work with the Department for Communities and Local Government and the Department for Education and Skills to develop the National Improvement Strategy and scope further work on leadership development.

**Consultation question**

Qu.20 What do local commissioners need in terms of national support for developing commissioning capability?
Local leaders tackling health inequalities on a shoestring

Dr Zafar Iqbal, South Staffordshire PCT, has tackled inequalities by ‘pulling everyone together’, getting them to see that deprived groups can be reached and improvements made without extra funding.

There are pockets in South Staffordshire PCT suffering from high levels of substance misuse, crime, teenage pregnancy and obesity. Because South Staffordshire generally is not considered deprived, these issues were not being given a high profile. Dr Iqbal felt something had to be done: “A lot of people didn’t want to know. It took a long time to get everyone involved and for people to accept there was a problem.” A workshop was organised for statutory services and partners. One hundred people turned up, from organisations ranging from the council to schools to the local Tesco. Ideas were batted about and people became interested in the issue.

He and his team undertook a health needs assessment that identified some areas to target were aspirations and achievement; parenting; economic development; sense of community; mental health; and lifestyle. Armed with the statistics, he persuaded local opinion-formers of the problems, and built effective coalitions with funders and providers. Much of the subsequent partnership work has been about targeting mainstream services in a different way rather than seeking additional resources. The council contributed a run-down building, formerly an area housing office, and the lease is being taken on by the mental health trust. A local church group has successfully bid to manage the building and will be supported by a committee representing the lead partner organisations. The set-up and running costs have been kept to a minimum and statutory partners are contributing to them from within existing resources. The county council is managing the pooled budget.

Many organisations will be providing services from this building. The list includes the youth service, adult and community learning, teenage advice agency Connexions, health visitors, midwives, the Citizens’ Advice Bureau, the community mental health team, charity Age Concern, Staffordshire Police and the university. The project is a high priority in the area. It is run by a sub-group of the Stafford Local Strategic Partnership, which includes representatives from health, local government, education and the voluntary sector. Work is under way to incorporate objectives of the project into Local Area Agreements. Some of the projects are already showing improved outcomes, for example a police-led partnership initiative has led to a reduction in both burglary (66%) and overall crime (25%) in the area.

Adapted with permission from Health Services Journal, Jan 2007
Annex A – Joint Strategic Needs Assessment

What is a Joint Strategic Needs Assessment?

A.1 A Joint Strategic Needs Assessment (JSNA) is the means by which Primary Care Trusts (PCTs) and local authorities will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs.

A.2 JSNAs form the basis of a new duty to co-operate for PCTs and local authorities that is contained in the current Local Government and Public Involvement in Health Bill.

A.3 JSNAs will take account of data and information on inequalities between the differing, and overlapping, communities in local areas and support the meeting of statutory requirements in relation to equality audits.

Why do an JSNA?

A.4 The reason for doing an JSNA, and doing it well, is to develop the whole health and social care response so it more closely meets the wants and needs of local people. It will provide an opportunity to look ahead three to five years and support and direct the change that needs to happen in local service systems so that:

- services are shaped by local communities (‘voice’)
- inequalities are reduced
- social inclusion is increased
- these outcomes are maximised at minimum cost.

A.5 Good JSNAs will:

- provide analyses of data to show the health and well-being status of local communities
- define where inequities exist, and
- use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestment services.
What are the outcomes of a good JSNA?

A.6 A good JSNA will:

> define achievable improvements in health and well-being outcomes for the local community
> send signals to existing and potential providers of services about potential service change
> support the delivery of better health and well-being outcomes for the local community
> inform the next stages of the commissioning cycle
> aid better decision-making
> underpin the Local Area Agreement and the choice of local outcomes and targets, as well as the PCT’s own prospectus.

However, we cannot expect the new duty of JSNA to define precisely what commissioners should ‘buy’ each year.

What does a good JSNA look like?

A.7 It is not for central government to prescribe in detail, without allowing for local perspective. Local authorities and PCTs (and local people) would probably want to consider asking the following questions about current circumstances:

> Which groups are getting a raw deal?
> How many children are living in poverty?
> What are people dying of?
> Which of our communities dies youngest?
> Roughly when do people die?
> How many people are there over 75?
> Are we spending our money on the right things?
> What illnesses are people living with?
> What are people living with that makes their lives difficult?
> What help do the groups who are getting a raw deal want and need?
> Where do the groups getting a raw deal live?
How can you produce a good JSNA?

Information is the key to a good JSNA as it is all about developing answers to the sort of questions outlined above. Analytical support will be necessary to shine light on where inequalities are and where they persist. Information on illness, what people are dying of, and what stops people living the best life they can, is available, but not necessarily in one place or systematically. It can be used, alongside cost information, to make the best judgements possible. Programme budgeting information will help local authorities, PCTs and the wider Local Strategic Partnerships to understand where they are spending their resources and identify the potential for shifting resources between activities to produce better outcomes. The diagram below illustrates the process.

**STRATEGIC NEEDS ASSESSMENT**

**INPUTS**
(Data / information needed)
- Demography
- Social & Environmental Context
- Current known health status of populations
- Current met needs of the population
- Patient Voice
- Public Demands
- Analysis of Inequalities - Outcomes - Service Access
- Programme Budgets and Outcomes

**OUTPUTS**
(The link to other stages of commissioning)
- Programme of systematic service reviews (NHS / Social Care)
- Prioritisation framework for annual contracting procurement
- Mediumterm market development (capacity to deliver desired service configuration)
- Local Government and NHS
- Primary Care Investment Commissioning decisions (NHS)
- Capital Investment Plans (local / regional government and NHS)

What decisions will be made by whom?
- PCT
- LSP
- PCT outcome metrics chosen
- LAA targets

Tables 1 and 2 are a first description of the types of the minimum sets of data and analyses that PCTs and local authorities might expect to have been carried out in order to inform the JSNA for their area. This is a proposed minimum and is not comprehensive. It should be complemented by other locally appropriate data on the wider determinants of well-being, e.g. details of the number of offenders in custody locally or under supervision in the community, information from the Environment Agency.

At [www.commissioning.csip.org.uk](http://www.commissioning.csip.org.uk) there are further details on the minimum data set and sources of data.
Table 1: primary data needed for a Joint Strategic Needs Assessment

| 1 | Demography | Population numbers | Current population estimates x5-year age bands and gender  
Population projections 3-5 years’ time  
% Change |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Births</td>
<td>Current births and projected rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Older people</td>
<td>Current total aged 65+, male and female and five-year projection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>Current numbers, percentages and projections</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Social and environmental context</td>
<td>Benefits data</td>
<td>Children under 16 in households dependent upon Income Support</td>
</tr>
<tr>
<td></td>
<td>Deprivation</td>
<td>IMD 2004</td>
<td></td>
</tr>
</tbody>
</table>
|   | Characteristics | Housing tenure  
Living arrangements/over-crowding  
No access to car or van  
Employment data  
Average incomes  
Rural or urban location |
| 3 | Current known health status of population | Illness and lifestyle | British health survey 2004  
Quality and Outcomes Framework GP QMAS data  
Risk factor data (smoking prevalence) |
|   | Teenage conceptions | Age <16 rate plus 95% CI  
Age <18 rate plus 95% CI |
|   | Census 2001 | Standardised limiting long-standing illness ratio (persons in household) |
| 4 | Current met needs of the population | Social care | RAP 3: Source of referrals  
P1: Clients receiving community-based services  
RAP P2f: Clients receiving community-based services  
RAP C1: Carers  
SWIFT |
|   | Primary care | Predicted prevalence versus known prevalence of x diseases  
Dental: % DMFT 5-year-olds – trend  
Immunisation: Resident-based uptake rates |
|   | Hospital care (HES data) | Top 10 causes of admission  
Top 10 diagnoses consuming most bed days  
Average, median and range of length of stay |
| 5 | Patient/service user voice | Social care | User surveys  
P1A: Client satisfaction surveys  
PALS/LINks data (qualitative and quantitative)  
Complaints data  
SWIFT  
PALS/LINks data (qualitative and quantitative) |
|   | Primary and community-based care | GPAQ  
Complaints data  
Self-reported health outcomes  
Patient satisfaction surveys |
|   | Hospital care | Self-reported health outcomes  
Patient satisfaction surveys |
| 6 | Public demands | Local authority | Annual residents survey  
Health scrutiny reports  
NHS Petitions received |
Table 2: secondary analysis of data for Joint Strategic Needs Assessment

<table>
<thead>
<tr>
<th></th>
<th>Outcomes</th>
<th>Service access</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Analyses of current inequalities</td>
<td>by geography (e.g. life expectancy by ward)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>by ethnicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>by gender</td>
</tr>
<tr>
<td>2</td>
<td>Projection of service use in 3-5 years' time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>based on historical trends and current</td>
<td></td>
</tr>
<tr>
<td></td>
<td>activity</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Projection of outcomes in 3-5 years' time</td>
<td>Outcomes</td>
</tr>
<tr>
<td></td>
<td>based on historical trends and current</td>
<td></td>
</tr>
<tr>
<td></td>
<td>activity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Value for money and return on investment</td>
<td>Programme budgets and outcomes</td>
</tr>
</tbody>
</table>

What will make JSNAs better in the future?

A.8 We are investing in better information systems to capture and use data more effectively. However, the systematic and routine capture of community views on services remains the biggest challenge. Health services should build on and co-operate with local authorities who have more experience of doing this and very often have the infrastructure that can be used to identify the well-being needs of communities.

Who will do JSNAs and who will use them?

A.9 The production of JSNAs are the responsibility of senior directors in the NHS and local authorities, but many others are likely to have a role to play in getting the JSNA right and delivering better outcomes.

A.10 Table 3 shows that everyone has an interest in JSNAs and getting them right. Local communities and providers, such as GPs, who are close to their communities, play a vital role in supplying information to shape the future through JSNAs. GP practices will not only want to shape the JSNA but also deliver the outcomes on a day-to-day basis in the way they work with their patients and how they refer.
A.11 Regional bodies will need to aggregate locally developed JSNAs to look much further forward in time to ensure the long-term infrastructure to deliver high performance is available, including a workforce fit-for-purpose, a responsive primary care capital base and the long-term hospital needs of large populations, as more services are brought closer to communities and patients.

**TABLE 3: How a JSNA can help**

<table>
<thead>
<tr>
<th>Time horizon (years)</th>
<th>1-3</th>
<th>3-5</th>
<th>5-10</th>
<th>10-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communities (including practice based commissioners)</td>
<td>Articulate changing demands/wants</td>
<td>Innovate in clinical practice</td>
<td>Innovate with new service provision models and providers</td>
<td></td>
</tr>
<tr>
<td>Local Strategic Partnerships</td>
<td>Defined capacity needed from 3rd sector, primary care services and hospital based care</td>
<td>What do we want the local community to look like?</td>
<td>What outcomes will we have achieved?</td>
<td></td>
</tr>
<tr>
<td>Government Offices of the Regions</td>
<td></td>
<td></td>
<td></td>
<td>What are the large infrastructure developments needed to influence health and well-being positively?</td>
</tr>
<tr>
<td>National Government</td>
<td>System rules/priorities/operating framework</td>
<td>System development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How often will JSNAs have to be done?**

A.12 JSNAs will become an integral part of the planning cycle of local authorities and the NHS and, because of this, we expect they will need to be carried out in line with the three-year Local Area Agreement cycle (subject to Secretary of State’s directions).

**Key questions for the consultation**

Q21. How might Joint Strategic Needs Assessments inform other aspects of community planning?

Q22. What could be added in to Tables 1 and 2?

Q23. What is the most efficient way to provide the necessary information and analysis to commissioners?
Q24. How can we ensure that the Joint Strategic Needs Assessments are used effectively?

Q25. Should Joint Strategic Needs Assessments be linked to the three-yearly Local Area Agreement planning cycles, or should timing be left to local discretion (subject to Secretary of State’s directions)?

Q26. Will this approach to Joint Strategic Needs Assessment effectively define the needs of children and young people?
Annex B – Investing in prevention

Why are prevention and promotion important?

B.1 Core NHS and social care investment has traditionally concentrated on commissioning treatments for people with ill health and the highest level of need, with intervention at the point of crisis. Persuading local decision makers to shift investment patterns to earlier targeted interventions that promote health, independence and well-being, while achieving in-year financial balance, requires effective use of available evidence.

B.2 At the same time, the disease burden has moved from infectious diseases and trauma as the main cause of death, to the massive impact of increasing chronic disease prevalence in the population. This presents a major challenge to commissioners of health and social care services.

B.3 Evidence suggests that primary prevention interventions need to be an integral part of primary and secondary care for at-risk populations. Significant funding, targeted at those with the most to gain from prevention, should be commissioned in as robust a way as secondary treatment services, with a similar emphasis on achieving measurable outcomes.

B.4 Commissioners should consider the local ‘big killers’ or threats, model these conditions and seek out prevention interventions. This includes initiatives aimed at promoting independence and prevention. Where evidence-based interventions are available these should be prioritised.

B.5 An overarching goal is to reduce health inequalities and this should underpin all local decisions; equity audits should be applied to ensure that those with greatest need are targeted.

Financing investment

B.6 Developing revenue streams to support initial return on investment decisions may require commissioners to review existing portfolios. It may be feasible to choose to disinvest from procedures or services where evidence suggests that they are of limited or negligible effectiveness, in favour of investment in interventions with proven effectiveness.
B.7 The Wanless Report ([www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm](http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm)) highlights the economic argument for refocusing investment on preventive approaches to care, reducing the future financial burden of longevity and population change. The Partnerships for Older People Projects (POPP) initiative demonstrates how return on investment strategies can be developed across health and social care to deliver whole systems benefits. See: [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4099198&chk=5OV7NB](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4099198&chk=5OV7NB). Financial returns from health and well-being interventions are both long term (reduced disease burden) and shorter term (reduced risk and better management of pre-existing conditions). Both are an essential part of a commissioner’s investment portfolio.

**Joint and practice based commissioning**

B.8 Local authorities have taken an historical lead securing this portfolio across communities. PCTs and practice based commissioners should work with local authorities in partnership across communities.

B.9 Risk sharing across organisations is required to help deliver the savings achievable. Clear commissioning plans and strategies allow providers to innovate and deliver better value interventions or alter their provider portfolios.

B.10 Practice based commissioners can use tariff calculations and, by modelling reductions in activity, predict from reduced morbidity, return on investment calculations. The National Reference Group for Health and Well-being will in future help signpost what investment strategies are most promising and likely to impact locally. POPP pilots will also add considerably to the existing evidence base. Best-value investment strategies also play a role as local communities prioritise how best to invest health and local authority funding to deliver greatest community gain while reducing inequalities.

B.11 In turn, this analysis can be built up to local authority, PCT or local cluster practice based commissioning level. Local analysis allows commissioners to agree what interventions should be invested in through annual planning cycles, three-yearly Local Area Agreement cycles and wider, longer-term cycles.
**Case studies and criteria**

B.12 Included in this paper are links to several case studies, which may contain lessons that can be translated to the local environment, using locally appropriate return on investment calculations.

B.13 The work initiated in Croydon PCT, taken forward as a London case study by the London Health Observatory, illustrates how PCTs and clinicians, taking a pan-London approach, can agree where disinvestments may generate potential revenue for reinvestment in interventions with a positive evidence base. Providers in turn are not funded for these services except on a named, agreed exception or pre-agreed managed volume basis. The London case study shows how a regional system of intervention monitoring could provide timely feedback to commissioners and highlight the potential range of savings achievable for each PCT if common criteria were adopted. Commissioners could optimise this approach more widely using similar methods of local activity analysis and management. Maximum and minimum savings indicate the significant savings to be achieved.


B.14 Other examples of where health systems have assessed the evidence base and used this approach more widely to support local ROI investment proposals are:

- Milton Keynes PCT – see [www.commissioning.csip.org.uk](http://www.commissioning.csip.org.uk)
- Oxford PCT – see [www.commissioning.csip.org.uk](http://www.commissioning.csip.org.uk)
- ChaMPs – see [www.nwph.net/champs/Publications/Improving%20the%20health%20of%20patients%20through%20Practice-Based%20Commissioning.doc](http://www.nwph.net/champs/Publications/Improving%20the%20health%20of%20patients%20through%20Practice-Based%20Commissioning.doc)
- SLIPS model – see [www.commissioning.csip.org.uk](http://www.commissioning.csip.org.uk)

In each case, national and international evidence has been applied to local populations to calculate local investment returns.

**Managing exceptions**

B.15 Commissioners will need to ensure that exception processes for interventions not normally funded are agreed and locally owned. This includes securing agreement with providers, clinicians, operational staff and local people.
The future

B.16 In summary, by combining these approaches, commissioners:

- develop an investment/disinvestment strategy based upon evidence of effectiveness, using this to drive market development
- agree and enact local exception policies through engaging clinicians, operational staff and citizens
- work with providers to co-manage changes in investment portfolios and reduced activities in areas to be decommissioned
- reinvest in community-wide strategies that deliver more fully engaged communities. This links to better value for money and return on investment strategies, based upon current known evidence
- reduce the future costs associated with current chosen lifestyles, working in partnership to invest in health and well-being interventions

B.17 In future, commissioners will receive guidance and support from the recommendations of the National Reference Group for Health and Well-being.
Annex C – Tools and resources to support commissioning

Toolkits

C.1 The following commissioning toolkits are available to support implementation of system reform in specific services:

> Diabetes commissioning toolkit
  www.yhpho.org.uk/diabetes_commissioning.aspx

> Stroke commissioning guide and interactive resource (ASSET – action on stroke services: an evaluation toolkit for commissioners)
  www.dh.gov.uk/stroke

> Health inequalities intervention tool
  www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx/

> Modernising maternity care – A commissioning toolkit for England 2006 (joint publication RCM, RCOG & NCT)
  www.rcog.org.uk/index.asp?PageID=1178

> Joint planning and commissioning framework for children, young people and maternity services (DH/DfES 2006). A supplement will be produced in early summer 2007 to demonstrate alignment between this document and the Commissioning Framework for Health and Well-being
  www.everychildmatters.gov.uk/planningandcommissioning

> Commissioning toolkit for community-based eye care services

> Commissioning toolkit for long-term conditions
  www.commissioningforthelongterm.org.uk/

> Framework for planning and commissioning of services related to health needs of homeless people
  www.communities.gov.uk/index.asp?id=1505737
> Needs assessment toolkit – applying the method of results-based accountability or ‘turning the curve’ within Portsmouth:
  www.everychildmatters.gov.uk/strategy/planningandcommissioning/
> Sexual health commissioning toolkit. This will be updated during 2007 to reflect the health reform programme and the implications of this Commissioning Framework for Health and Well-being.
> PCC (Primary Care Contracting) Primary Care Service Frameworks:
  – Long-term conditions
  – Support for self-care
  – Sexual health
  www.pcc.nhs.uk/204.php

C.2 An evaluation of existing commissioning toolkits, carried out between September and October 2006, evaluated 30 tools and identified five tools of potential interest in strengthening the commissioning process. This is available at: www.commissioning.csip.org.uk

C.3 The following commissioning toolkits and guidance are planned for publication in the next year:

> Implementing care closer to home: providing convenient quality care for patients
> Cancer commissioning guidance: variety of toolkits to be developed as part of new cancer reform strategy
> Guidelines on commissioning mental health services for asylum seekers and refugees
> Co-commissioning framework for offender health services
> Commissioning guide for long-term neurological conditions
> A joint Department for Education and Skills/Department of Health pooled budgets toolkit
> Child health promotion commissioning guide
> Looked-after children commissioning toolkit
> Self-assessment tools to help PCTs to commission maternity services and children’s services
> Promoting mental health for children held in secure settings: a framework for commissioning services (due to be launched on 26 March 2007).
> Toolkits to support effective commissioning for children and young people, especially those with psychological/mental health needs, disability/complex health needs and children in care
> Updated Department of Health/Department for Education and Skills guidance on promoting the health of looked-after children.
> SHAPE (Strategic Health Asset Planning and Evaluation) is a web-enabled toolkit, which is being designed to inform and support the strategic planning of services and physical assets across a whole health economy
> A Catalyst for Change II: Tackling the long ascent of improving commissioning
> Choice and risk: a guide to best practice in supported decision making
> Revised commissioning strategy for mental health high secure services (due to be launched on 31 March 2007).

C.4 Further information will be available on the consultation website at: www.commissioning.csip.org.uk

**Integrated Care Network (ICN) guidance**

C.5 A wealth of resources is available from the Care Services Improvement Partnership (CSIP), including information on Local Strategic Partnerships, Local Area Agreements, accounting for pooled budgets and the governance of inter-agency partnerships. For further information, please see: www.icn.csip.org.uk

**Additional resources**

> Department of Health (2006), Models of care for alcohol misusers (MoCAM)

> National Treatment Agency for Substance Misuse, Review of effectiveness of treatment for alcohol problems

> National Treatment Agency for Substance Misuse, Alcohol misuse interventions: guidance on developing a local programme of improvement
  www.dh.gov.uk/assetRoot/04/12/36/82/04123682.pdf
Commissioning framework for health and well-being

  www.dh.gov.uk/assetRoot/04/12/22/39/04122239.pdf

> Department of Health (2006) Supporting people with long term conditions to self care: a guide to developing local strategies and good practice


> Department of Health (2006), Creating a disability equality scheme a practical guide for the NHS

> Department of Health (2003), Health Equity Audit

> Association of Public Health Observatories, Inequalities intervention tool
  www.apho.org.uk/apho/tools.htm

> Department of Health practice based commissioning tools
  www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4130824&chk=dL5ECW

> National Strategic Partnership Forum’s Making partnerships work: Examples of good practice (forthcoming)
Commissioning framework for health and well-being

> Department of Health (2006), Informing healthier choices: Information and intelligence for healthy populations
  www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4135308&chk=JUbu1h

> Department of Health (2006), A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services

> Race for Health Programme
  www.raceforhealth.org

References

Introduction

> Department of Health (2004), Choosing health: making healthy Choices Easier

> Department of Health (2006), Our health, our care, our say: A new direction for community services
  www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/fs/en

> Department for Education and Skills (2003), Every child matters
  www.everychildmatters.gov.uk

> Wanless Reviews:
  www.hm-treasury.gov.uk/Consultations_and_legislation/wanless/consult_wanless_index.cfm
  www.hm-treasury.gov.uk/Consultations_and_legislation/wanless03/consult_wanless_index.cfm

79
Commissioning framework for health and well-being

> Department of Health (2006), Health reform In England: update and commissioning framework  

> Department of Health and Department for Education and Skills (2006), Joint planning and commissioning framework for children, young people and maternity services. A supplement will be produced in early summer 2007 to demonstrate alignment between this document and the Commissioning Framework for Health and Well-being  
  [www.everychildmatters.gov.uk/planningandcommissioning](www.everychildmatters.gov.uk/planningandcommissioning)

> Department for Communities and Local Government (2006), Strong and prosperous communities – The Local Government White Paper  

> The Children Act 2004  
  [www.dfes.gov.uk/publications/childrenactreport](www.dfes.gov.uk/publications/childrenactreport)

**Putting people at the centre of commissioning**

> Department of Health (2006), Our health, our care, our say: A new direction for community services  

> Local health profiles  
  [www.communityhealthprofiles.info/](www.communityhealthprofiles.info/)

> Department of Health Patient Choice website  

> Link Age Plus  

> Developing a year of care for diabetes  

> IDeA  
  [www.idea.gov.uk](www.idea.gov.uk)
Understanding and planning for the needs of individuals and of the local population

> Patients at Risk of Re-hospitalisation (PARR) case finding tool
  [www.kingsfund.org.uk/health_topics/patients_at_risk/index.html](http://www.kingsfund.org.uk/health_topics/patients_at_risk/index.html)

> Combined predictive model case study
  [www.kingsfund.org.uk/health_topics/patients_at_risk/combined1.html](http://www.kingsfund.org.uk/health_topics/patients_at_risk/combined1.html)

> Disease prevalence models to support 2007-8 PCT Local Delivery Plans (LDPs)
  [www.apho.org.uk/apho/models.aspx](http://www.apho.org.uk/apho/models.aspx)

> Department of Health and Department for Education and Skills (2006), Joint planning and commissioning framework for children, young people and maternity services
  [www.everychildmatters.gov.uk/planningandcommissioning](http://www.everychildmatters.gov.uk/planningandcommissioning)

> Care Services Efficiency Delivery (CSED)
  [www.csed.csip.org.uk](http://www.csed.csip.org.uk)

> Health inequalities intervention tool

Sharing and using information more effectively

> Department of Health (2003), The NHS Confidentiality Code of Practice: Guidelines on the use and protection of patient information

> Guidance on data sharing:
  - Department for Constitutional Affairs
    [www.dca.gov.uk/foi/sharing/index.htm](http://www.dca.gov.uk/foi/sharing/index.htm)
  - Department for Education and Skills
    [www.everychildmatters.gov.uk/informationsharing/](http://www.everychildmatters.gov.uk/informationsharing/)
  - Common Assessment Framework:
  - Guidance on the ‘lead professional’, including ‘budget holding lead professional’ pilots:
    [www.everychildmatters.gov.uk/deliveringservices/leadprofessional](http://www.everychildmatters.gov.uk/deliveringservices/leadprofessional)
Commissioning framework for health and well-being

– ContactPoint: Tool to enable practitioners delivering services to children to identify and contact one another easily and quickly, so they can share relevant information about children who need services
  www.everychildmatters.gov.uk/deliveringservices/contactpoint/

> Further information on cross-government work on data sharing:
  – Cabinet Committee – MISC31 – Data sharing
    www.cabinetoffice.gov.uk/secretariats/committees/misc31.asp
  – Prime Minister’s policy review: Impact of data-sharing and privacy laws on customer service
    www.number10.gov.uk/output/Page10759.asp

> Connecting for Health work:
  Work is being taken forward by Connecting for Health on the harmonisation of information governance standards between the NHS and social care providers. This is being addressed through extension of the NHS information governance toolkit and reporting mechanisms to cover social care organisations and provides the opportunity for organisations to demonstrate equivalence and performance against standards.

> Resources for alignment of IT systems:
  – MIQUEST
    www.mkiobservatory.org.uk
  – Neighbourhood knowledge management
    www.nkm.org.uk/publish.html
  – Tool to support delivery and improvement for SEN and low attaining children and young people:
    www.teachernet.gov.uk/npf

**Assuring high quality providers for all services**

> Department of Health Social Enterprise Unit
  www.dh.gov.uk/socialenterprise

  www.dfes.gov.uk/rsgateway/DB/RRP/u014975/index.shtml
Commissioning framework for health and well-being

> Department for Communities and Local Government (2006), Developing the local government services market to support the long term strategy for local government
  www.communities.gov.uk/index.asp?id=1504332


> Department of Health (2007), Third Sector Market Mapping

> The Compact on relations between government and the voluntary and community sector (VCS) in England
  www.thecompact.org.uk/

> SHAPE
  www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/PrivateFinanceInitiative/InvestmentGuidanceRouteMap/InvestmentGuidanceArticle/fs/en?CONTENT_ID=4133060&amp;chk=1FULSf

> Department of Health (2006), Health reform in England: update and commissioning framework

> Department of Health Payment by Results website

> Additional useful resources:
    www.hm-treasury.gov.uk/spending_review/spend_ccr/spend_ccr_guidance.cfm
  – Cabinet Office (2006), Partnership in Public Services: an action plan for third sector involvement
    www.cabinetoffice.gov.uk/third_sector/public_service_delivery/
Recognising the interdependence between work, health and well-being

> Department of Health, Department for Work and Pensions, Health and Safety Executive (2005), Health, work and well-being – Caring for our future: a strategy for the health and well-being of working age people

> Investors in People
www.investorsinpeople.co.uk

> Office of Government Commerce (2006), Social issues in purchasing. This focuses on the different stages of the procurement process, and the way social issues can legitimately be incorporated into the purchasing cycle

Developing incentives for commissioning for health and well-being

> Legal position regarding the flexible use of NHS funds

The Secretary of State’s main duties to provide services are set out in Section 3(1) of the NHS Act 1977, which provides as follows (including the main prospective amendments):

Section 3(1) – It is the Secretary of State’s duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements

(a) hospital accommodation;

(b) other accommodation for the purpose of any service provided under this Act;

(c) medical, dental, nursing and ambulance services;

(d) such other services or facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;

(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of
persons who have suffered from illness as he considers are appropriate as part of the health service;

(f) such other services or facilities as are required for the diagnosis and treatment of illness.

This means that in order to fall within the scope of the NHS and represent a legitimate use of NHS funds, PCTs will need to satisfy themselves that:

(a) the interventions concerned would constitute facilities (or, from 1st March 2007, services) for the prevention of illness, or for the care of persons suffering from illness or the after-care of persons who have suffered from illness; and

(b) such services or facilities form an appropriate part of the health service.

Making it happen – local accountability

  www.opsi.gov.uk/si/si2000/20000617.htm

> For further details on establishing the new, independent health and social care regulator see paragraphs 3.42 to 3.47 in: Department of Health (2006), The future regulation of health and adult social care in England
  www.dh.gov.uk/assetRoot/04/14/08/27/04140827.pdf

Making it happen – capability and leadership

> PCT Fitness for Purpose programme:

> Commission for Social Care Inspection (2006), The state of social care in England 2005-06:

> Department of Health (2006), Health reform in England: update and commissioning framework
Details of a range of nationally available development programmes, tailored to the needs of commissioners of social care, can be found at the following sites:

- NHS Institute for Innovation and Improvement  
  www.institute.nhs.uk
- Social Care Institute for Excellence  
  www.scie.org.uk
- CSIP  
  www.csip.org.uk
- Integrated Care Network  
  www.integratedcarenetwork.gov.uk/
- Integrated Service Improvement Programme  
  www.isip.nhs.uk
- Skills for Care  
  www.topssengland.net/
- Skills for Health  
  www.skillsforhealth.org.uk
- IDeA  
  www.idea.gov.uk
- Improvement Foundation  
  www.improvementfoundation.org
Annex D – High impact changes to reduce health inequalities

Know your gaps

D.1 The first stage in addressing inequalities gaps is identifying the scale and nature of local problems.

D.2 The diagrams below are based on national modelling of what is driving the life expectancy gap and the interventions to narrow it by 2010. They need to be interpreted locally in the light of local demography and performance. The left hand bar shows which diseases are causing the gap in mortality between Spearhead areas and England. The right hand bar shows the impact of key interventions, based on evidence. Note that since the baseline the life expectancy gap between Spearhead areas and England has widened to 11 per cent for men and 16 per cent for women. However, there are early signs of progress, with some three-fifths of Spearhead areas on track to narrow their own gap with England by 10 per cent by 2010 for either men or women or both.

D.3 To meet the life expectancy health inequalities target, the commissioning focus in Spearhead areas needs to be on preventing deaths starting in early middle age whilst not forgetting the importance of the over-75 age group and, in some Spearheads, the under-1s. Deaths in women aged over 75 are contributing strongly to the quickly increasing gap between Spearhead areas and England as a whole.

D.4 Cardiovascular disease (CVD), cancer and respiratory disease account for about two-thirds of the gap between Spearhead areas and the national average. Commissioning to reduce the number of smokers and effectively find and manage cases of high blood pressure and high cholesterol are the three key factors that will make most difference most rapidly, both locally and nationally.

D.5 The rest of the gap can be narrowed by work on priorities such as early detection of cancer, infant mortality and alcohol-related disease. Programmes such as Health Trainers and NHS Lifecheck should also be considered as strong delivery tools for commissioners.
Modelled interventions to reduce the gap – Standards and Quality Team and Health Inequalities Unit, Department of Health 2006
Commissioning framework for health and well-being

**Tackling the gap**

D.6 A number of strategic tools are available to commissioners to ensure that services are targeted to meet local need.

D.7 The Department of Health has commissioned the Association of Public Health Observatories to produce a tool for commissioners in Spearhead areas that enables them to identify the size of their local gap with England, what diseases are driving it and to see the effect that commissioning specific local changes (e.g. increasing the number of four-week smoking quitters) will have on life expectancy and its proxy measure All Age All Cause Mortality (which is now included in Local Delivery Plans and Local Area Agreements). The Health Inequalities Intervention Tool focuses on smoking cessation, prescribing of antihypertensives and statins, and infant mortality. A prototype of the tool, which is fully useable and includes real data is available at [www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx](http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx) The diseases driving the gap can be compared with programme budgeting information, available at [www.nchod.nhs.uk/](http://www.nchod.nhs.uk/).

D.8 The Health Poverty Index enables commissioners to compare areas and groups in terms of their 'health poverty'. A group’s 'health poverty’ is a combination of its present state of health, the root causes and intervening factors. At present, comparison data is available to 2003 at local authority level, including by ethnic group, and across a range of comparators, with comparison by ethnic group to 2001. See [www.hpi.org.uk](http://www.hpi.org.uk)

D.9 Health Equity Audit is a pragmatic tool that identifies differences between service provision and need and provides a structure for action to tackle any gaps. It should be used as part of a continuous cycle of quality improvement. Using local evidence on health inequalities to inform commissioning will help improve both access to services and health outcomes.

D.10 The table below sets out some of the high impact changes which will have most rapid impact on health inequalities. These rely on strong local partnerships, including with the voluntary and community sectors, to drive effective change.
## High impact changes for the NHS and local government to narrow health inequalities

<table>
<thead>
<tr>
<th>High impact change – population</th>
<th>High impact change – disadvantaged groups / individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know your life expectancy gap</td>
<td>Know your local problems, which diseases are driving the gaps and your high risk groups. Ensure those with disease or at high risk are accessing treatment and prevention services. Measure your All Age All Cause Mortality gap quarterly. Use Health Equity Audits to get a better balance between service provision and need. Ensure there is high quality primary care in areas of high need.</td>
</tr>
<tr>
<td></td>
<td>For cardiovascular disease:</td>
</tr>
<tr>
<td></td>
<td>• develop a register and use prevalence models to inform effective case-finding</td>
</tr>
<tr>
<td></td>
<td>• control existing risk factors and implement lifestyle changes</td>
</tr>
<tr>
<td></td>
<td>• establish smoking cessation services</td>
</tr>
<tr>
<td></td>
<td>• appropriate prescribing of statins, aspirin and beta blockers</td>
</tr>
<tr>
<td></td>
<td>• encourage appropriate physical activity</td>
</tr>
<tr>
<td>Know your infant mortality gap</td>
<td>• Reduce maternal smoking</td>
</tr>
<tr>
<td></td>
<td>• Improving maternal and infant nutrition</td>
</tr>
<tr>
<td></td>
<td>• Reduce teenage pregnancies, and target support of teenage mothers</td>
</tr>
<tr>
<td></td>
<td>• Target interventions to prevent sudden unexpected deaths in infancy</td>
</tr>
<tr>
<td></td>
<td>• Encourage early booking and uptake of antenatal screening</td>
</tr>
<tr>
<td>Improve the detection of disease in disadvantaged communities, especially cancer, cardiovascular disease and respiratory disease</td>
<td>Target information and screening programmes at high risk, low engagement groups</td>
</tr>
<tr>
<td></td>
<td>• Smoking cessation services</td>
</tr>
<tr>
<td></td>
<td>• Improve diet – 5 a day</td>
</tr>
<tr>
<td></td>
<td>• Raise awareness of screening services and symptoms</td>
</tr>
<tr>
<td>Make smoking history – reduce smoking prevalence</td>
<td>Make smoking history – target deprived areas</td>
</tr>
<tr>
<td>Link into smoke-free legislation</td>
<td>Identify barriers to accessing services</td>
</tr>
<tr>
<td>Strengthen local tobacco control policies and partnerships</td>
<td>Develop effective local services for health and well-being</td>
</tr>
<tr>
<td>Develop effective local services for health and well-being</td>
<td>Use health trainers to improve access to services for vulnerable groups</td>
</tr>
<tr>
<td>Use the local authority duty of well-being to improve health and opportunities for local communities</td>
<td>Focus Health Trainers and Life Check on tackling health inequalities</td>
</tr>
<tr>
<td>Use the influence of Overview and Scrutiny Committees to reduce health inequalities</td>
<td>Empower disadvantaged communities to aspire to good health</td>
</tr>
<tr>
<td></td>
<td>Use Expert Patient Programmes</td>
</tr>
<tr>
<td></td>
<td>Responsive and culturally appropriate services</td>
</tr>
<tr>
<td></td>
<td>Ensure that Local Area Agreements (or other local plans) impact on making better choices for health and well-being easier to access by individuals, particularly in disadvantaged groups</td>
</tr>
</tbody>
</table>
Annex E – Summary of consultation questions

Putting people at the centre of commissioning

Qu1. Are these measures set out in this section sufficient to enable people to take greater control of decisions about their health and care? What further action could central government take?

Qu2. What special arrangements might be needed to ensure that the views are heard of those who do not routinely use local services?

Understanding and planning for the needs of individuals and of the local population

Qu3. Will the approach set out in this section and in the supporting Annex A (on joint strategic needs assessment) help commissioners to undertake (a) an assessment of an individual’s needs, (b) an assessment of the needs of particular groups or communities and (c) joint strategic needs assessments?

Qu4. How can we shape the duty of Joint Strategic Needs Assessment to have the greatest impact on health and well-being?

Qu5. How will this approach to needs assessment described in this section be suitable for children and young people, for whom services are commissioned through children’s trust arrangements?

Sharing and using information more effectively

Qu6. Are the main information requirements for effective commissioning identified in chapter 4? Are there any obstacles or gaps that need to be addressed?

Qu7. Is the legal position with regard to information and data sharing for the purposes of commissioning clearly set out in this section? Is there any need to review the current rules (including primary and secondary legislation, audit processes, etc.) in order to facilitate information and data sharing?
Qu8. Are there any specific issues around sharing information on children and young people that should be addressed at national level?

Qu9. Would it be helpful for the Department of Health to work with other government departments and national stakeholders to develop a set of common principles to help underpin local agreements?

Assuring high quality providers for all services

Qu10. Will these proposals in this section support commissioners to assure a range of high quality providers for all services?

Qu11. Should the Department develop one contract template for out-of-hospital services (except GMS and PMS) or one for each of the main service segments (e.g. mental health, long-term conditions, etc.)?

Recognising the interdependence between work, health and well-being

Qu12. Does this section set out sufficient levers and incentives for commissioners and employers to improve health and well-being?

Developing incentives for commissioning for health and well-being

Qu13. What practical, legal and financial issues need to be considered in enabling PCTs and practice based commissioners to spend effectively on non-health interventions, as described in this section?

Qu14. What further changes would make it easier for resources to follow individual service users beyond those described in this section?

Qu15. What considerations do you see in increasing the use of single audit arrangements for pooled budgets?

Qu16. How can we ensure that practice based commissioning and children’s trust arrangements work effectively together to improve outcomes for children?

Making it happen – local accountability

Qu17. What further measures, beyond those set out in this section, might be required to clarify accountabilities for commissioners?
Qu18. Should a local authority have some say in the capital investment plans of a PCT (and vice versa) to ensure they support more integrated service delivery, where appropriate?

Qu19. What metrics would best support a single health and social care outcomes framework?

Making it happen – capability and leadership

Qu20. What do local commissioners need in terms of national support for developing commissioning capability?

Annex A – Joint Strategic Needs Assessment

Qu21. How might Joint Strategic Needs Assessments inform other aspects of community planning?

Qu22. What could be added in to Tables 1 and 2?

Qu23. What is the most efficient way to provide the necessary information and analysis to commissioners?

Qu24. How can we ensure that the Joint Strategic Needs Assessments are used effectively?

Qu25. Should Joint Strategic Needs Assessments be linked to the three-yearly Local Area Agreement planning cycles, or should timing be left to local discretion (subject to Secretary of State’s directions)?

Qu26. Will this approach to Joint Strategic Needs Assessment effectively define the needs of children and young people?

Published alongside this framework are details of an initial equality impact assessment on the policy. A series of further consultation questions are posed in the summary report on the equality impact screening. We would welcome responses to these questions. We are also keen to receive any comments on the initial regulatory impact assessment, which is published alongside this document.

You are encouraged to share your views with regard to the proposals contained within this framework at our consultation website www.commissioning.csip.org.uk.
Glossary

**Care Programme Approach** CPA was introduced in 1991 and is intended to be the basis for the care of people with mental health needs outside hospital. It applies to all people with serious mental health problems who are accepted as clients of specialist mental health services.

**Children and Young People’s Plan** A single, strategic, overarching plan for all services affecting children and young people in a local area.

**Children’s trusts arrangements** that bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to co-operate, to focus on improving outcomes for all children and young people.

**Commissioning** The full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services meet the health and social care needs of individuals and communities.

**Commission for Social Care Inspection (CSCI)** The single independent inspectorate for all social care services in England

**Common Assessment Framework** The CAF is a standardised approach to conducting an assessment of a child’s additional needs and deciding how those needs should be met. It can be used by practitioners across children’s services in England.

**Community care** Care or support provided by social services departments and the NHS to assist people in day-to-day living.

**CSIP** The Care Services Improvement Partnership supports positive changes in services and in the well-being of people with mental health problems, people with learning disabilities, people with physical disabilities, older people with health and social care needs, children and families with health and social care needs and people in the criminal justice system with health and social care needs.

**Direct payments** Cash payments made in lieu of social service provisions to individuals who have been assessed as needing services. They create more flexibility in the provision of social services. Giving money in place of social care services means people have greater choice and control over their lives, and are able to make their own decisions about how care is delivered.

**Director of Adult Social Services (DASS)** A statutory post in local government with responsibility for securing provision of social services to adults within the area.
Director of Public Health (DPH) An executive director post in Strategic Health Authorities and PCTs, the DPH leads on improving and protecting the health of the community and reducing health inequalities, health emergency planning, professional leadership, clinical quality and patient safety. PCTs are encouraged to make joint appointments with local authorities, and to work with the Directors of Adult Social Services and of Children’s Services to promote the health and well-being of their local communities.

Equality impact assessment This systematically assesses and records the actual or potential impact of a policy on different groups of people. As far as possible, any negative consequences can be eliminated or minimised and opportunities for ensuring equality can be maximised.

Equity audit Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but, rather, relative to health need, otherwise inequities occur that lead to health inequalities.

Expert Patient Programme (EPP) An NHS programme designed to spread good self-care and self-management skills to a wide range of people with long-term conditions. Using trained non-medical leaders as educators, it equips people with arthritis and other long-term conditions with the skills to manage their own conditions.

Framework for procuring External Support for Commissioners (FESC) This is a ‘call-off’ framework contract that helps PCTs, should they wish, to bring in external expertise and skills to strengthen their commissioning functions.

Framework contract A contract listing a range of suppliers who have demonstrated that they are able to provide specified goods or services. Once in place, organisations call upon one or more of the suppliers for goods or services as required.

Fitness for Purpose programme The aim of this programme is to ensure that all PCTs become excellent commissioners. The programme is developing organisational assessment and commissioning capability diagnostic tools to support this process.

Full cost recovery Full costs are the direct costs of the project or service plus a relevant portion of organisational overheads (central administrative costs). Full cost recovery is the process of costing activities to include the appropriate share of overhead or indirect costs, as well as the direct costs of delivering a service.
**General Medical Services (GMS)** This is one type of contract PCTs can have with primary care providers. It is a nationally negotiated contract that sets out the core range of services provided by family doctors (GPs) and their staff. Other types of contract include Personal Medical Services (PMS) and Alternative Provider of Medical Services (APMS).

**Government Offices of the Regions** Representing 10 Whitehall departments, Government Offices are the primary means by which a wide range of government policies are delivered in the English regions.

**Health Direct** This will be a national multimedia service designed to support people in making healthy lifestyle choices. It is in the early stages of development by NHS Direct, and is due for national roll-out from 2008. The service will provide information, advice and support on diet, physical activity, alcohol, smoking, sexual health and mental health.

**Healthcare Commission (HCC)** The independent inspectorate in England and Wales that promotes improvement in the quality of the NHS and independent healthcare.

**Health inequalities** The health gap between disadvantaged groups, and communities and the rest of the population

**IDeA** The Improvement and Development Agency for local government works for local government improvement so councils can serve people and places better.

**Individual budgets** These are designed to provide individuals who currently receive services with greater choice and control over their support arrangements. The individual budgets pilot project is a cross-government initiative led by the Department of Health working closely with the Department for Work and Pensions and the Department of Communities and Local Government.

**Integrated Service Improvement Programme (ISIP)** An NHS programme that integrates the planning and delivery of benefits from the investment in workforce reform, Connecting for Health, and best practice from the Modernisation Agency and NHS Institute. The programme aims to drive delivery of efficiency through effective commissioning and integrated planning.

**NHS Lifecheck** Announced in the Our health, our care, our say White Paper, the Life Check service focuses on prevention and well-being, aiming at helping people assess and tackle their lifestyle risks. The service will be developed and evaluated in 2007, ahead of a wider roll-out.

**Link Age Plus** Funded by the Department for Work and Pensions, this aims to provide a single gateway to services provided in the community – ranging from housing matters, social care and financial benefits to transport, health
and volunteering opportunities. Link Age Plus is currently being tested in eight English local authority areas.

**Local Area Agreement (LAA)** A three-year agreement setting out the priorities for a local area in certain policy fields as agreed between central government (represented by the Government Office), and a local area, represented by the local authority and Local Strategic Partnership (LSP) and other partners at the local level. The agreement is made up of outcomes, indicators and targets aimed at delivering a better quality of life for people through improving performance on a range of national and local priorities.

**Local authority** Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation.

**Local Involvement Networks (LINks)** These networks will be able to provide flexible ways for communities to engage with health and social care organisations in ways that best suit the communities and the people in them. LINks will be established for every local authority area with social services responsibilities.

**Local Strategic Partnerships (LSPs)** LSPs bring together representatives of all the different sectors (public, private, voluntary and community) and thematic partnerships. They have responsibility for developing and delivering the Local Area Agreement (LAA).

**Long-term conditions (LTCs)** Those conditions (e.g. diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.

**Mental health services** A range of specialist clinical and therapeutic interventions in mental health and social care provision, integrated across organisational boundaries.

**NHS Connecting for Health** An agency of the Department of Health delivering the National Programme for IT to bring modern computer systems into the NHS, which will improve patient care and services.

**NHS Institute** The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

**Outcomes** A health or care outcome is the result or effect of an intervention or lack of intervention on a previous health state or condition.

**Overview and Scrutiny Committee (OSC)** A committee made up of local government councillors concerned with local NHS and social care matters.
Payment by Results (PbR) A scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, whereby all trusts are paid the same for equivalent work. See also Tariff and Tariff unbundling.

PCT Prospectus A document which sets out the strategic direction for local health services, highlighting commissioning priorities, needs and opportunities for service providers, providing a focus for discussion with patients and the local community, and an opportunity to open dialogue with potential providers.

Practice based commissioning (PBC) PBC gives GPs direct responsibility for achieving best value within the funds that the Primary Care Trust (PCT) has to pay for hospital and other care for their practice’s population.

Primary care The collective term for all services, which are people’s first point of contact with the NHS.

Primary Care Trusts (PCTs) Freestanding statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.

Provider A generic term for an organisation that delivers a healthcare or care service.

Quality and Outcomes Framework (QOF) Part of the contract Primary Care Trusts (PCTs) have with GPs. It is nationally negotiated and rewards best practice and improving quality.

Segmentation The process of splitting a market or system into different groups, or segments, within which people share the same or a comparable set of needs, such as a care group or service. Examples in the health and social care system include care services for children, or health services for people with a long-term condition.

Single assessment process (SAP) An overarching assessment of older people’s care needs to which the different agencies providing care contribute.

Social enterprise Businesses with primarily social or environmental objectives. Their surpluses are reinvested principally in the business or the community. The social enterprise sector is diverse, some examples are cooperatives, development trusts, community enterprises, housing associations, and social firms. Social enterprises use a wide range of legal forms. There are at least 55,000 social enterprises in the UK, and they contribute £8.4 billion per annum to the UK economy, almost 1% of annual GDP.
Social exclusion Social exclusion occurs when people or areas suffer from a combination of linked problems, including unemployment, poor skills, low incomes, poor housing, high-crime environments, bad health and family breakdown. It involves exclusion from essential services or aspects of everyday life that most others take for granted.

Strategic Health Authority (SHA) The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts (PCTs) are performing well. They are the link between the Department of Health and the NHS.

Tariff A set price for each type of procedure carried out in the NHS, for example a hip replacement. See also Payment by Results.

Tariff unbundling Current tariffs include several stages of a procedure, for example the follow-up outpatient appointments after an operation as well as the operation itself. Unbundling breaks the tariff down to cover these constituent parts.

Third sector The full range of non-public, not-for-profit organisations that are non-governmental and ‘value driven’; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

Voluntary and community sector An umbrella term referring to registered charities as well as non-charitable, non-profit organisations, associations, self-help groups and community groups, for public or community benefit.

Well-being The subjective state of being healthy, happy, contented, comfortable and satisfied with one’s quality of life. It includes physical, material, social, emotional (‘happiness’), and development and activity dimensions (Felce and Perry 1995; Danna and Griffin 1999; Diener 2000).

‘Year of Care’ approach Describes the ongoing care a person with a long-term condition should expect to receive in a year, including support for self-management, which can then be costed and commissioned. It involves individual patients through the care planning process, enabling them to exercise choice in the design of a package to meet their individual needs.
You are encouraged to share your views with regard to the proposals contained within this framework at our consultation website: www.commissioning.csip.org.uk