



consultation

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Commissioning framework for health and well-being

The *Commissioning framework for health and well-being*, published by the Department of Health (DH) in March, is a consultation document detailing proposals for making commissioning of primary, community and social care services more effective and in keeping with last year's white paper, *Our health, our care, our say*.

This *Consultation* highlights issues of particular relevance to primary care trusts (PCTs) and invites the comments of NHS Confederation members on the key issues raised in the document.

Key points

- Commissioning for health and well-being must involve the local community in providing services that not only treat people when they are ill but also keep them healthy and independent.
- The DH proposes to place a duty on PCTs and local authorities to produce a joint strategic needs assessment encompassing a minimum data set.
- Commissioning should move its focus from volume and price to quality and outcomes.
- PCTs and practice-based commissioners are encouraged to use NHS funds more flexibly to avoid expensive interventions.

Context

The *Commissioning framework for health and well-being* is aimed at commissioners and providers of health and social care services and local authorities. The framework described forms part of the implementation of the *Our health, our care, our say* white paper. This latest consultation is key to the development of a final document, which is due to be published this summer.

While *Health reform in England*, published by the DH last year, dealt mainly with commissioning hospital services covered by choice and payment by results, this framework covers commissioning of primary care (except the negotiations on the general medical services contract), community healthcare, social care, public health and well-being.

The document outlines how commissioners can implement the

policies described in *Our health, our care, our say*, the 2003 green paper *Every child matters* and the Treasury-commissioned Wanless reviews.

In line with these, the commissioning framework stresses the need for commissioning that invests now to reduce future ill-health costs and that shifts towards services which are personal and maintain independence and dignity. Each chapter includes a section on person-centred care as well as one on commissioning for the local population.

The framework also reinforces themes set out in last year's local government white paper, *Strong and prosperous communities*, which proposes ways in which local government and health can work in partnership.

Effective commissioning for children and young people is regarded as a success story and an example to be emulated.

The framework

The focus of the framework is on taking action and partnership working. It aims to be practical and includes extensive examples of good practice as well as detailed information on tools and resources.

The underlying vision is of a wider range of more innovative providers offering services tailored to individual needs, with care closer to home and a greater emphasis on prevention.

A basic premise is that NHS commissioning currently focuses too much on volume and price and that this should shift to an emphasis on quality and outcomes.

DH's eight steps to more effective commissioning

- 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
- Local accountability
- Capability and leadership

Putting people at the centre of commissioning

The challenge to commissioners is to make greater local choice and engagement a reality. The document criticises the current 'one size fits all' style of commissioning and lack of local engagement that often results in poorly designed services. Measures include:

- forthcoming DH proposals on extending choice across all services – commissioners will be expected to implement the new policy from 2008, with PCTs indicating their initial approach in their prospectuses
- providing local communities with good information – for example, by using local health profiles to show how their health compares with that of people in other areas
- using practice-based commissioning creatively to design care packages
- redesigning services around users' daily lives – for example, by co-locating services on sites used by children.

Commissioners can empower individuals to voice their concerns by making it easier to supply feedback and by developing innovative mechanisms to involve patients – for example, through blogs (web logs) and internet groups.

In particular, commissioners should seek to empower the socially excluded, looking at whether information promotes social inclusion. Social marketing approaches can make a major contribution. Commissioners should also ensure that local people know how to challenge poor services – for example, through petitions.

Understanding the needs of individuals

A major focus of the framework is assessment of need, especially joint strategic needs assessments. Although integrated needs assessment is increasingly used for people with complex needs, more should be done to target individuals or communities whose needs remain unrecognised and may be at risk of developing substantial health and social care needs in the future.

With individual needs assessment, commissioners' understanding can be improved by using recognised assessment and care-planning processes. The document argues that progress has been made in this area – for example, in assessing the needs of those with serious mental health problems. A common assessment framework for adults is already being drawn up. Assessment of risk factors in individuals is also progressing. The Quality and Outcomes Framework (QOF), for example, incentivises GP practices to case-find diseases. However, QOF does not yet incentivise the systematic identification of those at risk of developing illnesses such as cardiovascular disease.

From 2007/08 local delivery plans will highlight the gap between QOF performance on management of hypertension and cholesterol and expected local prevalence. This should help commissioners to fill the gap. PCTs will also be able to use chronic heart disease, diabetes and hypertension models on the Association of Public Health Observatories website. This will highlight the gap between recorded and expected/actual prevalence, and PCTs should ensure the use of local interventions matches estimated prevalence.

'A major plank of the framework is the proposal to place a duty on PCTs and local authorities to produce a joint strategic needs assessment'

Joint strategic needs assessment

A major plank of the framework is the proposal to place a duty on PCTs and local authorities to produce a joint strategic needs assessment: "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."

The DH is consulting on a proposed minimum data set and a list of stakeholders who should be involved. Meanwhile, the DH expects all local commissioners to carry out assessments as a matter of good practice and in line with the proposed duty. PCT directors of commissioning will need to work with directors of public health, adult social services and children's services to manage the process across organisations.

The document stresses that assessments should be based on a joint analysis of current and predicted health and well-being outcomes, what the local community wants and a view of the future predicting new or unmet needs.

Under the proposals, joint strategic needs assessments will be made available to current or potential providers. Strategic health authorities (SHAs) and government offices will be key in building capability, including sharing scarce analytical and support skills and providing leadership. The joint strategic needs assessment should:

- describe future health, care and well-being needs of the local population and the strategic direction of service delivery to meet those needs
- look ahead three to five years
- analyse data
- define where there are inequalities
- use local views and evidence of effectiveness of interventions to shape investment and disinvestment services
- define achievable improvements in health and well-being outcomes.

The assessment will not define precisely what commissioners should 'buy' each year, and the document stresses that it is not the role of central government to provide a detailed description of what form an assessment should take.

Outputs from the joint strategic needs assessment include a programme of systematic service reviews, prioritisation for annual contracting procurement, medium-term market development and primary care investment commissioning decisions.

Production of joint strategic needs assessments will be the responsibility of senior directors in the NHS and local authorities and will become an integral part of the planning cycle. The DH expects assessments to be carried out in line with the three-year local area agreement cycle.

The assessment should be used to plan over a range of timescales, including annual, medium and long-term. It must be conducted by upper-tier local authorities.

The assessment will be a key basis for agreeing the longer-term priorities in the sustainable community strategy via the local strategic partnership and will 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 SHA.

Health and social care commissioners can benefit from analytical techniques used in other industries such as actuarial forecasting, market segmentation and cost-benefit analysis. These require skills which may not be readily available at local level, so commissioners are encouraged to buy in expertise or pool their resources to share expertise.

Sharing and using information more effectively

The document argues that pooling of information can make commissioners more effective. However, a major obstacle to sharing has been a lack of understanding about what is legally permissible.

Commissioners should work with providers to develop ways of sharing information about individuals where there is clear patient consent.

Commissioners also need to work together to identify which data sets and information infrastructures are permissible. The use of data collected at service-user level can be regarded as a secondary use, and further guidance on secondary uses of health and social care data will shortly be issued by the Care Record Development Board. The Secondary

‘Commissioners need to commission for outcomes and outputs rather than counting services given such as treatment episodes’

Uses Service (SUS), developed by NHS Connecting for Health and the Information Centre for Health and Social Care, will provide indicators on health service commissioning and support in terms of data, tools and facilities such as pseudonymisation. The DH expects public health directors to lead this work jointly with directors of adult social services and children’s services and to ensure that data is fit for purpose.

Assuring high-quality providers

Commissioners have a crucial role in shaping the market to stimulate providers to produce innovative solutions. This can be done through early discussions with provider communities about need; through transparent procurement; and by addressing potential barriers to entry. It may currently be difficult for potential new providers – especially third sector providers – to enter new areas without active support.

In order to secure cost-effective high-quality provisions, commissioners need to commission for outcomes and outputs rather than counting services given such as treatment episodes. Commissioners also need to:

- involve providers in needs assessment
- establish a local provider forum to engage with providers

- develop better market intelligence, including understanding of third-sector organisations
- provide easily accessible information to help people – whether self- or state-funded – choose between providers
- adopt fair procurement processes by being transparent on pricing, minimising transaction costs and allowing providers to produce realistic tenders
- encourage entry of new participants into the provider market, including social enterprises and the third sector – for instance by using additional incentives such as a supplement to tariff or guarantee within the contract.

Other considerations include contract length, principles of fair and reasonable trading, how the risk is shared between provider and commissioner and any ‘social dividend’.

Health and well-being

A major strand of the framework is the need to improve the health and well-being of people in employment and to help individuals improve their well-being through employment. Commissioners can do this by:

- delivering services that help people remain in or return to work
- using their powers as employers to recruit from their community and help individuals with manageable health problems to maintain or regain work
- using the power of commissioning to influence the health and

well-being of people employed by providers.

Developing incentives

The document details incentives – particularly financial and contractual incentives – to encourage commissioners to work together.

A major issue covered by the paper is the flexible use of NHS resources on non-health interventions and to support better self-care. PCTs and practice-based commissioners are encouraged to be more flexible in using NHS funds so they can provide an alternative to hospital admission or avoid more expensive interventions that may reduce independence.

Practice-based commissioners will have to submit a business case to the PCT for a decision on expenditure of this type. PCTs should ensure that the proposed use of funds is consistent with legal requirements, is of demonstrable benefit to the NHS and does not breach acceptable procurement practice. PCTs should encourage commissioners to experiment with new models of care.

Commissioners can create local financial incentives to encourage early action for those at risk. The DH expects all practice-based commissioning incentive schemes in 2008/09 to include incentivising to reduce lifestyle risks.

Pooled budgets – especially budgets with one lead commissioner rather than a committee structure – can be very effective in delivering joined-up services. Contracts can, of course, also be used to incentivise. For example, commissioners may choose to award preferred status or apply a premium

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to providers who deliver improving outcomes and contribute to reducing social exclusion.

Local accountability

The Government is developing appropriate channels to hold each public body to account for its commissioning, and the aim is for these channels to be consistent with those in the local government white paper.

Current accountability arrangements are unsatisfactory in that local commissioners often work separately, leading to inefficiencies, gaps and overlaps.

As well as requiring commissioners to undertake and publish joint strategic needs assessments, new commissioning accountability arrangements would:

- empower individuals and communities through powers of complaint and innovative consultation methods
- require PCTs to publish prospectuses setting out unmet needs and gaps in services and how these will be addressed
- require practice-based commissioners' business plans to show how they will contribute to goals in the PCT prospectus and local area agreement.

Capability and leadership

The DH considers building organisational commissioning capability a key challenge for the next phase of developing commissioners.

Current development plans – for example, under the fitness for purpose programme – are of varying quality and lack coordination.

It is the responsibility of local commissioners to ensure that they have the necessary skills to commission for health and well-being. For PCTs the starting point remains the fitness for purpose programme and the DH will ask the Healthcare Commission in 2007/08 to assess PCTs' progress in building capability. PCT development programmes should use the commissioning cycle model set out in *Health reform in England* and should be accredited. The NHS Institute for Innovation and Improvement will lead on accreditation.

Confederation viewpoint

Many of the ideas in the framework document will be familiar to PCTs as it represents a synthesis of a number of policy statements over the last year.

Some commentators have expressed disappointment that the framework is relatively short on prescription and has only a limited range of new ideas for local implementation. The Confederation has a different reading and feels that the framework leaves a significant amount of discretion for organisations and their partners to create a vision that is locally owned and appropriate to the needs of the area. This will bring some significant challenges.

There are a number of welcome proposals – for example, the development of joint strategic needs assessment and the measures to deal with the frustrating issues surrounding data-sharing between agencies.

The section on the commissioning of social care by practices and PCTs

Tell us what you think

The full list of consultation questions can be found at www.dh.gov.uk.

However, we are particularly keen to hear from members on key issues:

- Does the guidance support you in putting people at the centre of planning and commissioning, including those who do not typically access services? What more can be done?
- What are the barriers to sharing and using information more effectively and how can they be overcome?
- Does the framework offer sufficient guidance on market management and commissioning from a more diverse range of providers?
- Are there sufficient levers and incentives for commissioners and employers to improve health and well-being?
- How much influence should PCTs and local authorities have on each others' investment plans?
- What do local commissioners need in terms of national support for developing commissioning capacity?
- How can we ensure that the joint strategic needs assessments are used effectively? Do you have further feedback on them?

Your responses will inform the formal PCT Network and NHS Confederation response. Please email your contributions by 22 May to sarah.campbell@nhsconfed.org

helpfully sets out the legal position. The emphasis on opportunities to spend NHS resources outside traditional health services is welcome as long as there are safeguards to ensure that this does not lead to a shift of resources by local authorities out of social care.

The section on incentives raises some significant issues. The ideas on individual budgets do not appear to have been worked through. Our work in this area suggests that while this is an attractive and potentially powerful idea, the practical issues such as budget-setting, dealing with unexpected expenditure and transactions systems are quite significant.

The framework document fails to deal with the fact that the tariff system is not particularly well aligned with the objectives of improving long-term conditions management. In many places this will require the cooperation of acute providers, but in the current system there is

little incentive for this. We have raised the issue of how practice-based commissioning interacts with children's trusts, but this conundrum remains unresolved.

The Local Government Bill will make local area agreements a much more significant part of the local planning machinery, and PCTs will be given a statutory duty to participate.

We strongly believe that other providers should participate as appropriate and be obliged, where necessary, to promote the local area agreement. However, this should be achieved through the contract with the PCT and not by a legislative duty being applied. At

present, the proposals in the Local Government Bill would impose an unequal burden on NHS providers compared to independent or third sector providers.

Overall, a very substantial programme of work is needed to achieve the objectives envisaged in the framework document. And because of the generally permissive and high-level nature of the policy, PCTs and their partners will need to develop their own approaches. This is challenging but positive. The DH will need to make it very clear that it will not revert to the more prescriptive approaches that have marked other guidance – for example, on practice-based commissioning.

Further information

Our health our care our say: a new direction for community services, 2006

No excuses. Embrace partnership now. Step towards change! Report of the third sector commissioning task force, 2006

Health reform in England: update and commissioning framework, 2006

Securing good health for the whole population, 2004

All above on www.dh.gov.uk

Every child matters, 2003 www.dfes.gov.uk

The NHS Confederation

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. We help our members deliver better health and healthcare by:

- influencing policy and the wider public debate on the full range of health and health services issues
- supporting health leaders through information sharing and networking
- working for employers to improve the working lives of staff and, through them, to provide better care for patients.

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