

Commissioning Framework for Health and Well-being – Making it Happen

Annex: responses to the consultation

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Detailed consultation responses

1 Introduction

- 1.1 We published the Commissioning Framework for Health and Well-being in March 2007 and launched a consultation exercise on its proposals, which was concluded at the end of May. We received almost 300 responses from a wide range of organisations and individuals, including many joint responses from partners in local health and care communities. This annex provides an overview of these consultation responses and a summary of your responses to each of the consultation questions in the *Commissioning Framework for Health and Well-being*.
- 1.2 A link to the consultation responses that we have received permission to publish is available at:
<http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

2 Overview of consultation responses

- 2.1 Most responses from all sectors were positive about the overall direction of the framework. People welcomed the opportunity to strengthen existing partnership working, and the greater focus on health and wellbeing and a shift towards preventative services. People supported the person-centred approach we advocated in the framework, which built on the vision outlined in *Our health, our care, our say White Paper*. Most people agreed that the framework has the potential to empower people to take control of decisions about their health and wellbeing.
- 2.2 Many respondents suggested that to meet the objectives of the framework, needs assessment, priority-setting, and decisions on how needs will be met, must be made locally. This requires both local leadership and local partnership working. The Joint Strategic Needs Assessment, and associated proposed statutory duties on partners, were seen as an effective vehicle to achieve change.
- 2.3 People welcomed references to the importance of mental health and interconnections between people's medical, environmental, educational and social needs. Many respondents also welcomed the recognition in the framework of the connections between health, personal, social and economic well-being.
- 2.4 Respondents suggested there was potential for the overall approach of the framework to support the Disability Equality Duty, provided that we give due regard to the need to promote disability equality in the detail of the framework.

3 Putting people at the centre of commissioning

- 3.1 We want to make sure that all citizens in a local area – adults and children, their family and carers, and all care groups – feel able to make choices about health and social care services that suit them, have their voice heard and be in control of what happens to them.

Q1: Are the measures set out sufficient to enable people to take greater control of decisions about their health care? What further action could central government take?

- 3.2 Most respondents to this question thought that the measures set out were generally adequate and did give people greater choice. Although it was agreed it was a challenge, the framework was seen as a powerful tool that could give people better choice and control.
- 3.3 Respondents welcomed the framework recommending engagement with residents rather than just with patients who currently use services and this needs to be reflected in any performance monitoring of the area.
- 3.4 Local Involvement Networks (LINKs) were welcomed as an opportunity for involvement, and it was suggested they be used as a means to ensure local inclusion of disabled people, including people with mental health problems and/or learning disabilities. The approach to advocacy was also welcomed, and was seen as key to ensuring that people whose voices might not otherwise be heard were able to influence commissioning.

Concerns and potential barriers to implementation

- 3.5 Many respondents thought that in order to give people (especially older people) real control and choice, direct payments and individual budgets should be developed so that individuals can actually 'buy' the services they want.
- 3.6 Another barrier identified by many respondents was commissioner capacity to support advocacy, and that this would also take extra resources. Several respondents also said that if all service users are to be able to voice concerns about services it is crucial that unthreatening complaints procedures are developed (in particular in relation to young people).

Detailed suggestions and support required

- 3.7 Respondents from all sectors suggested that there should be more explicit guidance for commissioners on how they can support people to make choices around their health and social care services. This included support for commissioners to engage young people, particularly those from more vulnerable or marginalised communities. Respondents suggested that a 'code of practice' be developed for consultation.
- 3.8 Some suggestions by the third sector for support to improve information, advice and independent advocacy services included development of local information and advice services as a joint local government and health responsibility, making it much easier for people to access help where they live, and investment in independent advocacy services in every community to support those people who are most vulnerable and excluded. It was also suggested that social enterprises / third sector organisations could play an important role in reaching hard to reach groups, given that a key characteristic of social enterprise is often a close understanding of and commitment to hard-to-reach groups in the local population, often including the involvement of disadvantaged people in the organisational structure.

Q2: What special arrangements might be needed to ensure that the views are heard of those who do not routinely use local services?

- 3.9 There was a general view that there was the opportunity for the NHS to build on existing local links developed by local authorities, who may have particular consultation routes for specific communities, for example, Hertfordshire County Council manages some sites for Gypsies and Travellers and can use its consultation processes to collect views from these communities.
- 3.10 There was also a general view that there shouldn't be an over-reliance on formal structures to engage these groups – and that more innovative ways should be used to engage with individuals – at the point where they use services, but also to engage the people who may not use statutory health or care services.
- 3.11 There were also many suggestions that the third sector is well placed to facilitate the engagement of a wide range of people.

Areas of concern and potential barriers to implementation

- 3.12 Concerns were raised across sectors around resources and capacity for engaging with socially excluded groups.

Detailed suggestions and support required

3.13 Some suggestions for ensuring hard to reach groups were targeted included:

- > Local media work to ensure people were aware of the canvassing of views, such as through local newspapers - it must be made as easy as possible for these people to get their views across, through a variety of means such as telephone canvassing or online forms;
- > Recommending that commissioners should make every effort to engage innovatively with children and young people, making full use of a wide variety of methods, including consideration of internet sites such as myspace.com, text messaging;
- > Arranging consultation in creative ways through community services – for example, supermarkets, gyms and leisure centres (both private and local authority), parks, shops, public transport, pubs and cafes, hairdressers and nail bars, private nurseries, churches and mosques, petrol stations etc.
- > Using community pharmacies to engage with people who do not otherwise access NHS services;
- > Using libraries in engaging with hard to reach groups;
- > Outreach work – and evidence of best practice and efficient methods;
- > Using virtual consultations and young adult community forums;
- > Focus groups, and special support;
- > Social marketing techniques;
- > Exploring the role of independent advocacy for the most vulnerable groups of children and young people;
- > Using the existing expertise within LAs (and children’s centres) around consulting with children and young people - the NHS and LAs should undertake joint consultative exercises;

4 Understanding the needs of populations and individuals

- 4.1 We want to make sure that local commissioners do a thorough assessment of the needs of the whole local population, including identifying people who currently get a raw deal. Good joint strategic needs assessment is the foundation for all good commissioning decisions.

Q3: Will the approach set out 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 Assessment?

- 4.2 The principle of the Joint Strategic Needs Assessment (JSNA) approach was widely supported, and the proposal that requires the JSNA to be used to inform Local Area Agreements was also welcomed. It was broadly agreed that the approach on JSNAs would support commissioners to undertake a needs assessment of an individual, a group and a community. It was suggested that it should be an ongoing process (not a one-off product) that requires regular review as people's needs change over time.
- 4.3 It was suggested across sectors that the JSNA should be used to underpin strategies for the development of future communities and the local economy, e.g., sustainable social housing, as one element of a whole system approach to tackling social exclusion, and it could inform local government planning around community provision such as community schools, children's centres and older people's resource centres, as well as urban and rural planning; and intelligence about health inequalities and health status and deprivation should inform planning for economic renewal and job creation.
- 4.4 It was also suggested that the duty should go beyond health and social care partners to include wider local authority services including, for example, Trading Standards whose work around food standards and crime prevention are major contributors to public health and supporting older people to remain in their communities, Housing, the Police and the Fire services.
- 4.5 Representative groups suggested that the role of community pharmacists could be reinforced as a partner in the development of a Joint Strategic Needs Assessment in order to utilise their knowledge of the needs of their local population, and as an alternative provider of services.

Areas of concern / possible barriers to implementation

- 4.6 There was general concern about the organisational and developmental capacity of commissioners needed to undertake robust needs assessments and how these, in turn, can be developed into overarching commissioning strategies to be implemented locally.
- 4.7 Some local authority respondents again raised the issue of the shift in resources from acute services to community services, and suggested that Local Area Agreements could be the vehicle for this transfer
- 4.8 Some local authority respondents were concerned about the timetable for this process, and that it would be necessary for the JSNA infrastructure arrangements to be set up well before the Local Area Agreement requirements are in place by April 2008, to ensure that LAAs are genuinely influenced by the needs and aspirations of local people.

Detailed suggestions and support required

- 4.9 Respondents suggested that it would be useful for further guidance around JSNAs, including:
 - > Clarity on how these should be performed in two-tier authorities;
 - > How to address health inequalities within this process in the most effective way;
 - > Examples of good practice from elsewhere in engaging communities to inform the needs assessment.
- 4.10 In addition, further central support was identified around:
 - > capacity and capability to complete the JSNA;
 - > analytical support to inform the JSNA.

Q4: How can we shape the duty of Joint Strategic Needs Assessment to have the greatest impact on health and well-being?

- 4.11 It was recommended by many respondents across most sectors that the duty on both parties needs to be not just to undertake the assessment but to agree an integrated plan to address the issues revealed by the assessment, and that the focus on health and well-being needs to be explicit in the responsibility. This should be combined by introducing good partnership working across a range of key stakeholders. The roles, responsibilities and duty of partners to contribute need to be properly

established and written in a fair way between health services, local government and other partners, for example the Police (there could even be a duty to work together and include other stakeholders such as carers, users etc). In addition, many recommended that the JSNA be aligned to other statutory local plans, for example, the Local Area Agreement, the Children & Young People's Plan so it would be seen as a joint requirement in relation to implementation.

- 4.12 Several women's interest groups recommended that in line with gender equality duty, needs require data which can be disaggregated by sex, age, race, sexuality, disability etc.
- 4.13 The framework also asked whether the approach to JSNAs would be suitable for children and young people, for whom services are commissioned through children's trust arrangements. Responses to this are covered later in this annex in the section on children and young people.
- 4.14 We also received responses to Annex A of the *Commissioning Framework for Health and Well-being* which contained more detailed questions around the JSNA and the minimum requirements. These more detailed comments are summarised later in this document.

Detailed suggestions and support required

- 4.15 To ensure the greatest impact on health and well-being it was recommended that the process of Joint Strategic Needs Assessment be reflected in national policy across health and local authorities. LAA targets should be required to reflect priorities identified in the JSNA. Business planning cycles should be integrated and performance indicators shared. It would also be useful to create a duty on district councils, registered social landlords and DWP (and Job Centre Plus) to co-operate with the Joint Strategic Needs Assessment by meeting all reasonable requests for data.
- 4.16 In addition, it would be useful to clarify the role of the Health Overview and Scrutiny Committees in scrutinising local authority and NHS responses to key strategic needs assessments.

Q5: Will the approach to JSNA be suitable for children and young people, for whom services are commissioned through children's trust arrangements?

- 4.17 Some respondents suggested that a wide range of additional information should be used to build a clear picture of the needs of individual children and young people as well as mapping their needs within communities.

Children and their families access services in a wide range of environments and it is important that information held for example on school health records, is seen as part of the overall needs assessment.

- 4.18 It was also suggested that the approach involve children, young people, parents and carers, those agencies and individuals working closely with vulnerable children and young people such as the SHAPE teams, schools, PTA's and educating parents.
- 4.19 Many respondents – across the range of sectors, asked that further information was issued to make clear the linkages between practice-based commissioning and Children's Trusts.
- 4.20 This question is also covered briefly in the section on commissioning for children and young people at the end of this annex.

5 Sharing and using information more effectively

- 5.1 We want to make sure that local commissioners and professionals are able to share information, where this is appropriate and helps them to provide better health, social care and well-being services. This is vital to ensure that individuals get properly personalised care, and to ensure that the data needed to do a good JSNA, is easily available.

Q6: Are the main information requirements for effective commissioning identified here? Are there any obstacles or gaps that need to be addressed?

- 5.2 Comments broadly supported the information requirements for effective commissioning. Some third sector respondents suggested the use of information from provider, carer, user and voluntary organisations (with common terminology and definitions).
- 5.3 The main obstacle highlighted was around local interpretation of the guidance on information sharing. This is a complex issue as local instances of sharing often raise specific issues that can only be resolved by the exercise of judgement in each case.

Concerns / barriers to implementation

- 5.4 Many respondents indicated that staff were unclear about what data was available, and who held the data, which led to duplication of effort in collection. It was also considered a barrier that there is a wide variation and lack of consistency in the population levels at which different datasets are held.
- 5.5 Patient representative groups highlighted the need to differentiate between individual and population level data to avoid inappropriate sharing of personal information.

Detailed suggestions and support required

- 5.6 Gaps in information that were identified included:
- > Unintentional injury data - more training and awareness for staff required;
 - > Identification of exactly what information is required to share between partner agencies;
 - > Training for commissioning;
 - > Delegated power to buy best practice/services;

- > Greater pooling of information across commissioners;
- > Capacity to respond to requests for data;
- > Small numbers make some needs difficult to identify and then commission appropriate services ;
- > Staff awareness;
- > The quality of community based data on health care and treatment;
- > Inability to link episodes of care across different community-based health professional groups, and between primary, community and secondary-based health care.

Q7: 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?

- 5.7 Many responses said that the legal situation is set out quite clearly in the framework – however, it was not always clear how some of the obstacles and difficulties can be overcome at a local level – e.g. varying interpretations between professional groups and organisations about what constitutes legitimate data sharing.

Concerns / barriers to implementation and solutions

- 5.8 Many local government respondents asked for clarity around the NHS Confidentiality Code in particular how it applied outside of the NHS 'family', and the area of patient consent. Respondents recommended national guidelines, to be adapted locally, on how NHS confidentiality requirements should apply to non-NHS organisations providing health and social care services.
- 5.9 Many respondents across sectors identified the need to review data sharing to identify who owns data networks and who has access to the data contained on those networks. In addition, it was felt there are no clear guidelines as to the legal ownership of data and data networks funded by statutory agencies and provided by the third or private sectors.
- 5.10 Incompatibility of IT systems and IT failures were also listed as challenges to intelligent commissioning locally. This also included the potential of joining up the systems of third sector front line service providers.

5.11 The framework also asked whether there are any specific issues around sharing information on children and young people that should be addressed at national level. This question is covered in the section on commissioning for children and young people later in this document.

Q8: Are there any specific issues around sharing information on children and young people that should be addressed at national level?

5.12 Respondents suggested joint training on issues of:

- > handling sensitive data, and
- > confidentiality.

5.13 This question is also covered briefly in the section on commissioning for children and young people later in this document.

Q9: 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?

5.14 The majority of respondents to this question agreed that it would be very helpful for the Department of Health to work with other departments and national stakeholders to develop a common set of principles, as there continues to be uncertainty and debate about this area at an operational level.

6 Assuring high quality providers for all services

- 6.1 We want local commissioners and providers to work together to get the best health and well-being outcomes possible. Commissioners should commission for outcomes, and free up current and potential providers develop innovative solutions for the needs identified in the JSNA.

Q10: Will these proposals support commissioners to assure a range of high quality providers for all services?

- 6.2 The aim of encouraging a wider range of more innovative providers that work with commissioners to offer services better tailored to the changing needs of individuals, was broadly welcomed. The elements of user-focused, outcomes-led, creative and flexible commissioning were seen as encouraging, with value placed on user-led services and the third sector as sources of innovation and diversification of supply. Provision tailored towards prevention/early intervention/maximisation of health and well-being was also welcomed.
- 6.3 Some representative bodies supported the use of public libraries as a channel for community information, and suggested that commissioners should recognise public libraries as vital services that are community based and accessible; trusted and supportive; and providers of relevant and valued related services associated with healthy living.
- 6.4 A variety of respondents supported unbundling of NHS tariffs, and that this could help local authorities and the NHS work more coherently in commissioning providers to meet an individual's health and social care needs.

Areas of concern/potential barriers to implementation

- 6.5 It was recognised that the development of a range of high quality service providers will take time to deliver – there would be some voluntary sector agencies that would be able to take on provider responsibilities as set out in formal contract arrangements, including financial probity / governance and formal monitoring procedures / regulation. However, there would be many more agencies that do not have the size or infrastructure that would permit them to be considered as potential service providers. In addition, the possible capability and capacity gaps amongst commissioners to do this consistently, was highlighted.
- 6.6 A small number of representative bodies/ groups voiced concern that more providers would increase fragmentation and undermine collaborative working, and result in greater variation in local service provision.

Detailed suggestions and support required

- 6.7 Third sector organisations suggested that:
- > the participation of existing third sector providers should be supported - include resources for training, promotion of the market, and set up costs of new services;
 - > full cost recovery should be supported, in particular in relation to grant funding so that providers would not be disadvantaged.
- 6.8 Further advice for commissioners in relation to contracting with the third sector was deemed important – in particular around advocacy and brokerage, and contract management.
- 6.9 It was highlighted that the framework doesn't mention the difference between commissioning services for children, young people, and adults. Service providers are clear that there are large cost and complexity differences in commissioning for these different groups. Some respondents suggested the separate needs of children and young people may require difference assurance mechanisms for providers than those necessary for adult focussed services.
- Q11: 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.)?***
- 6.10 Views were mixed as to whether one contract template should be produced or one for each of the main service segments. It was generally agreed that one size would not fit all and there should be some overarching principles that inform contract templates.
- 6.11 Arguments for the case for one contract include it would ensure common standards were in place across different services and service providers, whilst allowing for derogations and additions to be made to reflect the needs of specific groups and communities, by ensuring there is local flexibility to introduce local arrangements for the separate areas.
- 6.12 Arguments for the case for a contract for each service segment include that the differences in requirements between services are so great that a single template could be too general to be helpful. It was also suggested there should be a separate contract template for children and young people's services that can be shared with local authorities.

7 Recognising the interdependence of work, health and well-being

- 7.1 Work – or other meaningful activity – has a huge impact on people’s health and well-being. Commissioners, working with their providers and other local employers, can harness this impact and make a real difference to the health and well-being of local people.

Q12: Are there sufficient levers and incentives for commissioners and employers to improve health and well-being?

- 7.2 The emphasis on work and health to support well-being was widely welcomed. Several respondents also suggested that the framework should include incentives for employers to be good models, and should consider the needs of carers who are employees. Many third sector and interest groups welcomed the inclusion of the important role of carers, and suggested promoting the employment of disabled people with a wide range of mainstream employers.
- 7.3 Some respondents from local government welcomed the role that practice based commissioning can play in promoting prevention and early intervention, and commissioning social care types of services as early intervention and crisis management for those who do not yet meet the eligibility criteria or need acute health care.
- 7.4 Representative groups also suggested promoting libraries as a foundation for supporting all sections of the population in promoting their own health and well-being. It was also suggested there should be some other rewards for employers and commissioners — it could be a national award or could include things like an additional annual leave day for low absence, e.g. for young people, a reward might be something related to an activity they enjoy.

Areas of concern/ Potential barriers to implementation

- 7.5 Some interest / representative groups and third sector organisations suggested that the approach should also focus on those people that are marginalised from the job market (e.g. people with learning disabilities, mental health service users). It was suggested health services should be collaborating with supported employment services that give skills and support to enable people with a learning disability to access the world of work, and incentives should be offered to contractors to work with these supported employment providers so people with a learning disability are more likely to be considered as potential employees in local areas. It was also suggested that for the most excluded, there needs to be a

greater emphasis on engaging them in any activity that they are interested in that may improve their life chances.

- 7.6 Some local government respondents highlighted that medium and small businesses are not well supported to engage with this agenda, and that further levers and incentives might be required to support employers, particularly small employers, to improve health and wellbeing.

Detailed suggestions and support required

- 7.7 Respondents suggested that sharing further resources and existing learning in taking issues around employment forward would be useful.
- 7.8 Sports interest groups highlighted the usefulness of a sports focus in relation to well-being and the role of sport and physical activity in enabling people to lead a healthy lifestyle, and that it would be important for this to be included in the development of the new LAAs.
- 7.9 Some respondents (mainly from third sector organisations) called for the role of volunteering to be explicitly acknowledged in the framework to identify more clearly how volunteers can deliver and enhance services – and how commissioners and volunteers might be supported to do this. The suggested impacts include:
- > The direct benefits of services delivered by volunteers to the rest of society;
 - > The effects on individuals of volunteering, and the contribution to their own health and well-being;
 - > Increasing social cohesion and enabling individuals to feel part of their local neighbourhood;
 - > Contributing to citizenship, enabling individuals and groups to comment and campaign about services as they affect them

8 Developing incentives for commissioning for health and well-being

- 8.1 When commissioning services for their local populations, commissioners not only look at acute needs, but also to commissioning services which promote health and well-being. Practice based commissioning is becoming increasingly important, so we have encouraged practice based commissioners to spend money on any interventions that keep people well, where this will save the NHS money in the short or medium-term.
- 8.2 The suggested non-health interventions that were set out in the *Commissioning framework for health and well-being* (page 52) are summarised below.

Examples of flexible use of NHS resources through practice based commissioning

- > **Purchase of respite care**
- > **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**
- > **Support to parents** – This could involve using trained volunteers with mothering experience to support local parents.
- > **Developing practice-based multi-disciplinary mental health resources**
- > **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.
- > **Developing social and practical support for isolated older people** – Building community capacity to support isolated older people to maintain their independence.

Q13: What practical, legal and financial issues need to be considered in enabling PCTs and practice based commissioners to spend effectively on non-health interventions?

- 8.3 In general, the approach on funding non-health interventions was supported, as well as the bringing together of local partners (using Local Area Agreements) to better promote health, well-being and independence, by using contracts, pooling budgets and using the flexibilities of existing initiatives such as practice-based commissioning.
- 8.4 Local government respondents suggested that to succeed, this must be a joint approach between PCT/PBC and local authorities to make a real impact on the health and well-being of the community, so that GPs can utilise the skills already existing within social care services.

Areas of concern / challenges

- 8.5 Many respondents highlighted the challenges of developing clarity and capacity for different levels of commissioning eg strategic, operational and individual, joint commissioning arrangements between GPs (with accountabilities to their registered populations) and local authorities (with accountabilities to residents) in terms of shared needs assessment, planning and delivery mechanisms. This was further highlighted by the disparity around free NHS services and charged-for LA services.
- 8.6 Some NHS responders highlighted that establishing clear accountabilities for commissioning will be essential, as will engaging with the local public on issues of commissioning, especially on issues of priorities and disinvestment in acute services. Most sectors had concerns around how non-health interventions would be funded.

Detailed suggestions and support required

- 8.7 It was suggested that partnerships would be key to the approach, and that incentives need to focus on prevention rather than treatment and could be incorporated into practice based commissioning plans where financial incentives already exist.
- 8.8 Some NHS respondents wanted further emphasis and development of guidance to help those decommissioning services – including good case studies, strategies for social marketing and communications, and methods for identifying opportunity costs of investing—or disinvesting—in one service, compared to another.

- 8.9 One of the main issues highlighted was around clarity on commissioning non-health interventions - in what circumstances 'health funding' may be used by PCTs on non-health interventions. Respondents advised that it would be helpful if additional criteria/or a good practice checklist were designed to further assist. It was suggested it would be useful to share and develop evidence of cost effectiveness of non-health interventions for the health economy.

Q14: What further changes would make it easier for resources to follow individual service users?

- 8.10 Suggestions from respondents included:

- > The exploration of individualised budgets for NHS provision. However, individual budgets for all patients suffer from problems of insufficient data on the individual to accurately assess the resource/budget needs of the patient. This introduces the problem of misallocating resources. However, the person-based resource allocation research, which is looking at the possibility of allocating to practices on the basis of individual characteristics, will still allow some flexibility in resource use at practice level
- > Preferred provider lists
- > Pooled budgets
- > Clarifying what is the GPs role within this, as opposed to the practice based commissioner
- > Clarifying the definitions around the use of NHS funding – there is uncertainty around whether direct payments and individual budgets could be used for health services
- > Clarification around whether an individual's right to access a service changes if they move e.g. in Haringey the mobile population requires the development of solutions at a sub-regional/regional level to overcome entitlement barriers linked to place of residence or registration with a particular practice
- > Prices/benchmarked costings for out of hospital care would help the development of tailored health and social care packages and the costings of non-health interventions.

Q15: What considerations do you see in increasing the use of single audit arrangements for pooled budgets?

- 8.11 The use of single audit arrangements for pooled budgets was widely supported by respondents to this question. Respondents suggested that it is vital that in any use of pooled budgets, there is clear recognition of

where responsibilities for different areas of provision lie – a clear partnership agreement.

8.12 Some respondents voiced areas of concern around individual budgets:

- > Concerns that the introduction of individual budgets for social care alone is causing a disintegration of integrated services on the ground
- > What systems need to be put in place to inform and support decision making for those holding individual budgets.

8.13 Respondents commented on the introduction of direct payments:

- > How user's spending decisions are evaluated in terms of cost effectiveness, clinical appropriateness/health gains and wider benefit (i.e. reduction in acute service usage)
- > How user feedback on the services they have received feeds into the commissioning cycle; wider issue
- > Data to support this area needs to be explored
- > Resources must be allocated to develop staff competencies in using the new system and the impact of the data gathering burden should be fed into workforce planning.

8.14 Respondents also highlighted the contrast between funding for NHS and social care services - in that the NHS is free at the point of delivery, and social care services for adults have to be paid for, in whole or in part, by or on behalf of the person using the service.

9 Making it happen: local accountability

- 9.1 We want commissioners to be held directly accountable for all the consequences of their actions, not only by government but also by local people. Our aim is to create a system of accountability which incentivises commissioners to work together to achieve the best possible health and well-being outcomes for local people.
- 9.2 Question 16 is covered in the section on commissioning for children and young people at the end of this annex.

Q17: What further measures may be required to clarify accountabilities for commissioners?

- 9.3 Joint respondents stated that the Local Area Agreement was already a very important framework locally because of the performance incentives and it could be strengthened to work more through it jointly – the proposals for bringing the performance framework for local authorities and health bodies together as in the introduction was supported. It was also suggested using the role of the Director of Public Health's Annual Health Report as a starting point for a joint strategic needs assessment.
- 9.4 Third sector organisations recommended that the contribution made to palliative care by both the voluntary and independent sectors should be recognised - it was suggested that one element of their accountability should be in relation to their working with the non-statutory sectors.
- 9.5 Respondents from the NHS suggested performance monitoring of the health and well being framework needs to incorporate key performance indicators to identify outcomes have been achieved or at least progress towards them. Regular performance reports in meeting the target identified in the joint needs assessment. The DPH Annual Report may be a good vehicle to report to the public. Clear leadership at the highest level would be essential – a Joint Partnership Board with accountability of CEOs through their objectives with a move towards joint performance management, direct links to the LAA and other existing systems, strong and proactive scrutiny arrangements were all suggested.

Areas of concern / potential barriers to implementation

- 9.6 Areas of concerns suggested by representative bodies include limited information or innovation in respect of engaging with the local population. It was also suggested clarifying the interface with local government and PBC might be necessary.

Detailed suggestions and support required

- 9.7 Some suggestions for support required and solutions included:
- > Sharing examples of new and innovative consultation methods to identify the community's health and social care needs, as well as sharing strategies to engage, consult and interact with the public and key stakeholders
 - > Using the SHAPE (Strategic Health Asset Planning and Evaluation) tool to inform and support the strategic planning of services and physical assets across a whole health economy
 - > Using the Children and Young People's Plan from the Children's Trust as the overarching document that outlines the priorities expected to be reflected in the Children and Young People's section of all the other plans
 - > Creating a robust and effective Health and Well-Being Partnership to aid implementation and partnership working
 - > Inclusion of health inequalities information and use of Health Inequalities Impact Assessment tool
 - > Training, clarification and standardisation across PCTs - clarification of roles of other members such as PEC and Trust Board members /non executives/LSP/local councillors in terms of influence.

Q18: 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?

- 9.8 Most respondents to this question thought that local authorities should have some say in the capital investment plans of a PCT and vice versa - development of joint estates strategies with a focus on co-location models should help to achieve the vision of integrated service delivery, both for the front line services and organisational infrastructures.

Areas of concern / potential barriers to implementation

- 9.9 There were concerns around implementation e.g. where a PCT may have to liaise with a number of different local authorities, all of which may have very different priorities.

Detailed suggestions and support required

9.10 Clarification around the role of overview and scrutiny committees was requested.

Q19: What metrics would best support a single health and social care outcomes framework?

9.11 Respondents suggested that the template for the Joint Strategic Needs Assessment contained some of the metrics that would best support a single health and social care outcomes framework. Some additions were suggested including linking to consumer voice / existing performance measures, and metrics affecting morbidity/mortality and inequalities – for example:

- > 7 outcomes for adult social care
- > Dignity in Care challenge – 10 aspects
- > Better Metrics work (Office of the SHAs) e.g. for neurological conditions, as these indicators bring health and social care outcomes together and include access to direct budgets and individual payments
- > 'End of Life Care' elements and mental health metrics.
- > Metrics focussing on the factors, which most directly affect morbidity and mortality i.e. smoking, alcohol and diet/exercise. In addition, in order to narrow the gap in health inequalities, indicators on the areas of teenage pregnancy rates, fuel poverty, decent homes standards and access to high quality pre-school services are useful.

Areas of concern / Potential barriers to implementation

9.12 Concern was expressed that any outcomes framework should recognise that people's experiences and outcomes depend upon a wide range of contributions to quality of life from sectors and disciplines beyond traditional health and social care, for example, accessible toilets with changing facilities, leisure, housing, good public transport and effective street lighting.

9.13 In addition, concerns were also raised the framework should be a dynamic framework within which two distinct systems, one nationally and the other locally accountable, can operate collaboratively, maximise effectiveness and best use of resources, and respond creatively and with the minimum of bureaucratic rigidity to the strengths and needs of individuals and families.

10 Making it happen: capability and leadership

10.1 We want all local commissioners – PCTs, local authorities, practice-based commissioners, and in partnerships such as children’s trust arrangements, to secure the capacity and the required skills, knowledge, leadership and confidence to achieve the best possible health and well-being outcomes for their population, whilst reducing health inequalities.

Q20: What do local commissioners need in terms of national support for developing commissioning capability?

10.2 Many respondents believed that commissioning skills are underdeveloped, and suggested that health and local government develop a joint capability and improvement approach. This should include training, sharing learning and capacity building actions across PCTs, practice-based commissioners, and local authorities to improve commissioning activity.

10.3 Some respondents highlighted that development of commissioning capabilities would be critical for the implementation of the frameworks commitments and called for a more explicit statement about the competencies and capabilities required for the task, to be published either in this framework or in a forthcoming DH/DCLG publication. (in particular in relation to preventative services).

10.4 Other suggestions included:

- > Further guidance on what might be most effective and in turn commissioned in relation to the well-being agenda;
- > National and local support for commissioners, systems that enable them to network and learn from others, share good practice etc;
- > Further clarity around the commissioning synergies and boundaries between PBC, PCTs and social care in order to better support and facilitate local joint commissioning;
- > There should be a formal accredited national training programme for commissioners linked to recognised standards and accreditation.
- > There should be joint training/workshops for health and social care in the implementation of Joint Strategic Needs Assessments (JSNAs) and ensure commitment and ownership by executive teams.

- > Provision of guidelines towards local and sector wide work in support of public consultation and involvement to improve, develop and where appropriate, de-commission services. This should also include guidance on how best to assure that providers are of high quality and offer value for money.
- > Investment in staff development and the necessary infrastructure to support the collection, anonymisation and collation of information on individual needs and outcomes to inform commissioning
- > Inclusion of the role of Regional Centres of Excellence, Government Office, Regional Partnerships, CSIP, Strategic Health Authorities, Valuing People Regional Leads and others in supporting local commissioners
- > Guidance on how to prioritise approaches and conflicting priorities
- > A set of tools and standards for assessing their performance as commissioners

11 Commissioning for children and young people

11.1 The framework covers commissioning for all of the population in a locality – adults and children, their family and carers, and all care groups. However, it particularly highlights the continued importance of effective commissioning for children and young people - investing in services for children and young people improves outcomes for individuals and society now and in the future. The framework therefore asked a number of questions related to emphasising and reinforcing proposals around maximising health and well-being and achievement for children as set out in *Every Child Matters*.

From the section on understanding and planning for the needs of individuals and of the local population – including proposals for Joint Strategic Needs Assessments (JSNAs):

Q5: Will this approach be suitable for children and young people, for whom services are commissioned through children's trust arrangements?

11.2 The majority of respondents across all sectors broadly agreed that the JSNA approach would be suitable for children and young people, provided that it supports commissioning arrangements in Children's Trusts. It was highlighted by many that the assessment would need to work in conjunction with and link to other children's planning – e.g. the Children and Young People Plan.

From the section on Sharing and using information more effectively

Q8: Are there any specific issues around sharing information on children and young people that should be addressed at national level?

11.3 Most respondents to this question asserted that in most cases information on children and young people should be shared in the same manner as for adults. However, areas such as child protection need special consideration, as there is a need to ensure that all agencies working with children are aware of issues in an appropriate manner.

Areas of concern/ Potential barriers to implementation

11.4 The link with primary care commissioners and children and young people should be clarified – it was reported there were still concerns from when some practitioners on what information they are permitted to share and consent of the young person and/or parent/carer must be obtained and when action can be taken without it.

Q16: How can we ensure that practice based commissioning and children's trust arrangements work effectively together to improve outcomes for children?

From the section on developing incentives for commissioning for health and well-being:

- 11.5 As with Children's Trusts, practice based commissioners will need to work with children, young people and families/carers to design appropriate care packages which include both health and social care elements, and take account of educational needs. Doing this in partnership with children's trust arrangements locally would ensure that services are designed around the child and the family, and that all partners are equally involved in both commissioning decisions and in the development of new service models and delivery systems. Third sector providers, in particular, deliver services for vulnerable children and young people who need to be integrated into local arrangements and support may be necessary to ensure that third sector capacity can be developed to play an active role in Local Area Agreement arrangements.
- 11.6 Respondents across sectors said that it would be helpful to clarify who will lead on the commissioning of particular services with respect to the development of Children's Trusts and the role of PBC. Good local partnerships should enable these decisions to be made locally; the common objective is to ensure that improved outcomes are achieved.
- 11.7 It was suggested by a shadow children's trust that there should be a "community commissioning agreement" across a defined area that includes primary care, children's centres, extended schools, and other community investment initiatives. PBC needs to be represented at children's trust executive groups.

12 Equality and Regulatory Impact Assessments

- 12.1 We received a relatively small number of views on these assessments, but of those, the approach to the equality impact assessment was generally greeted as positive – and in particular the link between equality impact assessments and Joint Strategic Needs Assessments, and the focus on ensuring more equal health outcomes (in particular for people with mental health problems and/or learning disabilities and people with a disability).
- 12.2 The inclusion of an impact assessment in the consultation process was also welcomed, which covered the main issues expertly and well.

Areas of concern

- 12.3 It was suggested by several representative bodies that accurate ethnic monitoring would be key in order for the policy to be successful but that it would be useful to also highlight the need for accurate monitoring of gender, disability, age or any other equalities, which would also help PCTs and local authorities develop the evidence base they need for the JSNA.
- 12.4 Several interest groups / bodies were interested in more details around the basis of the assumptions of the costs of implementation in relation to the RIA.

13 Detailed consultation responses on Joint Strategic Needs Assessment

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?

- 13.1 These detailed questions were included in Annex A of the Commissioning Framework for Health and Well-being published in March 2007. We held a number of stakeholder workshops specifically on the JSNA , which were directed predominantly at commissioners (PCT and local government), Directors of Public Health and Information analysts. Feedback from these workshops supports the consultation responses and we are continuing to engage with these important stakeholders.
- 13.2 Many respondents across sectors (in particular those where joint responses were submitted) suggesting linking the JSNA duty to the needs assessments that underpin the LAA targets since these are already focussed on outcomes for individuals and communities, and LAAs include a much wider partnership.
- 13.3 It was suggested the JSNA needs to be owned by the local LSP with all-partner sign up and endorsement. Priorities and recommendations contained within JSNA need to be directly reflected in Sustainable Communities Plan and other organisational plans such as the LDP.

- 13.4 Many helpful additions were suggested as data collection to ensure the needs of children and young people were included, as well as focussing on prevention (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?), and outcomes.
- 13.5 Views were mixed around how data should be provided to commissioners - but most agreed that any approach should ensure clarity on reporting structures, remove duplication of data collection and encourage regular reporting of needs data. Several respondents suggested providing information and analysis to commissioners through a website where data sources and direct links to data can be accessed.
- 13.6 In relation to ensuring that the Joint Strategic Needs Assessments are used effectively, it was suggested by many respondents that they need to be embedded as part of planning processes – and many suggested the LAA needs to be underpinned by the JSNA. When considering whether Joint Strategic Needs Assessments should 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), the majority of respondents on this question advocated that the JSNA should be linked to the LAA planning cycles, but on a rolling basis. Most advocated that this approach would be key to giving the JSNA real bite so it is seen as an integrated element of local planning across the system – and should be integrated into overarching strategic planning cycles. Aligned local processes reduce the possibility of duplication of effort and increase the chances of cost saving.

Suggestions and support required

- 13.7 Further clarification was requested on how, and how often, the JSNA should be undertaken in order to ensure quality, enable standardised regulation of process and outcome and to ensure linkage to three-yearly LAA planning cycles.