HOUSING LIN POLICY BRIEFING

COMMISSIONING FRAMEWORK

Background

This consultation paper and accompanying factsheets were published on 6th March 2007. The consultation closes on 28th May 2007 and stakeholders are invited to participate in the consultation at www.commissioning.csip.org.uk. Specific consultation questions are also set out at the end of each chapter summary.

The framework is for commissioners of health and social care services and local government in its broadest sense. It is to be shared with providers as it signals a commitment to greater choice and innovation.

There is little specific information in the consultation paper on housing and/or housing related care or support with the exception of the dataset for the proposed Joint Strategic Needs Assessment (see below) which includes housing tenure. We would encourage providers to respond particularly in connection with future commissioning of capital and revenue programmes for services for older people and vulnerable adults.

The framework builds on the Department of Health (DH) White Paper, *Our health, our care, our say* and key themes are:

- Keeping people healthy and independent and not just treating their illness
- Partnership
- Moving from price and volume to quality outcomes
- Increasing the number of providers
- Decreasing long term care provision in institutions

The framework identifies eight steps to more effective commissioning:

- Putting people at the centre – quality and control, access to information and advice
- Understanding the needs of populations and individuals – joint strategic needs assessments by local authorities, Primary Care Trusts (PCTs) and practice based commissioners
- Sharing and using information more effectively – clarifying what can be shared and joining up Information Technology (IT) systems
- Assuring high quality providers for all services – focus on outcomes, innovation and wider range of providers
- Recognising the interdependence between work, health and well-being

- Developing incentives for commissioning for health and well-being – Local Area Agreements (LAAs), pooled budgets, direct payments and practice based commissioning
- Making it happen – local accountability – DH and Department of Communities and Local Government (CLG) will develop a single health and social care vision and outcomes framework
- Making it happen – capability and leadership

1. INTRODUCTION

The 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.*

Key outcomes of, and requirements for good local commissioning are:

Translating aspirations and need into services which;

- Deliver 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 health and well-being of individuals means:

- Helping people to look after themselves and stay healthy and independent
- Helping them 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 framework includes a table setting out the vision. Almost all the characteristics of the new system already exist but not altogether in one place. The key elements of the vision are:

- Promotion of health, well-being and independence
- Enablement
- Promoting equality
- Quality, efficiency and value including health and well-being value
- Using real time data
- Prevention, early intervention and support for self care
- Wider range of providers

- Improved transition between services
- Commissioning at practice and individual level as well as local authority and PCT
- Shared strategic needs assessment
- Payments linked to work done and outcomes
- Focus on outcomes and outputs
- Improving commissioning capability
- Improving quality and choice
- Engagement with individual and local communities

2. PUTTING PEOPLE AT THE CENTRE OF COMMISSIONING

Choice and control

The challenge to commissioners is how to listen and learn to local views and to give greater choice and control. Greater control can be achieved by:

- Offering greater choice and help to self care. In Spring 2007 DH will be publishing a set of proposals about how this can be achieved
- Using local health profiles and relevant data to compare health and well-being with other areas
- Access to advice and information
- Encouraging people to use the HealthSpace facility www.healthspace.nhs.uk to view their personal care record and obtain health information
- Educating young people about healthy choices about food, alcohol, smoking etc.
- Implementing the lessons from direct payments and individual budgets pilots
- Using practice based commissioning so that teams work with patients, families and carers to design care packages and for G.P.'s to work with social care and individuals to decide how health and social care resources are deployed
- Redesigning local services e.g. co-locating relevant services
- Commissioning more easily accessible services and extending self care through community pharmacists, dentists, care workers etc.; local information, voluntary and community groups and promotion campaigns
- Supporting the roll out of the Expert patient programme
- Identifying and supporting the needs of carers
- Commissioning shared care

Voice

Commissioners should empower individuals to influence services. This can be done by:

- Making it easier to provide feedback on services
- Developing mechanisms for involvement in shaping commissioning priorities and services
- Ensuring there are effective advocacy services and complaints procedures in place
- Informing people about their rights to challenge poor service

Promoting health, well-being and independence for all
Empowering individuals to make choices that promote their health and well-being;

- Providing information on how to improve health and stay healthy
- Support programmes designed to increase physical activity, healthy eating, sensible drinking, smoking cessation and good mental health

Commissioners should enable local people to have greater involvement and influence:

- Learning from authorities that have developed innovative methods of involvement
- Engaging with Local Involvement Networks (LINks)
- Supporting advocacy for groups that find it more difficult to express their views
- Building on the work that local authorities and children's trust arrangements have made
- Explaining how they use 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 to promote debate with service users

Consultation Questions

Q1 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?

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

3. UNDERSTANDING AND PLANNING FOR THE NEEDS OF INDIVIDUALS AND OF THE LOCAL POPULATION

This chapter considers needs assessment in particular joint needs assessment including the needs of self funders, people who already use services and people who may need them in the future.

The aim is to move away from historic service use and investment and old style cost and volume commissioning to strategic needs assessment. Needs assessment should also include individual needs assessment which should inform strategic assessment.

DH will publish guidance on person centred and integrated care planning later this year. The expectation is that by 2008 everyone with long term health and social care needs will have a care plan if they want one and that by 2010 everyone with a long term condition will be offered a personal care plan.

Front line practitioners should identify individuals at high risk of needing future health or social care services. A number of tools are available such as the Quality and Outcomes Framework and the Patients at Risk of Re-hospitalisation (PARR tool) and Combined Predictive Model. The latter can help predict the risk of admission to

hospital across an entire population. At a simpler level PCT's and GP practices have identified that the death of a spouse can be a significant trigger for ill health, particularly for older people. There should be preventative services for those identified as being at risk, for example to stop smoking, falls prevention, weight reduction etc. In 2007/08 PCTs will be able to use the chronic health disease, diabetes and hypertension models on the Association of Public Health Observatories (APHO) website.

Joint strategic needs assessment is based on joint analysis of current and predicted health and well-being outcomes, what local people want from their services, a view of the future and predicting and anticipating new or unmet need. The proposed new statutory Joint Strategic Needs Assessment will be used to inform the development of Sustainable Communities Strategies.

The Joint Strategic Needs Assessment should be used to inform planning over a range of timescales and be conducted by upper tier authorities.

Examples of what Strategic Needs Assessments should answer about the current situation:

- Which members of the community die youngest?
- Which groups are getting a raw deal?
- Are we spending our money on the right things?
- How many people are over 75?
- What are people living with that makes their lives difficult?
- What illnesses are people living with?

Examples of what they should say about three to five years time:

- Has the health of the poorest improved?
- How do we get more people to help older people have better lives?
- How do we create more responsive service providers?

The Care Services Efficiency Delivery (CSED) programme is developing a database forecasting system with Care Services Improvement Partnership (CSIP) that will provide local commissioners with population projections to district level with characteristics and prevalence assumptions from research. Tools such as APHO's Inequalities Intervention Tool will allow commissioners to take an evidence-based approach to achieving specific inequalities reductions.

DH are proposing to establish a duty on PCTs and local authorities to produce a Joint Strategic Needs Assessment and are consulting on a proposed minimum dataset and list of stakeholders to be involved. **DH would welcome views on this.** The dataset includes housing tenure, but nothing else on housing and nothing at all about housing and support. More details are set out in Annex A of the framework.

There are a range of analytical techniques used in other industries such as actuarial forecasting, market segmentation and cost-benefit analysis to refine predictions and identify communities at risk of developing significant health problems. DH are making a variety of analytical tools available to support commissioners in assessing the demand for services and how this can be met.
Details are in Annex C.

Consultation Questions

Q3. Will the approach set out in the framework and 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?

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

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

4. SHARING AND USING INFORMATION MORE EFFECTIVELY

Commissioners can be more effective where they pool relevant information and analysis, this could include identifying information held by other organisations (including providers) that would be useful in commissioning care and information sharing.

There is often a lack of understanding about what information it is permissible to share. People need reassurance that confidentiality will be respected, whilst enabling commissioners to make appropriate use of information within legal and ethical constraints.

Improving information sharing at individual level can be achieved by:

- Clarifying what information can be shared and in what circumstances
- Joining up IT systems of front line practitioners
- Consolidating informatics, analytical skills and capability across public sector partners

Guidance on data sharing has been produced by a number of government departments (details in Annex C of the framework). The NHS Confidentiality Code of Practice explains the differing constraints on data.

NHS Connecting for Health has established an electronic social care record board with responsibility for overseeing national implementation of the electronic social care record. A scoping study of closer integration between health and social care systems is due to be completed by May 2007.

In the near term commissioners are expected to work with their providers to ensure information is shared.

Commissioners should work together to identify datasets and information infrastructure required to support effective commissioning. Sharing information at population or group level is acceptable if the information is anonymised. Much of the nationally collected data on health and social care is freely available (see Annex A).

Additional guidance on the secondary use of data collected at service user level will be provided by the Care Record Development Board in the near future.

Alignment of IT systems will be necessary to support the Joint Strategic Needs Assessment. This can include summary statistics for neighbourhoods, local survey data and data from GP practices. It is also possible to set up databases at household level from sources such as police, social services and health, but this must be done in a secure environment. Considerable leadership will be required and DH expect Directors of Public Health to lead this work with Directors of Adult Social Services and Directors of Children's Services and ensure it provides data fit for purpose.

Consultation questions

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

Q7. Is the legal position with regard to information and data sharing for the purpose 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?

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

Q9. Would it be helpful for DH 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

The vision is for a wider range of innovative providers that work with commissioners to offer services better able to meet the changing needs of individuals, shift care closer to home and place a greater emphasis on prevention.

In the current situation commissioners may find providers unwilling or unable to provide appropriate or innovative services and providers may feel that their scope is restricted by overly prescriptive approaches. A number of recent reports have identified that a key gap in developing the local market is the need for more proactive market shaping by commissioners and central government. Another crucial factor is the involvement of service users in assessing need and designing services.

Commissioners are more likely to secure cost-effective quality provision if they:

- Commission for outcomes and outputs, judging success by tangible benefits achieved by service users
- Involve current and potential providers in needs assessment and in how to address need, including making the Joint Strategic Needs Assessment available to providers
- Engage provider constructively about market shaping and development
- Develop better market intelligence and understanding of the role of providers, including third sector and user led organisations and how to commission services from them

- Provide information and guidance to help people make choices
- Systematically review the range of providers and determine how to incentivise them to improve or change their services
- Develop the local market
- Adopt procurement practices that are fair and open
- Draw clear distinctions between grants and contracts
- Adopt appropriate and proportionate contractual mechanisms
- Encourage a strong provider market and encourage new providers
- Pay a supplement to the tariff where this is necessary to secure new provision
- Provide guarantees within contacts
- Reduce capital investment required from providers
- For suitable primary care providers consider providing pump priming loans

Other important considerations are contract length and proportionate risk sharing.

Consultation Questions

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

Q11. Should DH 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. RECOGNISING THE INTERDEPENDENCE BETWEEN WORK, HEALTH AND WELL-BEING

Health, work and well-being – Caring for our future (see Annex C of the framework) sets out a clear vision for improving the health and well-being of people in employment. Commissioners have a key role to play in helping to deliver that vision.

Absence due to sickness costs the economy an estimated £12.7 billion each year. Sickness absence in the health and social care workforce are the highest of all sectors. There are three ways that health and social care oganisations can have a positive impact on people in employment:

- Delivering services that improve health and well-being and support people to remain at or return to work
- As employers by recruiting individuals with manageable health problems
- Using commissioning to improve the health and well-being of individuals working in health and social care

The role of commissioners is to:

- Re-design services to ensure speedy access to diagnosis and treatment
- Ensuring effective collaboration between agencies such as primary care and Jobcentre Plus
- Working with small and medium sized businesses to improve the availability of occupational health

- Encouraging providers to recruit locally and provide opportunities for individuals who have experienced long term illness or disability
- Encouraging volunteering
- Encouraging more flexible working options
- Encouraging providers to distribute health and well-being information

Commissioners should work with local Strategic Partnerships to:

- Incentivise providers to increase the health and wellbeing of their workforce and monitor levels of sickness absence
- Encourage all local employers to use the workplace for health improvement
- Ensure that health and well being are taken into account as part of economic development decision making
- Encourage community groups to get involved in health promotion

Consultation questions

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

7. DEVELOPING INCENTIVES FOR COMMISSIONING FOR HEALTH AND WELL-BEING

This chapter focuses on financial and contractual incentives. The aim is to deliver better integrated services based on individuals needs and to do this by:

- Enabling people to tailor their own care
- Spending NHS funds on non health interventions and self-care
- Personalised health and social care plans
- Multi-disciplinary teams across health and social care

This chapter encourages practice based commissioners to use NHS funding for more innovative and preventative services.

Examples are wide ranging and include respite care, crisis avoidance and intervention, provision of Citizens Advice or similar advocacy type services and social and practical support for isolated older people.

The legal position on the use of NHS funds is set out in more detail in Annex C.

Consultation questions

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

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

Q15. What consideration do you see in increasing the use of single audit arrangement for pooled budgets?

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

8. MAKING IT HAPPEN – LOCAL ACCOUNTABILITY

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 for those it delivers in partnership.

The framework identifies that different business planning cycles and performance criteria can frustrate joint working.

Holding local commissioners to account will include:

- Empowering individuals – complaints procedures, petitions and other mechanisms
- New methods of engagement and involvement
- Joint Strategic Needs Assessments
- Requiring PCTs to publish prospectuses
- Business plans of practice based commissioners showing how they will contribute to the Prospectus and Local Area Agreement
- Local Area Agreements taking account of the Joint Strategic Needs Assessment and PCT prospectus
- Legal framework for Local Strategic Partnerships to ensure local engagement in Sustainable Communities Strategies and targets in Local Area Agreements
- Consistency between Sustainable Communities Strategies and the Joint Strategic Needs Assessment
- Thematic partnerships to inform Local Strategic Partnerships
- Establishing the new independent health and social care regulator (details in Annex C)
- A new performance framework based on local priorities and outcomes
- A single performance framework for local authorities
- Overview and Scrutiny Committees
- Co-operation on capital spend

Consultation questions

Q17. What further measure might be required to clarify accountabilities for commissioners?

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?

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

9. MAKING IT HAPPEN – CAPABILITY AND LEADERSHIP

Building organisational capability and skills will be a key challenge for commissioning organisations. For PCT's there is the Fitness for Purpose Programme and for social care the Commission for Social Care Inspection's report *The state of social care 2005/06* sets out how local authorities have met the challenge of strategic commissioning.

This chapter goes on to set out detailed steps for PCTs, practice based commissioners and commissioners of social care.

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

Annexes
Annex A provides details of Joint Strategic Needs Assessment
Annex B provides information on investing in prevention
Annex C provides tools and resources to support commissioning
Annex D – high impact changes to reduce health inequalities
Annex E is a summary of the consultation questions

Related CSIP Networks materials and information

- Briefing on DH White Paper, *Our Health, Our Care, Our Say: a new direction for community services*
- Briefing on CLG White Paper, *Stronger and Prosperous Communities*
- E-book on commissioning
- DVD/CDrom and workbook, Strategic Moves, on strategic commissioning

Information on the Housing LIN

If you would like to receive further briefings from the Housing LIN and/or information on our national/regional events and associated learning tools and resources, please email us at housinglin@cat.csip.org.uk or contact the Housing LIN c/o EAC, 3rd Floor, 89 Albert Embankment, London SE1 7TP, tel. 020 7820 1682.