Ensuring our reforms put people in control
This chapter on the structures in place for governance and empowerment includes:

- a stronger local voice to effect change in services when needed;
- the roles of local authorities and Primary Care Trusts (PCTs);
- a framework for commissioning;
- the benefits of Practice Based Commissioning (PBC);
- ensuring best value for money, through improved provision and commissioning of services;
- supporting social enterprise and the third sector.
Introduction

7.1 Previous chapters set out the public’s priorities for reform – better health and well-being, convenient access to high-quality services, support for those with longer-term needs, and care in the most appropriate setting, closer to home. In order to ensure that these priorities are delivered, we need to put mechanisms in place that ensure the public’s needs and wishes are acted upon.

7.2 The current changes to the health and social care system, as set out recently in Health Reform in England and Independence, Well-being and Choice, are designed to do just that:

- **Choice** means people will increasingly determine what services they want, and where. Providers that offer these services will thrive; those that do not won’t.
- **Individual budgets** will put far more control in the hands of people who use social care services, affecting the way six different income streams can be spent around their personal needs. Markets will need to be developed to ensure that they have an appropriate range of services to choose from.
- **PBC** will put more control in the hands of primary care professionals, who develop care packages for their patients. PBC will give local practices much more scope to provide alternatives to specialist referral, treatment and follow-up where appropriate, for example nurse-led clinics and follow-up telephone calls.
- **Payment by Results (PBR)** encourages practices and PCTs to commission care safely and more cost-effectively in the places people choose to be treated, encouraging shifts from inpatient to day case and outpatient, and treatment outside the secondary care sector.

7.3 This chapter explains how these reforms can be developed so that the system itself puts people first.

7.4 At the same time as giving people greater choice and control over the services they use, we also need to ensure that everyone in society has a voice that is heard. When people get involved and use their voice they can shape improvements in provision and contribute to greater fairness in service use.

Services that engage citizens and respond to their concerns

7.5 Systematically and rigorously finding out what people want and need from their services is a fundamental duty of both the commissioners and the providers of services. It is particularly important to reach out to those whose needs are greatest but whose voices are often least heard.
7.6 People’s voices – their opinions, preferences and views – need to be heard at a local level as that is where the vast majority of spending decisions are taken and where key priorities are set. They need to be heard in a variety of different ways. And they have to count – at present, people do not feel that health and social care organisations listen enough to their views. It is important that these arrangements offer scope to groups – such as children and young people – who do not always have a choice to participate.

7.7 There is progress that we can build on. Some organisations in the NHS, local government and the voluntary, community and private sectors have engaged users and citizens in a systematic and robust way. However, these are not the norm. We want to see all parts of health and social care open and responsive to what people feel and prefer.

7.8 People’s voices will be most effective if they directly affect how resources are used. Therefore, the forthcoming guidance on commissioning (see paragraph 7.51)

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**CASE STUDY**

**Networking to cope with HIV**

When you are living with a life-threatening disease, such as HIV, you want to have as much say as possible in your treatment. To achieve this, Camden PCT established a sexual health clinic patients’ network for people with HIV.

This network has helped people with HIV take responsibility in making healthier lifestyle and treatment choices by increasing patient involvement. Members of the network have been able to encourage and support each other.

A member of staff said: “We aimed to make sure that all HIV-positive patients were informed, consulted and able to have their say in the clinic in all areas relating to their physical and emotional well-being.”

The network has succeeded in reaching out to under-represented minority groups – in particular, heterosexual female African patients and heterosexual couples. It has moved from being an advisory group to becoming a fully independent patient network, responsible for its own membership, recruitment and organisation. It has also become more involved in the clinic’s decision-making process by sending representatives to monthly senior management meetings.

Finally, the network has made a major contribution to setting up a new in-house pharmacy and recruiting a part-time professional patient representative.

Taken from *Getting over the wall*, Department of Health, 2004
will set out how PCTs, practices and local authorities can ensure their decisions are fully informed and responsive. It will encourage PCTs and local authorities to consider the potential for Local Area Agreements (LAAs) to facilitate joint public engagement on health and social care.

7.9 As well as the increased focus on public engagement in commissioning, we also expect more rigorous fulfilment of existing duties to involve and consult the public in how services are provided. This applies to new providers too. Systematic engagement will complement other mechanisms already in place, such as Foundation Trust membership – which already involves half a million people – and patient surveys.

7.10 To assist organisations, advice and best practice guidance will come from the new Patient and Public Involvement resource centre, which will work closely with the Social Care Institute for Excellence (SCIE) and the Care Service Improvement Partnership (CSIP).

7.11 Organisations providing or commissioning NHS or local authority funded care must ensure local people play a full part in the planning, design and delivery of their services. How well they succeed will form part of their overall annual performance rating. Organisations will be expected to provide information on how they engage with the public.

7.12 In taking this forward, we intend to build on our experience since the NHS Plan in 2000. We will build on what works – there are lessons to be learned from Foundation Trust approaches, from the progress made by patients’ forums, from what many non-executives on PCTs have done, from our own Your health, your care, your say consultation and from innovations such as the National Institute for Health and Clinical Excellence’s (NICE’s) citizens’ councils.

7.13 We are clear that there has to be a means for the collective voice of people to be heard. The public should be able to take a view of health and social care in the round, though we recognise that the local arrangements may well differ between commissioners and providers given their different roles.

7.14 We can see many advantages to strengthening the involvement of the public in the work of the health Overview and Scrutiny Committees (OSCs) in local authorities. Before we can decide on that, however, more
needs to be done to map out on a whole-system basis how we can best embed a stronger local voice coherently at every level.

7.15 We are, therefore, committed to completing our existing fundamental review designed to strengthen the arrangements for ensuring a strong local voice in health and social care by April 2006.

7.16 One important area where we can strengthen links to communities at the most local level is by using individual ward councillors as advocates for the communities they are elected to represent. **We will consider options for a ‘community call for action’ where issues of concern to a community have not been resolved through other channels.** We will explore ways of giving local councillors a particular role in the process.

7.17 The views and experiences of people must also play an important part in the regulation and inspection of quality in health and social care delivery. We will bring forward legislation to merge the Healthcare Commission and Commission for Social Care Inspection (CSCI), detailing the functions of the single organisation, and we will make explicit the requirement for the full involvement of the public in its work. Between now and then both organisations will continue to strengthen their arrangements to involve people in their activities.

7.18 People also, quite rightly, want easy and effective ways of complaining when services have not been good enough. **To do this, we will develop by 2009 a comprehensive single complaints system across health and social care.** It will focus on resolving complaints locally with a more personal and comprehensive approach to handling complaints.

7.19 Handling of complaints should happen speedily and effectively. The merger of the two regulators provides us with the opportunity to review where best to place the independent review stage of a joined-up complaints procedure.

7.20 **We must also ensure that people with concerns or who wish to complain have access to effective support.** This is particularly important for people who find it difficult to make their views heard. To ensure people are supported, the Patient Advice and Liaison Service (PALS) will need to continue to develop its capacity. The Independent Complaints Advocacy Service (ICAS) has been strengthened and the new, improved service comes on stream in April 2006.

7.21 **We will go further in giving people the power to demand changes where community services are unresponsive or resistant to their needs.** As well as the independent user surveys referred to earlier, we will ensure that, where a specified number or proportion of users petition the service provider for improvements, the provider will have to respond, within
a specified time, explaining how they will improve the service or why they cannot do so. This will apply to local GP practices as well as other services commissioned or provided by the PCT. To facilitate the better use of surveys, the Department of Health will review the survey programme, reporting by autumn this year.

7.22 We will also specify other ‘local triggers’ relating to public satisfaction and service quality, to which a PCT will be expected to respond if there is evidence that the public’s needs are not being met. These include:

- indicators identifying inequalities in provision;
- Strategic Health Authority (SHA) assessments of PCTs; commissioning effectiveness; and
- the results of inspections by the Healthcare Commission.

7.23 The PCT will be expected to publish its response to these triggers and will have 12 months to make improvements and, if necessary, will be given support in doing so, for example, through the procurement waves outlined in Chapter 3 above. If, following this, problems remain – as evidenced by further surveys or other indicators – the PCT will be required to undertake a comprehensive, best-value tender of services from any willing provider to ensure that local needs are met.

7.24 We have explained why there is a clear need to develop new voice arrangements that are both stronger and also fit for purpose in the new system. While we are clear about the key elements, we still need to work with stakeholders on the detail; this we will do over the next few months.

**Effective commissioning**

7.25 The main responsibility for developing services that improve health and well-being lies with local bodies: primary health care practices, PCTs and local authorities. They have a vital role in making sure public resources are used effectively to promote health and well-being and to support high-quality services. Good local commissioning will help local people keep well and stay independent, and will provide real choices for their populations.

7.26 Commissioning is the process whereby public resources are used effectively to meet the needs of local people. The voices of local people will be vitally important in improving this process. Public involvement is part of our wider strategy to facilitate high-quality commissioning and, in particular, to make joint commissioning a reality.

**The role of local authorities**

7.27 Across England, social services departments in local authorities are locally accountable for securing high-quality, responsive care services for their local residents. Increasingly, this requires them to lead and co-ordinate the activities of different service providers across the public, private and voluntary sectors in their community, designing services around the needs of people rather than those of the providers.
7.28 If individuals using services are to have real empowerment and choice, the market will need to be developed and supported to offer a wider range of services, tailored to meet the rising expectations and needs of an increasingly elderly, diverse and culturally rich population.

7.29 To do this services must be secured for the whole community, including for those people who will fund their own care. It means developing commissioning that stimulates and supports the local market. It means strengthening local community capacity through using the voluntary, community and independent sectors. And it means working closely with providers to develop strategic workforce plans as part of the support for local markets.

The role of PCTs

7.30 PCTs are now responsible for over 85 per cent of the NHS budget. Over the next two years, we will not only continue to increase NHS funding at an unprecedented rate, but we will also make that funding much fairer. Every part of the country will get more, but the communities in most need will get most. Resources are allocated to PCTs on the basis of need – known as the ‘weighted capitation funding formula’. This ensures that all areas receive their fair share and areas with the greatest need receive the most funding. In 2003/04, the best-off areas were 30 per cent above their target funding levels, while the worst-off areas were 20 per cent below. We are correcting this imbalance. By 2007/08, the 5 per cent most needy PCTs will receive allocations of £1,710 per person. The allocation per head in spearhead PCTs will be £1,552 per person, and the national average will be £1,388 per person.

7.31 PCTs are responsible for improving health and well-being by securing the best possible care for their
local residents within the ‘fair shares’ resources they have been allocated. They will discharge this responsibility by securing the best and most equitable primary health care for their community by devolving indicative budgets to practices, by holding practices to account and by working with them to redesign clinical pathways and ensure that services are provided as close to the community as possible. They will also secure other community services either by commissioning services from separate providers or by providing services directly themselves. In either case, both PCTs and practices will be responsible for achieving best value in meeting the needs of local people.

7.32 PCTs were established three years ago, covering 303 different areas. There are many examples in different parts of the country of how PCTs have already significantly improved services and secured better health outcomes. In order to build on these achievements, SHAs and PCTs were asked last year to consider whether they had the right structure for the challenges ahead, in particular understanding and meeting the needs of local communities in partnership with local authorities, while also securing the best services and value from acute hospitals.

7.33 In most parts of the country, consultations are now taking place on options for changing PCT boundaries. Many of the options provide for PCT boundaries to be the same as those of local authorities with social services responsibilities, which would make it easier to achieve better integration of health and social care.

7.34 Decisions on PCT configurations will be made later this year, following local consultation. All PCTs, including those whose boundaries are unchanged, will then be expected to review their capability and ‘fitness for purpose’, looking especially at their skills in commissioning. This will be supported by a well-defined development and change-management programme.

7.35 Under the Civil Contingencies Act 2004, PCTs will retain the responsibility to contribute to multi-agency planning and response in the event of a major incident, whether accidental or intentional. All arrangements for the provision of community services will need to ensure that those services contribute to planning for, and are able to respond to, any major or catastrophic incident involving the PCT, including the provision of mutual aid to other organisations within the local health community.

Utilising existing flexibilities and reforms to improve our focus on health

7.36 Local authorities and PCTs already have significant flexibilities under the Health Act 1999 to develop integrated working, which allows a greater investment in prevention and health, for example through pooling budgets, transferring resources from health to local authority bodies or vice versa, and entering into lead commissioning arrangements. The NHS
Improvement Plan envisaged that use of these flexibilities would become extensive in the next few years.

7.37 For children’s services, joint commissioning by local authorities, PCTs, practice-based commissioners and other partners will be done through the Children’s Trust. Joint commissioning strategies will be based on the Children and Young People’s Plan, which is informed by children, young people, their families and the community.²

7.38 We will also continue to support the development of commissioning for adult social care and strengthen joint working via the development of the joint strategic needs assessment as set out in Chapter 2.

7.39 The Department of Health will sponsor work to develop and disseminate good-practice models of commissioning for people with long-term conditions/disabled people, within the partnership framework that the Department of Health has with the Disability Rights Commission. This work will assist PCTs to commission services for their whole communities, including excluded groups, and to reduce health inequalities through targeting people at highest risk of ill-health. It will help drive up standards of access for all health and social service users. The work will be developed with partners from health and social services and service users themselves.

CASE STUDY

Pooling budgets in Redbridge

The London Borough of Redbridge operates a £40 million Section 31 Agreement (Health Act 1999) covering services such as social work, health visiting, school nursing, speech and language therapy, child and adolescent mental health services, educational psychology and educational welfare services.

Pooling of budgets with the local PCT has smoothed the process of agreeing residential placements in particular, and has made supporting parent and children’s visits less complicated. There is more clarity about the resources available to each partner and the respective priorities.

Partnership working has become easier as the pooled fund is seen as being available to the population of children who receive a service from this part of the Children’s Trust. Partners are more worried about whether the needs of the child concerned meet general criteria for a service and are less worried about whether their needs are primarily health, social care or education related.
7.40 Shared use of an individual’s records, with the individual’s consent, will make it easier for different services to provide integrated care to the individual user, something that will become easier with the NHS electronic care record.

**Practice Based Commissioning**

7.41 Our health reforms are changing the way that health care is commissioned. As a result of PBR and patient choice, finance will flow to where clinical activity takes place. PBC reflects the fact that, every day, in the decisions they make, primary care professionals already commit NHS resources on behalf of PCTs as a matter of course.

7.42 Under PBC, health care practices will receive indicative budgets and will be able to see how much of their secondary care budget is going on, for example, emergency hospital admissions. They will then be able to free up money to do more for people with long-term conditions and other priority needs. PBC will provide incentives to avoid unnecessary stays in hospitals, which the public would prefer to avoid, and enable them to devote more resources to more cost-effective prevention, including social care.

7.43 PBC will give primary health care teams a real freedom and a real incentive to look after their population more effectively. It is the health equivalent of individual budgets in social care and will give primary care professionals control over resources.3

7.44 We also expect that PBC will lead to the development of more responsive and innovative models of joined-up support within communities. Some practices, such as Bromley-by-Bow practice in Tower Hamlets, are already successfully developing such services. We will ensure that practice-based commissioners are free to pursue similar innovations, for example through locally enhanced well-being services.

7.45 Indeed, we will encourage more joint commissioning between primary care and local authority teams in their local areas. And PBC should increase the creative use of Health Act 1999 flexibilities. **We will highlight good practice in using the flexibilities as part of future guidance on PBC.** We are also aware of the need to understand better the inter-relationship between local authority Fair Access to Care Services (FACS) eligibility criteria and PBC in the light of practical experience.

7.46 PCTs will hold health care practices accountable for their use of public money under PBC. PCTs will be expected to support practices that are innovative and entrepreneurial, working with them to redesign clinical pathways and secure the services that are needed locally (for example, ensuring that diagnostic services can be provided in a local health centre or community hospital for the patients of several practices, or expanding the provision of community nursing services to support people at home or exploring opportunities to develop complementary and alternative health therapies). But where health care...
practices are unwilling or unable to make good use of PBC, PCTs will need to provide appropriate challenge and support.

**Information for commissioning**

*7.47* At every level, good commissioning depends upon good information. The *Choosing Health* public health information and intelligence strategy is developing information about communities that will help commissioners and providers target health improvement resources to those who will most benefit from them, or who are least able to engage with mainstream services. PCTs and local authorities will be better able to understand the health inequalities and challenges they face.

*7.48* The Director of Adult Social Services and the Director of Public Health will carry out regular needs assessments of their local population. This will require analysis and interpretation of data held by PCTs, local authorities, youth offending teams, the police, independent providers, voluntary and community organisations, Supporting People, the Department for Work and Pensions, census data and other data sources. This will enable the establishment of a baseline of current population needs in order to effectively plan for the future and provide the information needed to stimulate and develop the social care market.

*7.49* This will ensure that PCTs and local authorities have a better understanding of their local populations and the challenges they face in tackling health inequalities. They should already be mapping and targeting at-risk populations as part of their community strategies and local Neighbourhood Renewal strategies (in areas receiving Neighbourhood Renewal funding).

*7.50* This joint work on mapping can be strengthened by using tools such as Health Impact Assessments, and working across agencies on developing and responding to Health Equity Audits. *Choosing Health* set out our proposals to develop a tool to assess local health and well-being which will help PCTs and local authorities jointly to plan services and check on progress in reducing inequalities – a health and well-being equity audit. The Quality and Outcomes Framework (QOF) is now starting to provide useful data to inform and support effective commissioning.

**Providing support through a national commissioning framework**

*7.51* In *Health Reform in England*, the Department of Health committed to publish during summer 2006 comprehensive guidance on commissioning health services – from PBC to national commissioning of specialist services.

*7.52* This guidance will be the first stage of a comprehensive commissioning framework, setting out tools and approaches that lead to high-quality commissioning.
7.53 We commit to producing two further parts of this framework by the end of 2006. First, following consultation on Independence, Well-being and Choice, we will develop guidance on joint commissioning for health and well-being. This guidance will recommend what healthy living and well-being services are most effective or promising. Local commissioners will be able to use it as an assessment tool as they jointly undertake regular strategic reviews of health and well-being needs, and then specify and commission services.

7.54 It will also detail how those involved in different levels of commissioning can work together to improve market management and facilitate a shift towards preventative services.

7.55 Second, we will develop commissioning guidance specifically for those with ongoing needs by the end of 2006. This is necessary because commissioning for people with long-term needs has too often been episodic and organisational, rather than focused on individuals. Joint commissioning in this area is crucial, because 80 per cent of those using social care also have a long-term health care need.

7.56 The commissioning framework will also consider contracting for services. The Department of Health’s summer 2006 guidance for NHS commissioners will include a model contract for hospital services.

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**CASE STUDY**

Mapping pinpoints diabetes in Slough

Action Diabetes was launched in Slough in October 2004, to raise awareness of Type 2 diabetes in areas with populations most at risk. The project was designed and implemented by Dr Foster with the support of Slough PCT. Together they targeted hard-to-reach groups using health needs mapping (HNM) analysis, in partnership with Experian. This targeted approach and the use of volunteers from the local community meant that people were advised on lifestyle changes before their condition worsened. Interim results showed that the four-week campaign produced a 164 per cent increase in diabetes referrals among the most at-risk communities.

Grace Vanterpool, Diabetes Clinical Lead, Slough PCT, found this an invaluable technique for identifying at-risk groups: “By using HNM we’ve been able to calculate where the highest concentration of undiagnosed sufferers are, and implement a local marketing campaign to target these groups. This campaign has finally given me the opportunity to engage with local communities on a larger and far more effective scale, mainly because of the local volunteers. Awareness levels seem to be greater than ever before.”

Zishan Shafi, a volunteer health counsellor for the programme, really enjoyed the experience. “As I’m young, I can go into colleges and people will listen. I’ve even made progress sat at the mosque, giving out materials and explaining the dangers. My sister has diabetes and she’s been coming with me to talk about her experiences – it really helps.”
7.57 A key theme of the overall commissioning framework will be to encourage commissioners to use open tendering as a way of ensuring innovation, quality and value from any willing provider so as to improve quality and offer real choice to people who use services. This will be important to secure the participation of the independent and voluntary sectors, especially in areas experiencing health inequalities or where there is inequality in accessing services.

Supporting best practice
7.58 The NHS has taken great steps to deliver benefits from investment and reform through the development of an Integrated Service Improvement Programme (ISIP) in each local health community of PCTs, SHAs, trusts and practices. The ISIP considers how patient and user needs can be addressed through clinical service redesign based on world-class best practice culled from the Modernisation Agency and NHS Institute for Innovation and Improvement.

7.59 The programme also considers how these developments are supported by IT changes from NHS Connecting for Health and workforce reform on areas such as dealing with long-term conditions and urgent care. The programme is assured by the Office for Government Commerce and supports effective commissioning and local delivery planning. The ISIP will adapt, with closer integration with CSIP, to support joint planning and commissioning with local authorities.

Assessing commissioning
7.60 Finally, we will make commissioning more important in performance assessment. Working with SHAs, the Healthcare Commission and CSCI, the Department of Health will develop during 2006 a revised assessment for PCTs and local authorities to focus more effectively on how well they are discharging their commissioner functions, separately and jointly. This will build on the PCT diagnostic development programme being piloted in 2006. CSCI and the Healthcare Commission will inspect local commissioners to ensure joint commissioning becomes a major part of commissioning work.

7.61 The present performance assessment regime, for PCTs in particular, is overly focused on provider output measures, such as the number of patients breaching hospital access maximum waits. The new regime will focus more broadly on how well PCTs succeed in meeting the health needs and expectations of their populations.

7.62 Ultimately, for truly effective joint commissioning to occur, the performance management and assessment systems of health and social care need to be aligned. Having different performance measures and targets for PCTs and local authorities has not facilitated joint commissioning.

7.63 By 2008, we will ensure that both performance management systems are synchronised and that they clearly encourage good joint commissioning. This performance
management system will develop incentives for carrying out good joint commissioning and sanctions for failing commissioners.

**Commissioning responsive services**

7.64 Intrinsic to being a good commissioner is keeping under regular and systematic review the quality of those services that are commissioned on behalf of others. Local people need to be able to rely on this as one way of assuring quality. We need to support commissioners to do this well.

**Strengthening social care provision**

7.65 In some areas, local authorities are faced with weak and fragile social care and social services providers. This can be a consequence of the size of the local authority and associated market, differences in commissioning skills and competencies, or a lack of long-term, co-ordinated, strategic procurement of services. The result, however, is that local authorities can end up with poor value for money.

7.66 This weakness has a direct impact on the commissioning choices that local authorities can make. The fact that over 150 local social services departments are trying to commission services in isolation leads to weak procurement practices, including too many short-term contracts which hinder providers from making the longer-term investments that are required to raise service quality.

**CASE STUDY**

**Connected Care in Hartlepool**

People living in the poorest neighbourhoods with the greatest needs are often the least likely to have access to the services and support which would help them improve their lives and life chances. Connected Care is a pilot programme that aims to tackle this. It’s being developed through a partnership between Turning Point, a charity providing services for people with complex needs, Hartlepool PCT, the local authority and a range of community groups, involving the local community in the design and delivery of services.

Alison Wilson, Director of Primary Care Development and Modernisation at Hartlepool PCT, describes how a recently completed audit is giving the Connected Care partners insights into how better connected services could improve the lives of those in the greatest need.

“For instance, someone with substance issues or learning difficulties would often get a raw deal in the past because they wouldn’t know how to navigate through the system. Connected Care workers will be trained to understand what the different organisations offer so that if someone comes to them with housing issues they may also have problems with debt and with their health. Historically, they usually get one part of their problem dealt with or looked after but they tend to get pushed from pillar to post. This way they should see someone who has an overview of the whole system and can help with all their needs and complex issues.”
7.67 There is, therefore, a pressing need, identified by the Gershon review, to deliver greater standardisation through procurement and contracting in order to reduce bureaucratic costs to both commissioners and providers.

7.68 The Government has established Regional Centres of Excellence to support local authorities in delivering on the National Procurement Strategy for Local Government and in meeting their Gershon efficiency targets. This will also allow for benchmarking of services commissioned by individual local authorities across each region.

7.69 We believe that it is also necessary for local authorities to have a national organisation working with them to help them develop the market opportunities that they can work with.

7.70 We will ensure that CSIP, with support from the Department of Health, continues to work with local government to develop better the various social care markets so that social care users across the country have the benefit of a full range of social care services. We will also support this by delivering a procurement model and best practice guidance to underpin key aspects of our joint commissioning framework for health and well-being. This best practice will be driven further through health and social care as part of the ISIP in every health community.

**Strengthening community health provision**

7.71 Most PCTs provide community health services themselves. PCTs employ about 250,000 staff directly, including district and community nurses, health visitors, speech and language therapists and physiotherapists. These staff are involved in providing care to patients in partnership with GPs and hospitals, and in improving the well-being of communities and the people who live in them by providing advice, support and services which help people stay well or maximise their independence. Much of this work is done jointly with local government, which also has responsibilities for ensuring communities are healthy. There is no requirement or timetable for PCTs to divest themselves of provision.

7.72 A key priority for these staff is reducing health inequalities and promoting health. It is only through early interventions and a greater focus on prevention and public health that
inequalities and the future burden of ill-health will be reduced.

7.73 Community staff are, therefore, especially well-placed to help take forward the strategic shift set out in this White Paper. The changes we propose offer them new opportunities to develop their roles and to lead the process of shifting the focus towards prevention and public health, better integration of health and social care,
and putting individuals and communities in greater control.

7.74 The local NHS also draws on the expertise of many other community health care providers. Most practices are run by GPs who are self-employed contractors. These GP practices are run as small businesses and employ salaried staff, mostly nurses, allied health professionals, managers and administrative staff. A significant proportion of GPs are salaried staff, employed directly by their PCT or by a practice. All, quite rightly, are regarded as an integral part of the NHS.

7.75 Some pharmacists are self-employed people running their own business and employing other staff, while many work for pharmacy businesses ranging from single independents to large multiples. They, and other parts of the private sector, are playing an important part in the NHS. Some other services, including sexual health services, are often provided by the voluntary sector. Most mental health services are provided by specialist mental health trusts and PCTs, often integrating community and acute provision across social care and health. Voluntary and private sector providers also play a significant role, including in specialised services.

7.76 There is a plurality of providers in primary and community services, from the public, private and voluntary sectors. What matters most to the users of services is not who provides them, but how good the service is. We want to build on the strengths of the current system. As the introduction of PBC gives primary health care providers greater control over the use of local funding, they will need to work with the full range of staff in primary and community services to agree with PCTs how these services can be enhanced.

Ensuring that services are responsive

7.77 The core responsibility of PCTs is to ensure that all services for patients continually improve, whether commissioned by practice-based commissioners, the PCT itself or jointly with local government, and whether provided by the PCT or another provider.

7.78 From 2007 and as part of the normal commissioning process, we will expect each PCT to develop a systematic programme to review the services it commissions on behalf of the local population, working with practice-based commissioners and other local partners.

7.79 PCTs will be expected to ensure that providers of community health services accord with the direction set out in this White Paper:

- Equity – Are services fair? Do they focus on the most vulnerable and those in the greatest need?
- Quality – Are patients satisfied with services? Are services designed around people’s lives, putting individuals at the centre of all they do? Are services strongly geared towards preventing illness and promoting well-being? Do
they work seamlessly with services provided by other local partners?

- Value for money – Do services make the best possible use of taxpayers’ money? Are they providing cost-effective care?

7.80 Priority for review should be given to services where there is public or local authority OSC concern, a high level of complaints or where locally agreed business plans are not being met.

7.81 PCTs will be expected to seek the views of patients and users as an integral part of this process. Annual surveys, independently conducted, to cover all primary and community health services (including GP practices – see Chapter 3) will play an important role, helping to ensure users feed back their views on the responsiveness and appropriateness of local services.

7.82 PCTs will also be expected to use benchmarking information to assess the performance of services against good practice and develop an improvement plan as part of their wider development programme where needed. We will work with PCTs, SHAs and other stakeholders to ensure that this benchmarking information is made available.

7.83 Where local reviews show that services are high quality, PCTs can continue with the existing provider – in many instances this will be the PCT itself.

7.84 PCTs may also decide to look for new ways of providing services following a service review, or as they seek to continuously improve patient care. PCTs may decide that new models of service provision can offer real opportunities that are good for patients and are supported by staff.

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**CASE STUDY**

**Unleashing public sector entrepreneurship**

East Elmbridge and Mid Surrey Primary Care Trust has announced that it is continuing to move forwards with plans to put nurses and therapists in the driving seat by supporting further work to create a patient-focused, not-for-profit company to deliver nursing and therapy services to the PCT.

The company will be co-owned by the 700 employees currently working for the PCT across nursing and therapy disciplines, and will use established primary care contracting routes (specialist personal medical services) to provide NHS services (similar to contracts used by GPs). Central Surrey Health will use a social enterprise model with a focus on investing in the local community and adding ongoing value.
7.85 We expect PCTs to be robust in their management of services that do not deliver the necessary quality. Where there are deficiencies in service quality, PCTs will be required to set out a clear improvement plan as part of their wider development programme. This may include tendering for the service where standards fall below those expected, either immediately or where improvement goals are not delivered after one year.

7.86 Depending on the precise service to be provided, new providers could include GPs, nurse practitioners or pharmacists wanting to establish or expand services, a care trust, a social enterprise (which could be owned by staff on a co-operative basis), or a voluntary or private sector organisation.

7.87 If PCTs propose changes in the ownership of provision of their community services, staff will be fully and formally consulted before decisions concerning the future of provision are taken. We will work with our partners to explore what more could be done to give staff greater assurance on pension arrangements if they transfer to new enterprises delivering NHS services.

7.88 We have agreed to set up a working group to look at all of the workforce issues arising from this White Paper. The working group will include representation from the NHS and social care, trade unions and professional bodies.

7.89 PCT Boards will need to assure themselves and others that decisions about provision are made in the public interest. They will, therefore, need to develop mechanisms to deal with potential conflicts of interest, for example decisions about whether PCT provision should continue or whether alternative providers should be sought. Non-executives will have a key role in ensuring that the needs of all sections of the community are properly considered, that there is an evidence base for decisions and that these are made in a fair and transparent way.

7.90 Where PCTs provide services, as the majority now do, they will need to put in place clear governance procedures which ensure that there is no undue influence of the provider side on commissioning decisions. These procedures will include independent scrutiny by the SHA and will be transparent to all potential contractors and to staff.

7.91 PCTs will need to give a clear account of their actions, reporting progress in their annual report as part of an increased drive for public accountability. PCTs will also need to give account of their actions to the OSC of the local authority, which will be able to refer a PCT to the SHA if it believes the PCT is not discharging its responsibilities properly. OSCs will also be able to initiate their own review of a particular service.
7.92 We will develop and consult on more detailed guidance on all these issues during 2006.

Supporting the development of the third sector and social enterprise

7.93 One way of introducing high-quality provision will be to promote better use of health and social care ‘third-sector’ providers. They include organisations from the voluntary and community sector, as well as other forms of values-driven organisations such as co-operatives.

7.94 Such third-sector organisations can have advantages over the public sector in terms of better relations with particular groups (for instance mental health charities) or expert knowledge in a specific area (for instance single-disease bodies such as Diabetes UK) or expertise in a type of care (for instance voluntary hospitals).

7.95 We have established the Third Sector Commissioning Task Force, which includes representatives of the community and voluntary sector, social services, PCTs, Office of the Deputy Prime Minister, Home Office, Department for Education and Skills and the Department of Health, to address the key barriers to a sound commercial relationship between the public and the third sector. The task force will promote equality of access for third-sector providers alongside other sectors in the provision of public sector health and social care services.

7.96 The third sector, together with the private sector, already provides over 70 per cent of social care. However, there are currently considerable barriers to entry for the third sector in providing NHS services. If we are to utilise the expertise of third-sector providers, we need to lower these barriers.

CASE STUDY

Social enterprise in city academies

The creation of city academies has huge potential to create a school environment where health is central, not an add-on. The new city academy opening in Enfield in September 2007 recognises the need to help teenagers both live healthy lives and use health services.

Sponsored by the Oasis Trust, a faith-based social enterprise that brings together services for local communities, the academy will have a healthy living centre on site. The centre will have GPs, physiotherapy, counselling and other services accessible to students and the wider community. It is also expected to include a Children’s Centre and a community café.

Healthy eating will also feature in the dining hall and on the curriculum. Pupils will be able to eat nutritious, locally grown, organic school meals. The school will also offer a foundation course for future nurses.

Voluntary organisations should be included. In my community Age Concern provides services for local people.

PARTICIPANT AT THE CITIZENS’ SUMMIT IN BIRMINGHAM
Currently, a range of issues including pensions and IT make it difficult for the third sector to compete on a level playing field. **We commit to look at how to tackle these issues and report later this year.**

As well as tackling the barriers to third-sector provision in this way, we also recognise that other proposals in this White Paper will affect the third sector, and we commit to involve and consult them as the detail of specific proposals are developed further and implemented.

There is also significant potential to support and encourage social enterprise from within the third sector, the public sector (including the NHS and local government) and the private sector. The social enterprise model uses business disciplines for social objectives, and re-invests profits to support them.

**We will establish a Social Enterprise Unit within the Department of Health** to co-ordinate our policy on social enterprise including third-sector providers and ensure that a network of support is put in place to encourage the wider use of social enterprise models in health and social care.

The Department of Health will also establish a fund from April 2007 to provide advice to social entrepreneurs who want to develop new models to deliver health and social care services. This fund will also address the problems of start-up, as well as current barriers to entry around access to finance, risk and skills, to develop viable business models. The Department of Health will tender for an organisation to run the fund and provide these services.

The options will be described in detail in the forthcoming publication on integrated provision described in *Health Reform in England*.

**References**

1. *NHS Improvement Plan: Putting People at the Heart of Public Services (Cm 6268)*, The Stationery Office, June 2004
2. Further information on joint planning and commissioning of children and young people’s services and maternity services is available at [www.everychildmatters.gov.uk/strategy/planningandcommissioning](http://www.everychildmatters.gov.uk/strategy/planningandcommissioning)
3. For further information see *Practice Based Commissioning Guidance 2006/07*, Department of Health, 2006, [www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning)
5. A GP’s income depends upon the practice profits, not an NHS salary (as with hospital consultants)