

Final Summary of Feedback from the Regional Voices Listening Events for the Voluntary Sector

As part of the NHS Future Forum listening exercise Regional Voices has organised 9 listening events across the country, for voluntary sector leaders from patients, service users and carers groups and the wider voluntary sector.

A wide range of opinions were sought to feed into this response to the Future Forum. The main focus of the events has been around two Future Forum workstreams: Choice and Competition, and Patient Involvement and Public Accountability. Information has also come out of the events pertinent to the Education and Training workstream.

“this is the best advertisement I’ve ever heard for co-production”- listener

Choice and competition

How can we best ensure that competition and patient choice drives NHS improvement?

Overarching Points

Across the Regional Voices events it was expressed that choice and competition are not synonymous with high quality services, with improved health outcomes for all. The emphasis should be on improving quality and safety and reducing health inequalities and that in some cases choice and competition could support the quality improvement. Rather, the system needs to promote collaboration and partnership working- to be integrated, both between sectors and between the health services, preventative interventions and social care. The emphasis in the Bill on competition is a huge risk to collaboration, networking and sharing. Participants expressed that the danger with “choice and competition” is that too much can lead to fragmentation. Fragmentation of the health marketplace will lead to difficulties in audit, maintaining quality and sourcing data and intelligence.

Competition in the healthcare market must be underpinned by a requirement for integrated services, connected pathways and clinical excellence. Failure to achieve this will result in ill health and increased health inequalities. Integration must become part of the provider’s offer/quality assessment to ensure a seamless pathway for the patient. Integration should become part of the provider’s offer/quality assessment to ensure a seamless pathway for the service user. Responsibility should be placed on the commissioner to ensure providers integrate their services across health and social care (e.g. a GP may recommend a patient takes more exercise but the local authority is closing its leisure centre). The internal health market needs to be tackled first – it’s not open and transparent and so it’s difficult to access for non-private providers. There is a wealth of private providers that already operate within the NHS (such as ophthalmologists, optometrists, pharmacists, prosthetics, dentists, opticians, chemists, audiologists and GP practices) but are not competitive and are taking profit out of the system. The current market is fragmented and very condition-led. Mental health and learning difficulty are

examples of where service providers are sometimes better integrated and so could provide useful models in the new landscape.

Any competition that makes 'ill-health' a commercial commodity is absolutely unacceptable. All providers should be rewarded on the basis of keeping people well and out of intensive services – Marmot-based approach.

Strong opinions were expressed that expertise developed in PCTs is being wasted. PCT abolition should be stopped and they should be developed to have publicly elected boards to be more accountable. It was felt that there was no evidence presented that demonstrated choice and competition leads to increased quality of health services. It was expressed that a culture change was what was required more than a structural change of the NHS. A wider point was also expressed that the efficiency savings the NHS is being subject to is in fact a cut in budget. In the context of other public sector cuts with corresponding job losses, cuts to welfare benefits, it is likely that health inequalities will increase. It is suggested that huge changes to the NHS at this time could worsen the effect of these cuts on the health of our communities.

Improving quality, improving collaboration and tackling health inequalities should be at the heart of change, not structural reform. Genuine co-production is better than competition and has better health outcomes.

Lost in transition: Reforming the NHS, and the wider health and social care system, requires a managed evolution and co-operation. People value the NHS and not everything is failing- much works well and is continuing to improve- don't rush.

Care needs to be taken so that developments are not lost in the transition/modernisation and promotion of efficiencies. Considerable concern was expressed at the speed and the extent of the changes, particularly before the Bill has become law. The losses in development are likely to lead to higher costs for the health service at a later point. For example:

- integrated care pathways that have been developed through careful partnership working
- expertise of working with harder to reach groups, and community relationships e.g. work with migrant populations, promoting timely access to services
- resources for health staff to do outreach work and able to work with the voluntary sector (this has been disappearing)
- expertise and relationships in particular communities and services, particularly local voluntary sector services, which make the services excellent.

How much choice is safe and feasible? There is a tension between choice and quality and safety e.g. larger, better resourced hospitals give better quality, safer treatment- but less choice. The system needs to provide high quality, safe services with continuity of care - this may conflict with choice. It would be useful to have guidance clarifying the realistic limits of choice.

There cannot be competition on price. Competition needs to be on quality and on who the services reach. Serious care needs to go into pricing- how much services/outcomes cost in different areas and with different community groups e.g. it may cost more to treat people in rural areas or in D/deaf or BME communities than it does in urban, non disabled

communities. Where prices are set locally, competition may be fair at first, until price comparisons are done across the country (i.e. between commissioning clusters) which is likely to decrease costs and quality as an unintended effect. The cost of transport should be factored into any commissioning, to make choice more realistic.

The driver needs to be quality and improved outcomes for all, not choice; choice can't be the main mechanism to drive up quality. At the events delegates expressed that "choice", in this context, is rhetoric, not a reality. Currently, not all services are universally available across England, let alone choice being available. If there is choice, then people want to choose from excellent services.

The Wider Determinants of Health: Poverty is the driver of the wider determinants of health and of health inequalities; poverty won't be addressed by choice or competition. The agenda for modernising the NHS needs to be well integrated with the public health preventative agenda- ensuring the widest determinants of health are addressed. Thus strong Health and wellbeing boards will be crucial, and generally welcomed by delegates at Regional Voices listening events.

Collaboration: Delegates at Regional Voices events felt very strongly that collaboration was crucial to effective health services and that enhancing competition in the system will deplete the desire of organisations desire to collaborate, especially in the context of cuts. It was considered that hard won integrated pathways will disintegrate, that organisations will not want to share intelligence with competitors; collaboration will evaporate and this will limit any excellent choices for patients. Areas where different partners came together and collaborated are already being lost, including local strategic partnerships and networks around integrated clinical partnerships. Examples of networks where collaboration has flourished, that are now under threat, include the Northern Neurological Alliance, stroke networks and the Yorkshire and Humber Cancer Network.

Which are the types of services where choice of provider is most likely to improve quality?

Choice can be useful- particularly where it allows alternative providers to provide high quality services in a location/manner that encourages more people and more diverse people to use them. For example:

- locating sexual health services for young people in a situation that encourages young people to use the services (this is both "choice" and "collaboration")
- end of life care
- mental health services, where choice is a powerful component of treatment. It was noted that in this case it is useful to make a provisional choice and be able to change your mind later.
- support groups (e.g. drugs and alcohol), one size does not fit all
- choice of advocates, interpreters etc, to support access to services
- personalised services- that allow people with commitments such as jobs or caring responsibilities to flexibly fit treatment around their schedules and locations.
- single sex services

It should be remembered that people have created their own choices in the formation of voluntary and community services- these need supporting. There is a danger that much is

currently being lost with the speed and extent of the proposed reforms, particularly in the context of public sector cuts.

A common theme at the Regional Voices events was that “choice” per se is not what all people want, rather people want consistent, high quality, timely services as near to where they want the treatment as possible. In fact, choice may be seen as a barrier to more vulnerable groups, unless they are properly supported to make their choices. It was noted that, in the main, people don’t need choice in diagnosis, but it would be useful to have a choice of treatment offers in some areas. For very specialised services, where GPs won’t have the experience or numbers won’t support specialists e.g. transgender issues, then choice of places for initial consultation/diagnosis will be more important.

Voluntary sector role in reducing pressure on statutory services: Voluntary sector services, based locally, reduce pressures on the health service. By connecting with individuals and communities many holistic, preventative outcomes are reached, both working directly in health and in the wider determinants of health, people either do not require statutory health services, or are encouraged to access health services in a more timely (pre-crisis) fashion. Examples include:

- chiropody in the home, which as well as preventing discomfort and falls, doubles as a regular human contact and monitor e.g. to see if the house is warm enough
- supporting people into learning and employment, factors well known to reduce ill health
- providing advocacy and navigation services to help people know their rights, what services are available to them and how to access them before crises arise

Voluntary sector services can also support people being discharged from hospital and other services to promote reablement, independence and choices in care, thus reducing hospital readmission. For example:

- development of specialised peer support groups
- tailored counselling, helping people come to terms with change in circumstance
- support for carers
- support with end of life care
- befriending

The voluntary sector thus has a major role to play to help the health service deliver more competitively and would welcome opportunities to develop closer links with statutory partners to further develop choice of these independence and efficiency creating, wraparound, services.

What is the best way to ensure a level playing field between the different kinds of provider who could be involved?

Awareness of the voluntary sector: The voluntary and community sector can provide high quality, responsive, holistic services- that complements statutory services. Many participants at the Regional Voices events expressed a desire that GPs, hospitals and local authorities better understand, fund and signpost the diversity of services (both preventative and therapeutic) available through the community from the voluntary and community sector. Regional Voices is developing a resource to support commissioners and other stakeholders better understand the diversity of what the voluntary sector can offer to support them, including:

- Analysing community need; supporting and aggregating disparate community voices into the JSNA
- Shaping services and pathways
- Delivering services
- Monitoring, overseeing and reviewing services

Regional Voices would be keen to work with health and care bodies [strongly links to Education and Training workstream] in developing engagement strategies and guidelines and training materials, to help promote understanding and productive working between the sectors.

Sensitive contracting and grants: For some smaller voluntary sector organisations- it's difficult to compete in the proposed system. Funding streams with the PCTs and local authorities are being lost and proposed mechanisms such as "any qualified provider" may make it hard for organisations to provide services. There is a danger of providers "swooping in" from other areas will squeeze out small local providers even when they are working in consortia. It seems to delegates that Any Willing Provider is being pursued at expense of linking up health and social care with no emphasis on integration of services. It will be prohibitive for many to take on the risks presented by payment by results. A further issues was raised around Any Qualified Provider – that no additional providers will be added for four / five years – this is a barrier to competition.

There needs to be proportionality in the tendering process (large contracts can exclude small providers) and grants need to be maintained to fund the voluntary sector. Commissioners need to value what smaller providers can bring and be prepared to work with consortia. If possible, different areas should use the same commissioning processes and paperwork, to make tendering for contracts less bureaucratic.

Tenders to work in health, prevention and social care should be assessed according to how they address inequality, and bring additional social and environmental benefits to an area. Service providers should be subject to the public sector duties in the Equality Act 2010.

Sensible quality assurance processes: There should be strong quality assurance- about quality of service and outcomes. However, it shouldn't be bureaucratic or involve multiple "hoops" that exclude voluntary sector providers- particularly smaller groups that understand and can be responsive to local need.

Concerns about privatisation and cherry picking were raised that the proposals will allow the private sector to take over the profitable services and leave statutory services with the less profitable services. This could lead to destabilisation of local hospitals etc. It was strongly expressed that the proposed changes to the system mean that increasingly "profit" will seep out of the system whereas all money within the system should be spent on health and prevention of ill health. The health service should not be for profit. Savings from cheaper services should be fed savings into the more expensive services.

Co-terminosity: it would make tendering for work more accessible to voluntary organisations if commissioning clusters covered the same areas as local authorities, which

would also make health and social care integration easier. In the proposed system, organisations would need to compete in even more areas, which will increase administrative burden. Co-terminosity will also mean that patients can move smoothly from clinical to aftercare, without issues arising from different geographical areas, social dynamics and councils.

What else can be done to make patient choice a reality?

- Accessible information is required to make an informed choice. To have real choice takes time, information and understanding- there is a cost to this.
- If someone is not articulate and able to ask for information, for example people with a learning disability, or people who don't question health providers, then choice isn't real.
- For some people, trust in the health system and ability to make informed choices are low. These people need to be informed, engaged and supported; the voluntary sector can help. Tighter legislation was also suggested to improve trust in GPs- to that ensures GPs consider only clinical need when deciding how to treat patients.
- Signposting, peer support, brokerage and independent advocacy will help those struggling to navigate the system and require funding.
- Independent advocacy and interpreting services and cultural awareness training are currently being cut, impacting on the most marginalised communities.
- The gatekeepers to health and social care (and thus choices) need to understand the complex set of potential services available to patients in order to be able to signpost them (statutory and voluntary sector services)- infrastructure organisations can support this. It would be useful to develop some kind of "brokerage" arrangements to help commissioning consortia understand what is available from the full range of providers.
- To support GPs move from being gatekeepers of services/specialists ("who do you usually use?"), access to moderated information will help people to make an informed choice.
- If information is improved to support choice there needs to be some sort of indicator of quality. One way could be to develop a system such as the kite mark Bury LINK are developing.
- Not everyone wants patient choice, it can be confusing and time consuming- there needs to be some subtlety in the system to accommodate personal preference on options.
- Service quality, patient safety and the reduction of health inequalities need to be the main drivers for NHS modernisation and the improvement of the nation's health and wellbeing. Concern has been expressed that there is insufficient regulation to ensure patient safety
- Low volume/specialist services need to be commissioned across commissioning cluster boundaries; there should be a requirement for consortia to work together, with a clear line of accountability to the National Commissioning Board. Assurances need to be made that the needs of people with less common issues will be met by the new system.
- Commissioning of all services at local level may be unduly expensive, bureaucratic and lead to an unnecessary postcode lottery. Both very rare and very common services should all be commissioned at a larger (and maybe national) scale to ensure basic provision.

- Particular care will need to be taken that people in rural areas, where travel to alternative provision may be impossible without transport (or travel times excessive), so that they too can have choice.
- Choice needs to be meaningful, not the supermarket model; do you want hospital X or hospital Y?

Accountability and public and patient involvement

How can we make the NHS properly accountable to the public, and make sure that patient involvement is at the heart of its decision making?

Overarching Points

Participants at the Regional Voices listening events welcomed the principle that patients and carers should be at the heart of decision making. However, it was expressed that “no decision about me without me” currently feels like an empty strap-line, and there should be strong guidance on how to make it a reality.

Concerns about the listening exercise: Delegates at the events expressed concerns around the fact the Health and Social Care Bill has not been enacted and yet it is already being implemented; the Listening Exercise questions also seem to assume it has already been passed. Participants raised questions about the legitimacy of the process.

How can we ensure commissioning decisions are made transparent to the public, and that commissioning consortia engage fully with patients, carers and communities?

Patient and Public Involvement:

Delegates at Regional Voices listening events debated how realistic is transparency in such a complicated system, noting that transparency needs to be meaningful and wondering how much involvement people actually want and at what level. Overall it was decided that PPI must be objective, legitimate, done with integrity and happen across all levels within each organisation and structure, which will bring us closer to “no decision about me without me”.

- Systems and mechanisms for public voice need to be built in now – before the implementation goes too far.
- It is likely at a personal level that many people will want involvement in how they receive services.
- For service/pathway redesign it will be important to give the opportunity to all people, both existing patients and the wider public, to be involved properly- to actively try to engage people.
- It was noted that in the context of the cuts it may be hard to meaningfully engage with patients and the public. Involvement needs to be well funded.
- It was suggested that opportunities be created to get out into the community. Make it people friendly- simple, meaningful involvement. It may slow down commissioning, but it will make it better.
- It was noted that involvement shouldn't be a tick box exercise- it would have no impact on services further down the line and put people off being involved.
- Institutional memory on PPI mustn't be lost in the transition.

- It was felt that GPs are already supposed to engage patients and the public, some with more success than others. There needs to be teeth to make sure it happens and happens well. It was felt that this is a training and systems issue: there needs to be clear monitoring, sanctions and accountability around effective PPI.
- It was suggested that there is need for structured support to empower patients including development of patient participation groups, so that they could better participate and engage with issues affecting their health.
- It would be useful to develop overarching principles and an effective framework for patient and community engagement across the GP consortia, health and wellbeing board and HealthWatch. This should include: volunteer co-ordination and re-imbursement policies; re-imbursement for voluntary and grassroots community organisations who engage with excluded groups and communities and with deprived neighbourhoods; structured patient and community representation training programmes for service user and community representatives; structured patient and community engagement training programmes for staff and board members; health and well being engagement events to capture patients and communities' views; communication with patients, communities and the public on commissioning decisions (you told us... so we've) and mapping local voluntary and community sector as well as statutory sector service provision .

There needs to be meaningful voluntary sector engagement on both GP consortia and health and wellbeing boards- linked to a democratic constituency. This needs resourcing to do well. Individual patients/carers/organisation members cannot speak for wider constituencies- it is tokenistic and ineffectual.

Commissioning consortia Engagement: the consortia should have a duty to involve service users and communities, particularly marginalised groups. Voluntary sector organisations can support this. Involvement should be in: identifying local needs and experiences; designing / re-designing services; tender panels; and in monitoring and evaluation.

Delegates felt that there should be strong guidance for commissioning clusters as to how they commission services. Particularly with reference to working with hard to reach groups/ those who do not regularly visit their GP practices and for preventative services (e.g. mobile blood pressure checking units). It was felt the system could end up as a 'postcode lottery' and hard to reach groups would suffer the most.

Transparency is essential: Consortia commissioning decisions should be fully transparent and the information should be made locally and widely available in an accessible way. This cannot just be online as this presents a problem for many hard to reach groups. Suggestions were made that information should be put in libraries, community halls etc and written in succinct, accessible language. Transparency should involve all aspects of allocation, outcomes and impact. It also needs to be explicit how people can challenge commissioning decisions.

Involvement with health and wellbeing boards: The issue of voluntary sector representation on health and wellbeing boards has been raised at each event, with universal concern about how this will be implemented and a strong desire that the voluntary sector should be represented on the Boards. Voluntary and community

organisations help local voices to be heard in an organised way, ensuring that equality and reducing health inequalities are at the forefront of decision making.

We know that HealthWatch will have a mandatory seat on each Health and wellbeing board and the voluntary and community sector will work closely with it. However, the scope of the voluntary and community sector is far broader than HealthWatch which operates primarily in a patient or service user context. The perspectives brought by the voluntary and community sector also link closely with the wider determinants of health, helping to integrate health, public health and social care. By providing the sector with a space at the health and wellbeing board, these barriers could be overcome with a resultant Health and Wellbeing Strategy which truly meets local need. The guidance issued to local authorities in developing their health and wellbeing board does permit them to consider involving the voluntary and community sector. However, this part of the guidance appears to be being overlooked in many areas because of the misunderstanding about the role of the voluntary sector beyond service provision. We know that deciding who should sit on the Board needs to reflect the local context. However, we do think that further guidance would be helpful to remind local authorities of the full and varied role that the voluntary and community sector plays and the benefits that could be brought by having voluntary and community sector representatives on their health and wellbeing board, with local areas free to decide how best to implement this.

It was suggested that the principles of co-production and peer review should be enshrined in the Bill

Engagement with JSNA: The Joint Strategic Needs Assessment is critical to getting commissioning right, both for the health and wellbeing boards and the commissioning consortia. However, getting people involved in the JSNA is really difficult. The voluntary sector can help with this but it is hard to do in reality- very resource intensive. There needs to be demonstration about how the JSNA (and voluntary sector input to it) impacts on the health and wellbeing strategies and how it impacts on the ground. To date there has been very demonstration of impact.

LINKs/Local HealthWatch

- LINKs can't be effective when there are cuts- which is the experience of many this year. This will not help them develop into HealthWatches with expanded remits.
- There is a conflict of interest between local authorities and HealthWatch, if HealthWatch is to be funded by and managed by the local authorities. It is hard to scrutinise a funder. Funds should either be ring fenced in the local authority or HealthWatch should be funded by HealthWatch England.
- There was a query about how the CQC 16 standards for patient quality will be enforced. People need to understand what quality standards they should expect.
- Users' voice should feed into the criteria for a successful local HealthWatch.
- "nobody wants a watchdog that just watches; we want one that bites!"- HealthWatch must have teeth and the ability to hold commissioning consortia and health and wellbeing boards to account.
- It was felt that there needs to be further clarification on how HealthWatch sits in relation to the wider VCS and representation sought to fill the gaps.
- Questions were raised about the diversity of membership of some local LINKs. Without appropriate representation from minority communities in their area, there is

a danger that some patients' needs will be overlooked, leading to an increase in health inequalities.

- ICAS (Independent Complaints Advisory Service) can help to identify trends and issues and can provide a basis for challenging providers e.g. care homes. The concept of ICAS is good and should be continued. (Unfortunately the findings from ICAS weren't fed into the LINKs, but it was felt they should feed into the new local HealthWatch)

Ensuring good services for people with less voice: In some communities (both geographic and "of interest") there is not a culture of complaining about services and people are supportive of overworked NHS staff. If patient demand (either patient experience surveys or public patient engagement exercises) is to drive quality and choice, there is a danger that undemanding and less vocal communities get left behind in terms of health. This is likely to increase health inequalities in poorer areas, for people with a learning disability or with mental ill health, in BME communities and for older people. A balanced stance needs to be taken in consultation for service design etc between patient feedback and using evidence for what works well more broadly.

Accountability

Delegates generally felt that accountability across the proposed changes in the Bill is lacking; especially for addressing health inequalities and the needs of communities. All actors in the new structures must have a responsibility for reducing health inequality, from the Secretary of State through to commissioning consortia and local authorities. HealthWatch and the wider voluntary sector, if properly engaged and funded, can support communication between the wider community and the Board.

Accountability needs to look at different phases

- Identifying the broad picture of health needs (JSNA)
- Identifying services to be commissioned
- Holding services to account

Preventing ill health is cheaper, and better, than treatment. There needs to be integration in the system, and accountability, for decision making on spending on prevention. The health and wellbeing boards are welcome if they are given sufficient powers to improve integration. They also need to address the wider determinants of health- transport, housing, leisure, education etc.

For the JSNA to be effective, there should be a compulsion on GP consortia to integrate their plans with health and wellbeing plans, and for both to be clearly linked to community identified needs through the JSNA.

The health and wellbeing board and the commissioning consortia cannot be insular about decision making- there needs to be public access to commissioning decisions. People need confidence that GP are commissioning the correct services- not just the easiest/cheapest. If the commissioning consortia are to be accountable to the health and wellbeing board- then they can't have too much sway on that Board. They can't be on the deciding panel. It is not yet very clear how GP consortia will relate to health and wellbeing

boards especially if there is not a clear guidance that GP Commissioning Plans must relate directly to Health and Wellbeing Plans.

Overview and scrutiny- should be a separate independent resource. It needs teeth.

Intelligent 'targets' do have a role to play in accountability.

Assurances are required that there will be appropriate sanctions and support for poorly performing commissioning consortia.

Concerns were raised that the Bill repeals the Secretary of State's responsibility to provide a "decent NHS". It was felt that this should be taken out of the bill as a decent NHS is the Government's responsibility.

It was not clear to delegates how the NHS Commissioning Board and Monitor will be democratically accountable. Concern was also raised about the loss of powers for NICE to direct clinical decisions when they are the only organisation charged with assessing the evidence base for clinical decision-making. Although acknowledging problems with NICE's remit in the past, the current reforms do not seem to address these or improve procedures in the interests of patients. There were also concerns about the future of Health Protection Agency.

To ensure full engagement of patients, carers and communities, there need to be clear lines of accountability for both patient and voluntary and community sector representatives on GP consortia and health and wellbeing boards. It was suggested that legislation should ensure that HealthWatch is accountable to all the residents in its local area. Similarly voluntary and community sector representation will also need to be accountable, an organisation should not be represented on a consortia or Board merely to forward its own agenda. Presently local Councils for Voluntary Service provide this accountability mechanism through their networks of voluntary and community sector organisations working on health and social care or on health inequalities. It is recommended that health and wellbeing boards and GP consortia continue to support and use such networks to ensure accountable voluntary and community sector representation.

Issues of "commercial confidentiality" were raised which have led to a lack of accountability and poor service provision in the commissioning of independent treatment centres.

Co-terminosity between GP consortia and local authorities will aid accountability. The public will be better able to see how their needs are being served.

Are we doing enough to make sure the NHS at local level has the freedom it needs to take locally-based decisions?

Participants at events would have more confidence that locally-based decisions would result in better health outcomes for all if:

- HealthWatch was guaranteed to be appropriately funded in order to be able to monitor services
- Stronger guidance was produced on meaningful engagement with the voluntary sector with both the health and wellbeing boards and commissioning consortia
- Local grants are encouraged to address specific health inequalities

Bureaucracy could also be reduced locally by ensuring co-terminosity between local authorities and commissioning clusters.

Education and Training

How can we make sure that NHS staff in the future have the right skills to meet changing patient needs? Are the arrangements we have proposed for education and training the best ones to ensure this?

Delegates at Regional Voices events strongly expressed that improved understanding of the voluntary sector is crucial to taking a holistic and integrated approach to meeting community health and care needs. Regional Voices is developing a resource to support commissioners and other stakeholders better understand the diversity of what the voluntary sector can offer to support them, including:

- Analysing community need; supporting and aggregating disparate community voices into the JSNA
- Shaping services and patient pathways
- Delivering services
- Monitoring, overseeing and reviewing services

Regional Voices would be keen to work with health and care bodies in developing engagement strategies and guidelines and training materials, to help promote understanding and productive working between the sectors. Cross-sector work would be useful between the voluntary sector, health and wellbeing boards and commissioning consortia around roles in defining, stimulating and supporting the market place of provision.

It was felt that GPs are already supposed to engage patients and the public, some with more success than others. There needs to be teeth to make sure engagement is effective. It was felt that this is a training and systems issue: there needs to be clear monitoring, sanctions and accountability around effective PPI. Institutional memory on PPI mustn't be lost in the transition.

GP commissioning consortia have the potential to take a medical model view of issues, a broader, social engagement approach (social care, well being and the wider determinants of health) would be more useful and training would help to address that.

It is felt that equalities issues are in danger of being overlooked and these needed to be embedded into the commissioning process and commissioners needed more training in this area.

Identify and share good practice between local authorities and GP consortia for effective working with the voluntary sector to improve consistency in practice and to give a more holistic view of health and care services. This should include the areas of brokerage, co-production and peer review.

There is a wealth of information, knowledge and intelligence held by organisations that already provide statutory advocacy services across the country e.g. ICAS and IMCA (Independent Mental Capacity Advocate Service) that must not be lost or forgotten in the process as it could be useful for training and education

The language used within the NHS, social care sector and voluntary sector is different and jargon makes it difficult for service users and patients to understand the process. Ideally involve service users, patients and carers in education programmes to encourage a common language and understanding and to ensure service users and patients across the health and care spectrum are engaged.

Quality of commissioning varies hugely across areas and services and this must be addressed. Training on 'intelligent commissioning' will be key to ensure integration of services work, and it was suggested there should be a central body to monitor commissioning quality and highlight good/bad practice. Health commissioning should become a vocation, not just something added to a day job. It must be underpinned by ongoing CPD and training and a structured career pathway to grow better commissioning.

It is suggested that the training referred to should be for wider than just NHS staff, and should include other sectors and groups.



In each of the nine English regions there is a network which champions the engagement of the third sector within the region. They provide the bridge between local and national policy and share good practice across the region. On a national level, Regional Voices connects each of the regional networks, enabling the critical connection between national, regional and local infrastructure.

The Regional Voices project, Stronger Connections for better Health, is funded through the Department of Health Third Sector Strategic Partners Programme to ensure input from the sector in developing health and social care policy and to support organisations to improve health and social care services. As one of the Strategic Partners, Regional Voices is strengthening links between the Department of Health and the third sector.

Jo Whaley
Regional Voices
Jo.Whaley@regionalvoices.org
0113 394 2300

May 2011