

A photograph of a wide staircase with several people walking up and down. The image is heavily blurred, creating a sense of motion and activity. The lighting is somewhat dim, and the overall tone is muted.

**RSPH**  
ROYAL SOCIETY FOR PUBLIC HEALTH  
VISION, VOICE AND PRACTICE

# Guide for World Class Commissioners Promoting Health and Well-Being: Reducing Inequalities

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# Foreword Sir Muir Gray



One of the core missions of commissioners is to reduce health inequalities. Promoting health and well-being is necessary but not sufficient, and it is essential that improvements in commissioning and consequent improvements in service delivery, will not widen the gap between different groups in society. It is, of course, already difficult enough to decide how to commission services to promote health and well-being. There are practical, economic and ethical issues involved, but in addition the commissioner wishes to ensure that the gap

between the most healthy and the least healthy does not widen, they will have to think hard and commission carefully.

It is also crystal clear that it would be wrong to let 152 Primary Care Trusts find out for themselves how to do this. Firstly, it would be a massive waste of resources, and secondly, many Primary Care Trusts would be unable to deliver. This Guide has been produced by knowledge harvesting; by gathering the knowledge that commissioners have created and accrued, about successes as well as failures; and blending it into a single readable Guide.

### **Primary Care Trusts should not take action without reading this Guide first.**

I once complained to somebody that people were always reinventing the wheel. His reply was that the reinvention of the wheel was often necessary but the reinvention of the flat tyre was really what we had to avoid. This Guide will help people do good work more efficiently and will prevent a waste of resources, and it is strongly recommended to Primary Care Trusts.

A handwritten signature in black ink, reading "Muir Gray".

**Sir Muir Gray, CBE**

Director of The National Knowledge Service

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- NHS and Local Authority commissioners
- Health promotion specialists in the NHS and universities
- Third sector representatives

We are very grateful to the National Social Marketing Centre, especially Clive Blair-Stevens, for their input.

Special thanks to the team at RSPH and Jenny Griffiths for her editorial work, support and critical reviews.

# 1. How this Guide can help you

## Contents

1. Commissioning to promote health and well-being
2. The policy context (England)

## 1.1 Commissioning to promote health and well-being

### Health promotion and social marketing revitalised

Over the past five years or so, a quiet revolution has been underway in health promotion and social marketing. Regenerated and revitalised, they can help us to have much greater impact on the immensely challenging health problems of our time, use our scarce resources wisely to greatest effect – and deliver our performance targets.

### Accessing the best methods of promoting health

The revolution has been about a much better understanding of how we can support people as individuals within the social and environmental contexts in which they live:

- Much better insight into how we can help or empower people to make choices
- Much better ways of engaging with and mobilising communities, including the third sector, and the myriad informal groups within communities
- Influencing holistically the complexity of the systems and processes that impact on people's health – or in other words, where they live, work and play

### Flexibility brings multiple benefits

Investment in health promotion and social marketing has multiple benefits. It benefits not only individuals' health, but the quality of life and well-being of whole populations:

- Helping communities to be resilient in the face of the current major environmental and economic challenges
- Reducing crime and anti-social behaviour

The theories and methods of health promotion and social marketing are flexible and integrative, drawing on a wide range of disciplines, including a strong social science base. They help us with the societal challenge of joining up complex and different policy areas.

### Benefiting from two decades of international experience

Health promotion has been well-established internationally for the past twenty years and has developed an impressive knowledge and technical base during this time,<sup>1</sup> strengthened by learning from major programmes implemented in many countries around the world.

1. See International Union of Health Promotion and Education (2000) The Evidence of Health Promotion Effectiveness. A report for the European Commission

### **Integrating social marketing approaches**

In recent years health promotion has benefited from the tools and techniques of social marketing. In 2004, the Department of Health in England commissioned a national independent review of ways to strengthen its health improvement work. This review, published in 2006 as *It's Our Health*<sup>2</sup> found that integrating social marketing approaches had real potential to strengthen the impact and effectiveness of national and local health improvement. Key to the independent review findings was the validation of the importance of core health promotion principles and approaches and the need to build on these.<sup>3</sup>

### **Delphi consultation on health promotion and social marketing**

A Delphi consultation on health promotion and social marketing is being undertaken (2009) by the Public Health Resource Unit, funded by the Department of Health through the National Social Marketing Centre and in partnership with the Royal Society for Public Health. Its aim is to ensure the most effective and appropriate use of health promotion and social marketing skills and resources to promote health and well-being and reduce health inequalities. The report should be available by the end of 2009 and we hope that the outcomes will inform a second edition of this Guide.

### **Health promotion is the only way of ensuring a financially sustainable health service**

One of the main purposes of this Guide is to help to ensure that public money is spent wisely. The Wanless (2003) description of the "Fully Engaged Scenario"<sup>4</sup> is quite clear that unless there is substantial investment to support the public in active pursuit of their own health and well-being, the cost of treatment of chronic conditions by the NHS will become unaffordable.

### **World Class Commissioning – facilitating and enabling change**

Therefore it is essential to invest in health promotion and social marketing. Commissioners have an important role in facilitating and mobilising change for social good. This Guide aims to assist NHS and Local Authority commissioners in the development of specifications and contracts for programmes to improve the health and well-being of our local populations, and reduce health inequalities, as part of World Class Commissioning (WCC). It supports the WCC goals of quality, innovation, productivity, and of course prevention.

### **Helping providers too**

The Guide will also help service providers to develop their capability to respond to commissioners' needs and expectations.

2. National Social Marketing Centre, (2006) *It's Our Health!* London, National Consumer Council and Department of Health, [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

3. See Griffiths, J., Blair-Stevens, C. and Parish, R. (2009) The integration of health promotion and social marketing. *Perspectives in Public Health*, Vol 129, No 6, November

4. Derek Wanless (2003) *Securing Good Health for the Whole Population* H.M. Treasury

### Use the Guide in different ways

- As a **handbook** of **strategies and processes** for commissioning effective and high quality responses to health inequalities
- As a **“travel guide”**, showing you what to look out for, where to go, who and what to ask
- As a **guide to process, structure and governance**. Flowcharts and diagrams give technical advice
- As a **checklist** for action and resources – e.g. to clarify roles and relationships between commissioners and providers

### Language and definitions

In this Guide, the phrase **health promotion** takes in a range of terms, such as prevention of ill health, health improvement, policy formulation, community and organisational development and support for behaviour change.

## 1.2 The policy context

This Guide is intended to assist commissioners in making the best response to English Department of Health policy guidance. The issues will be similar in other UK countries, and climate change is, of course, a common priority.

### The NHS Next Stage Review

High Quality Care for All, *NHS Next Stage Review (2008)*,<sup>5</sup> focused on an NHS that prevents as well as treats illness. The *NHS Next Stage Review: Our vision for primary and community care (2008)* emphasised quality services focused around local needs. Lord Darzi<sup>6</sup> re-stated the need for innovation and laid special emphasis on creating an NHS that helps people stay healthy, with Primary Care Trusts (PCTs) commissioning comprehensive well-being and prevention services.

### From topics to people

Lord Darzi emphasised action in six areas: obesity, alcohol, drugs, smoking, sexual health and mental health. This Guide will help you with meeting your targets in all these areas and more. The most effective commissioning to promote health is holistic, i.e. involves people as entire human beings wherever they live, work and play. Action to tackle one problem, e.g. alcohol misuse, can often benefit other aspects of physical and mental health.

5. High Quality Care for All (2008) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

6. High Quality Care for All – NHS Next Stage Review Final Report (2008)



## Transforming Community Services

In 2009 the Department of Health guidance *Transforming Community Services – Enabling New Patterns of Provision*<sup>7</sup> and *Transforming Community Services and World Class Commissioning – Resource Pack for Commissioners of Community Services*<sup>8</sup> set out the strategic direction and processes for transformational change, including examples of social marketing and health promotion interventions in deprived communities.

### From strategic guidance to operational support

This Guide begins where the Department of Health strategic guidance ends. For example, the *Transforming Community Services* guidance stresses the importance of governance, strategic direction, management of organisational change and the development of capacity and capability, but it does not give “technical advice on how to commission for specific services” (p7). All of these areas are covered in this Guide.

### Department of Health National Support Teams

The Department of Health’s National Support Teams use many elements of health promotion in their work, for example; the importance of community engagement; of different settings for intervention; and of working on a whole-system scale beyond one-off projects.

### Around the commissioning cycle

The Guide takes you around all the steps in the commissioning cycle, with checklists to enable to you to assess your progress.

### The World Class Commissioning Cycle



Image used with acknowledgements to Robbie Currie, Department of Health: adapted with permission

7. *Transforming Community Services - Enabling new patterns of provision*. (2009) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093197](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197)

8. *Transforming Community Services & World Class Commissioning – Resource Pack for Commissioners of Community Services* (2009) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093194](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093194)

**Climate change: act now before it is too late**

Climate change, with other environmental threats, has the potential to destroy the ecosystems on which all life depends. A global rise in temperature of two degrees centigrade is the widely acknowledged likely tipping point for runaway climate change; this requires us to stabilise CO<sub>2</sub> emissions between 350-400 parts per million. The figure in 2008 was 385 parts per million.<sup>9</sup>

**Climate instability is the most important long-term threat to health**

The unpredictable rainfall, droughts, floods, melting glaciers and rising sea level globally put in peril the determinants of life – food and water – through water shortages, crop failure, ecosystem and economic collapse. Specific impacts include increases in heat-related mortality and deaths and disruption from flooding.<sup>10</sup> Inevitably, it will be the most disadvantaged who will feel the effects most acutely.

**What's good for the climate is good for health**

Carbon-intense lifestyles have been bad for the environment and health in almost equal measure. Low-carbon lifestyles can have a positive impact on our health. Commissioners are in a prime position to help refocus the health system on prevention of ill health and developing communities that are resilient in the face of the challenges ahead.<sup>11</sup>

9. Lancet and University College London Institute for Global Health Commission, *Managing the Health Effects of Climate Change*. Lancet (2009), 373, 1693-733

10. Rao, M. (2009) *Climate Change is Deadly: The Health Impacts of Climate Change* IN: Griffiths, J., Rao, M., Adshead, F., and Thorpe, A. (eds), *The Health Practitioner's Guide to Climate Change*. Earthscan Publishers

11. See Forum for the Future and NHS Sustainable Development Unit (2009), *Fit for the Future: Scenarios for low-carbon healthcare 2030*. [www.sdu.nhs.uk](http://www.sdu.nhs.uk)

## 2. Effective commissioning to promote health and well-being

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1. The characteristics of effective health promotion and social marketing
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6. Finding the evidence
7. World Class Commissioning and promoting health and well-being

### 2.1 The characteristics of effective health promotion and social marketing

#### The differences between effective and poor health promotion

Health promotion is NOT about posters and leaflets and telling people “You will do what we say”. Health promotion is about giving people information and tools to improve their own health. Health promotion is about improving the environments in which people live that often determine their choices. Health promotion focuses “upstream”, beyond individual behaviour change, to influence the context in which people make their health choices. It seeks to help people make decisions that are best for themselves and their families.

The aim is to help people and communities gain control over the influences on their health, making the healthier choices the easier choices

#### Effective health promotion influences the determinants of health

External influences on people’s health are often called the “determinants of health”. They are people’s values, cultural, social, economic and environmental living conditions. Social and personal behaviours are strongly affected by the conditions in which people are born, grow, live, work and age. The World Health Organisation’s *Commission on the Social Determinants of Health*,<sup>1</sup> Closing the Gap in a Generation (2008) stressed the importance of material conditions, of the psychosocial conditions that enable people to have control over their lives and to have a political voice. See the following diagram:

1. See [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html)



Image used with kind permission. Based on the Whitehead and Dahlgren (1991) diagram as amended by Barton and Grant (2006).

### **Effective health promotion implements structural solutions as well as supporting behaviour change**

The commissioning of effective programmes to promote health and well-being will engage, empower and mobilise people to:

- Implement structural solutions that help to **make the healthier choices the easier choices**, for example through making healthy food easily available, or developing social support networks (there are examples of these solutions later in this section);
- Support them to change their behaviour if they wish

### **Effective health promotion commissions simultaneously for physical and mental well-being**

“Health” encompasses physical health, mental health and well-being or quality of life. We should commission for them simultaneously. The evidence shows, for example, that physical activity and a healthy diet benefit both physical and mental health; and that poor housing and low income have adverse effects on both physical and mental health.

### **Effective health promotion embraces social marketing**

Social marketing and health promotion programmes should be commissioned in an integrated way. Social marketing is a systematic set of tools and techniques for achieving behaviour change goals, both directly with the public and with decision-makers.

### **The difference between effective and poor social marketing**

Poor social marketing is simply conventional marketing and social advertising. Effective social marketing is “the systematic application of marketing alongside other concepts and techniques to achieve specific behavioural goals for social good”.<sup>2</sup>

- **Strategic social marketing**

Where social marketing concepts and principles are used to inform and enhance policy formulation and strategy development.

- **Operational social marketing**

Where social marketing is undertaken as a planned process and worked through systematically to achieve specific behaviour goals, through a programme or campaign.

### **Gaining insight to design interventions**

Social marketing uses a comprehensive planning approach and a range of theories to identify, assess and segment the defined target audience’s needs and motivations, using this insight to design interventions which reinforce adoption of the behavioural goals through the provision of tailored incentives and other benefits, and strengthening barriers to negative behaviour.<sup>3</sup> See the criteria in Section 5 for more information.

### **Effective health promotion involves people as equal partners**

People are our greatest asset. In much clinical service provision people are relatively passive recipients of services, which they are usually not involved in designing. Effective health promotion works with people as resources and assets who contribute directly to their own health outcomes: our job is to enable them, to help them. People must be at the heart of decision-making about commissioning health promotion programmes to ensure real effectiveness. They must become “partners” in the success of a programme, active participants in a joint enterprise.

### **Effective health promotion is based on empowerment**

A central concept in health promotion, empowerment has been defined as: “A social process that promotes the participation of individuals, organisations and communities in actions with the goal of increased individual and community control, political efficacy, improved quality of life and social justice”.<sup>4</sup> People’s personal skills can be developed by enabling them to identify their own needs and involving them in planning and evaluation processes, which will in itself improve their health.

2. French, J, Blair-Stevens, C. Big Pocket Guide – Social Marketing (2nd edition) (2007). London: National Consumer Council and Department of Health, [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

3. For models and examples on how specialised health promotion and social marketing for health can be best deployed see Griffiths J, Blair-Stevens C. Thorpe A. (2008) Social marketing for health and specialised health promotion, *Stronger Together: Weaker Apart*, Shaping the Future, RSPH, NSMC

4. Handsley, S. The potential for promoting public health at a local level: community strategies and health improvement. In: Lloyd, C.E. et al., editors. Policy and practice in promoting public health. London: Sage Publications in association with the Open University, 2007

**Effective health promotion nurtures communities**

Communities – be they communities of place, of identity or of interest - have enormous assets: effective health promotion feeds and nurtures what is already going on in communities. NICE guidance on community engagement<sup>5</sup> suggests that approaches to help communities to work as equal partners, or delegate power to them, or provide them with total control, may lead to more positive health outcomes. Local control is therefore more likely to result in programmes and interventions that are self-sustaining in the longer term.

**Effective health promotion builds social networks**

“Social capital” is another central concept in health promotion. It means the social networks, relationships and structures, the assets developed by communities, can support lasting change (see also the FAQs in Appendix 1). Social networks build trust through bonding and bring people together across social divisions, building bridges between people. There is a strong evidence base linking people’s participation in networks and social structures with positive mental and physical health.

**Effective health promotion uses the assets of communities to ensure lasting success**

Commissioning a one-off, short-term activity is unlikely to achieve the outcomes we want. Isolated services that are not embedded in, owned and championed by the community will not usually have a lasting impact. If we build our commissioning on the assets of communities, their social networks and structures, our interventions or programmes are much more likely to endure long-term.

**Effective health promotion tackles climate change**

As noted in Section 1, the greatest health challenge now facing us is climate change. This needs to become a strategic element in all commissioning. We need to reduce carbon emissions in all we do. Commissioners can play a vital role by integrating it into their work. Policies that reduce greenhouse gas emissions will result in large health gains, with sizeable reductions in many of the major killers including heart disease, cancer, obesity, diabetes, road deaths and air pollution. For example, consuming less animal products reduces carbon emissions whilst reducing heart disease and stroke; less use of the car and more walking and cycling does the same. Low-carbon societies offer the prospect of a much improved quality of life, focusing on the community, self-sufficiency, family, relationships and contact with nature.

5. NICE (National Institute of Health and Clinical Excellence) Guidance on Community Engagement (February 2008), [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

## 2.2 Promoting health is not (mainly) about services

### **Programmes, facilities and interventions, not services**

To promote health and well-being, we commission programmes and interventions, not services and facilities. We shift from commissioning services to commissioning solutions. What solutions? They may be changes in organisational policies and practices, improved public policies, creation of community facilities, nurturing and mobilising local communities, or supporting people to change their personal lifestyles – see the table overleaf.

### **Not always the obvious solution**

The obvious solutions are not necessarily the most appropriate. For example:

- We have identified a high rate of teenage pregnancy in an area: Our intuitive response might be to commission more contraceptive services, but a consideration of the evidence base of health promotion will yield a range of options, such as:
  - Interventions to engage with the social, economic and physical environment in which young people live
  - Health education and/or social marketing to help people make informed choices

### **Most solutions will need to engage partner organisations**

Commissioning solutions that influence the determinants of health needs the active involvement of a wide range of partners, such as local authorities, other NHS organisations, voluntary sector organisations, the police and education providers. There will be existing partnerships which can be accessed, for example the Local Area Strategic Partnership, or themed partnerships such as Health and Social Care Partnerships, Children and Young People's Partnerships, Older People's Partnerships. Locally, they may, of course, have different names.

### **Commissioning includes the structured engagement of partners**

Partnerships provide a bridge between strategy and operations, because their members often have responsibility for delivery or managing outcomes. The commissioning role includes the engagement of these partners, with clear processes to ensure delivery, such as designated leads, and SMART objectives and milestones included in project plans.

**An outcome model for commissioning to promote health and well-being<sup>6</sup>**

<b>Health and social outcomes</b>	<b>Social outcomes</b>  <i>Measures include:</i> Quality of life, functional independence, equity	<b>Health outcomes</b>  <i>Measures include:</i> Reduced morbidity, disability, avoidable mortality	
<b>Intermediate health outcomes</b>  <i>Modifiable determinants of health</i>	<b>Healthy lifestyles</b>  <i>Measures include:</i> Tobacco use, food choices, physical activity, alcohol and illicit drug use	<b>Effective health services</b>  <i>Measures include:</i> Provision of preventive services, access to and appropriateness of health services	<b>Healthy environments</b>  <i>Measures include:</i> Safe physical environment, supportive economic and social conditions, good food supply, restricted access to tobacco and alcohol
<b>Health promotion outcomes intervention impact measures</b>	<b>Health literacy</b>  <i>Measures include:</i> Health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, self-efficacy	<b>Social action and influence</b>  <i>Measures include:</i> Community participation, community empowerment, social norms, public opinion	<b>Healthy public policy and organisational change</b>  <i>Measures include:</i> Enforcement of regulations, e.g. emissions, traffic calming Housing support Resource allocation e.g. specific funds and incentives for change Improvements to built and natural environment Guidance on organisational practices
<b>Health promotion actions</b>	<b>Education Social marketing</b>  <i>Examples include:</i> Public education School/college education, curriculum development Social marketing interventions targeted at specific behaviour changes Peer educators and mentors	<b>Social mobilisation</b>  <i>Examples include:</i> Community development Support for community champions Group facilitation Technical advice  Support for changes in organisational practices in all sectors	<b>Advocacy</b>  <i>Examples include:</i> Lobbying, political organisation and activism

6. Taken from: International Union of Health Promotion and Education (2000) The Evidence of Health Promotion Effectiveness. A report for the European Commission. Part Two, page 6



## 2.3 Commissioning to make the healthier choices the easier choices

### **Assess the degree of leverage you have on determinants of health**

Our purpose is to intervene decisively with the modifiable influences on people's health. The health of an individual or community is determined by the balance of forces for, or against, good health. Health promotion and social marketing use research-derived theory and practice to alter this balance. We need to assess the degree of leverage that we have locally for each of the main determinants of health.

### **Focus on determinants that can be changed**

Of course, some determinants, such as genetic inheritance, are not modifiable. Others cannot be altered in the shorter term, particularly those that are the result of government policy. Poverty for example can be intractable, but the life circumstances of those on very low incomes can still be improved – which will improve their health.

### **Seek to reduce negative determinants or increase positive determinants**

Commissioning will seek to reduce negative determinants of ill health or increase positive determinants. Large programmes may seek to influence both positive and negative determinants. A frequent question is whether to tackle the negative aspects that generate ill health or try to support positive elements that may counter-weight the negative aspects. This is a key question to ask during the scoping phase (see Section 3 of this Guide): the answer will depend on the degree of leverage, the opportunities and the cost.

### **A simple cause and effect situation**

If the challenge is reducible to a single cause then the cause can be removed or neutralised. The classic  $A+B=C$  cause and effect situation (called Positivism or the Scientific Method) is shown by the issue of hand hygiene in a residential home.

#### **Case example 1 MRSA infection in a residential home**

If a residential home has a high level of MRSA cross-infection or similar, specific and rigorous hygiene interventions will reduce the risk of transmission, in particular hand washing for all staff, visitors and patients. This will reduce the presence of the MRSA bacteria.

But most health challenges, including all the major priorities on obesity, alcohol, drugs, smoking, sexual health, mental health and climate change, have multiple and complex causes. These, therefore, require careful consideration of the strategic outcomes commissioners require and of how and where to intervene for the best outcome/s – see Case Example 2 for consideration of strategic options for prisoner health and Case Example 3 for consideration of approaches and options for tackling the determinants of obesity.

## Case example 2 Prisoner health – strategic options

### **Greater benefit from focusing on reducing re-offending behaviour**

What is the goal of prisoner health care? To reduce health inequalities, but how?

The first and obvious approach is derived from the Hippocratic oath that “All persons shall be treated equally according to need.” But another option is: “Can services be designed to reduce the likelihood of re-offending and thus both improve the health of offenders and avoid future victims, thus improving their health also?”

### **Spending money for the greatest health benefit**

Both options would reduce health inequalities, but the second option would offer greater health and social benefit. The choice of either option would result in commissioners spending money differently on the same population.

## Case example 3 Obesity

### **Commissioning to tackle the influences on people’s behaviour**

Commissioning services for obesity that are only focused on trying to persuade people to eat more healthily and take more exercise are unlikely to make much long-term impact on overall levels of obesity in the population, unless some of the influences on their behaviour are also tackled. The table below lists some of the main causes of obesity and some examples of the commissioning response to them.<sup>7</sup>

7. NICE Guidance on health and obesity can be accessed at: <http://www.nice.org.uk/>

**Commissioning to tackle the determinants of obesity**

<b>Influences on behaviour*</b>	<b>Challenge</b>	<b>Commissioning strategy</b>
Physical environment	Limited opportunities for physical activity	Response by public and private sectors to make much more accessible physical space available for physical activity – pedestrianisation, cycle routes, playgrounds, sports areas
Local culture for physical activity	Physical activity not valued	Create a culture where physical activity is seen as normal, by support to youth and sports associations, subsidised sports facilities, taster sessions, supporting communities and groups with their own initiatives
Community safety	Fears regarding personal security and security of property	Work with police and community groups to increase confidence in security for personal safety and property, by increased security of built environment, enhanced street lighting, safe storage of cycles at shops, stations
Social environment	Limited community knowledge/understanding of food and health	Work in partnership with communities, groups, educational institutions, shops, through allotment societies, community cafes, food co-ops
Access to healthy food	Access mainly limited to processed foods, limited access to fresh fruit and vegetables	Commission to improve access to non-processed foods via shops, markets, allotments, garden sharing, and other community initiatives
Socially marginalised people	Existence difficult and challenging. Personal energy used in survival rather than personal health	Commission easy and safe opportunities to develop personally and socially e.g. community cafes/adult learning, tenant associations, neighbourhood groups
Work environment	No opportunity for accessing healthy options	Commission support for employers to enable staff to access healthy options, allow meal breaks, space and facilities for cooking and safe food storage

\* This list is indicative only. Local health intelligence would define key determinants in more detail.

### **Let's Get Moving embedded in a wider commissioning strategy**

The Department of Health launched *Let's Get Moving* in 2009, a behaviour change programme that incorporates a physical activity care pathway.<sup>8</sup> This is an evidence-based approach, based on the recommendations of NICE public health guidance, which endorses the delivery of brief interventions for physical activity as both clinically effective and cost-effective. *Let's Get Moving* incorporates detailed guidance for commissioners. To improve its impact and achieve long-term change in physical activity in the population, *Let's Get Moving* can be placed within a wider commissioning strategy which aims to make the wider environment more conducive for people to be physically active: making the healthier choices the easier choices.

### **Integrated commissioning to reduce obesity and low-carbon lifestyles**

Commissioning to reduce obesity also provides opportunities to integrate commissioning for sustainable, low-carbon lifestyles. For example, dietary habits, food purchasing and preparation patterns can be modified at individual, group or community level, particularly by influencing the food supply chain. Schemes to support walking or cycling to work and school benefit health and reduce carbon emissions.

## **2.4 Targeting individuals and populations together**

### **The benefits of commissioning at population level**

At present, much commissioning to promote health and well-being is focused on helping individual people to make informed choices about their health. By commissioning at population levels, we are likely to be able to achieve greater value for money, and harness the considerable resources the community itself has to offer, as suggested by the table on page 16. The population can be any size from part of a street to a city.

### **The key is targeting and segmentation**

Blanket solutions are ineffective, wasteful of resources and do not tackle health inequalities. We need targeted approaches focused on specific population groups. The individual and population approaches come together through the use of segmentation, focus group research and online information gathering, all social marketing techniques that commission bespoke services matched to specific needs.

### **Case example 4 Teenage pregnancy in Rotherham**

Rotherham Primary Care Trust, working with its partners, used a range of information to identify a cohort of young women most at risk of teenage pregnancy in one particularly deprived area. It commissioned two support workers to work with that cohort, working with them one-to-one, or in groups, or offering peer support. This has led to a dramatic reduction of nearly 80 percent in the number of girls falling pregnant while teenagers.<sup>9</sup> It has also resulted in improved mental health and smoking cessation, reductions in drinking and antisocial behaviour and fewer participants not in education, employment or training.

8. Department of Health (2009), *Let's Get Moving: Commissioning Guidance*. A new physical activity care pathway for the NHS

9. Health Service Journal Supplement (2009) Information for Improvement, in association with the NHS Information Centre, 25 June, p10 and p20

## 2.5 The five main approaches

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### **The five evidence-based approaches**

Effective commissioning for promoting health and well-being systematically utilises five approaches:<sup>10</sup>

- 1. Building healthy public policy**
- 2. Creating supportive environments**
- 3. Strengthening community action**
- 4. Developing people's personal skills**
- 5. Reorienting health services**

### **Use combinations of all five approaches together**

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Evidence strongly supports the use of combinations of all five approaches to achieve the best health outcomes – this is much more effective than single-track approaches.<sup>11</sup> For the best investment of your funds, devise programmes that operate on multiple levels at the same time.

10. World Health Organisation (1986) The Ottawa Charter for Health Promotion. Available online at: [www.who.int/hpr/NPHdocs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPHdocs/ottawa_charter_hp.pdf)

11. National Social Marketing Centre, (2006) It's Our Health! London, National Consumer Council and Department of Health, [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

## Case example 5 Improving the health of disengaged young people

Disenfranchised, out-of-school young people can have a range of health problems (smoking, alcohol and drug abuse, unintended pregnancy, sexually transmitted diseases, suicide, sexual and economic exploitation, eating disorders, violence, and poor life chances). The evidence suggests that successful programmes can tackle these tough challenges:<sup>12</sup>

1. **Address not only the behavioural issues of young adults themselves, but also environmental factors** (social and economic conditions) and social norms that greatly influence behaviour. Young people's immediate social needs must be met, and they may need much practical assistance regarding housing and money, and training in coping skills and interpersonal negotiation
2. **Involve gatekeepers and stakeholders** at the outset, i.e. key opinion-formers and community leaders
3. **Involve young adults in all aspects of the interventions** to enable their needs and wants to be well understood. More effective messages and materials to be designed and greater insights to be gained into the contexts within which young people practice behaviours (social marketing techniques are invaluable here). The use of peer educators has been very successful. Involving young people directly provides ownership of the project by the target audience, generating a sense of the urgency and importance of the issues
4. **Participatory approaches** harness the creativity, energy and resourcefulness of young people and getting involved in itself promotes their health
5. **Seek to influence parents** and other social role models
6. **Mobilise communities** to provide alternative attractive places to go and things to do, including alcohol-free clubs, sports, crafts, music-making etc.
7. **Open up cultural, religious and societal dialogue** about key adolescent health issues to shift community norms and provide opportunities for marginalised young people
8. **Invest in support networks** and training activities throughout the life of the project
9. **Provide access to the necessary products and services** to practice the behaviour change, e.g. condoms, counselling services, clean needles
10. **Provide services that are confidential**, with staff trained to deal with young people, convenient opening hours, accessible to transport etc.

**“The most effective projects are born out of important community alliances.** They involve some combination of non-governmental organisations, health and education teams, individual youth, local clubs, sports organisations and other cultural groups. Any one sector or group could not possibly have reached a group of young people as dynamic and complex as those who are out-of-school. Only cross-sector collaborations ensure that access is gained and impact can be achieved”.<sup>13</sup>

12. International Union of Health Promotion and Education (2000) The Evidence of Health Promotion Effectiveness. A report for the European Commission. Part Two, Chapter Four

13. Ibid, page 52

- **The first of the five approaches is building healthy public policy**

Healthy public policy aims to overcome structural barriers to health. It is unlikely to be taken forward through procurement processes, but will be undertaken locally through Local Strategic Partnerships and other partnerships. Examples of key policies include ameliorating the impact of poverty and poor housing; improving access to exercise facilities and wholesome food.

**Advocacy** to build healthy public policy and organisational practices is a type of commissioning for health, though the methods used will not be contracts with external organisations. **Social marketing** tools and techniques help to improve the effectiveness of advocacy, ensuring that proposed structural solutions – for example to lessen the impact of poverty - meet people’s needs and that policy-makers’ motivations are understood.

- **The other four approaches can be formally commissioned**

Specifications and contracts can be developed to:

- Make environments more health-promoting
- Nurture communities, working with groups of local people to help them take action themselves
- Develop people’s personal skills and health literacy
- Embed health promotion in health services

- **Commission programmes in a range of “settings”**

Health promotion is systematic about reaching and involving target groups in the “settings” in which people live, work and play, which include neighbourhoods and communities, schools and colleges, workplaces, and health care and other public sector services. Mapping the various “settings” enables us to design comprehensive interventions for behaviour change and environmental or organisational change.

For example **mental health programmes** in different settings show wide benefits, including some beyond mental health:<sup>14</sup>

- Schools-based programmes to promote better mental health show clear evidence of achieving higher literacy levels and reductions in drop-out rates; there are additional health benefits with success in smoking cessation, reductions in substance abuse, reductions in the social consequences of teenage pregnancy and unsafe sex
- Work-based mental health programmes improve job satisfaction and reduce stress levels, and also help unemployed people return to work quicker and reduced the amount of sick leave in workforces

14. International Union of Health Promotion and Education (2000) The Evidence of Health Promotion Effectiveness. A report for the European Commission. Part One, p12

- **Healthy Cities, Healthy Communities**

The World Health Organisation's *Healthy Cities* programme, with hundreds of participating communities including many in the UK, provides a strong multi-agency framework and philosophical model of proven effectiveness for working in partnership with communities and building healthy public policy.

See <http://www.euro.who.int/Healthy-cities>

- **Effective health promotion in the health care sector**

The evidence suggests that the health sector can be successful in interventions to promote smoking cessation and to deal with problems of alcohol misuse, for example. The health sector also has an important leadership role by providing examples of what can be done to achieve a healthy environment for its own staff, and acting as an advocate for healthy public policies. However, engagement by the health care sector in health promotion is patchy. Effective commissioning requires detailed service specifications, with specific schedules such as those being developed by the Department of Health National Support Teams, and monitoring.<sup>15</sup>

Preventive services, such as screening and immunisation, need to be designed around the needs of users, using social marketing tools and techniques.

The World Health Organisation programme for *Health-Promoting Hospitals* is well-established internationally. The UK is hosting the international Health-Promoting Hospitals conference in 2010.

## 2.6 Finding the evidence

Programmes to promote health and well-being obviously need to be commissioned on the basis of a thorough assessment of the evidence from epidemiological, behavioural and social research. Specialist help will usually be invaluable, as we suggest in Section 3. But where do you go for a digest? Here are six sources:

1. **Individual Department of Health websites for health topics**

2. **NICE (the National Institute for Health and Clinical Excellence)** has a growing range of public health guidance, including guidance on Community Engagement (February 2008) [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009); and behaviour change (October 2007) [www.nice.org.uk/PH006](http://www.nice.org.uk/PH006) which are relevant to most major health issues, and specific guidance on a range of interventions.

3. **The Health Development Agency (HDA)** was transferred to NICE in 2005. It produced a wide range of publications to help support evidence-based decision making by public health practitioners. These publications were either:

- produced by the HDA, or
- commissioned by them, but published after its functions were transferred to NICE.

Many HDA publications are available from [http://www.nice.org.uk/aboutnice/whoware/aboutthehda/hdapublications/hda\\_publications.jsp](http://www.nice.org.uk/aboutnice/whoware/aboutthehda/hdapublications/hda_publications.jsp)

15. Ibid, p18 – and see chapter 11 in Part Two for detailed evidence



4. **The International Union of Health Promotion and Education** produced a detailed report in 2000 which assessed 20 years of evidence of the health, social, economic and political impacts of health promotion.

“The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe. A Report for the European Commission.”

This is available electronically at <http://www.iuhpe.org/index.html?page=50&lang=en>

5. **The NGO Forum published** “A planning guide: health inequalities and the voluntary and community sector” in October 2009. The NGO Forum is hosted by the Royal Society for Public Health. See <http://www.ngoforum.org.uk>

6. **The National Social Marketing Centre’s website** has a wide range of publications and case studies on effective social marketing: <http://www.nsmcentre.org.uk>

## 2.7 World Class Commissioning and promoting health and well-being

### The aim of World Class Commissioning is to improve health outcomes

*“The aim of World Class Commissioning, and therefore the ultimate test of its success, will be an improvement in health outcomes and a reduction in health inequalities”*

Claire Whittington, Deputy Director, Commissioning, Department of Health, England

### World Class Commissioning aims are health promotion aims

The purpose of WCC mirrors effective health promotion:

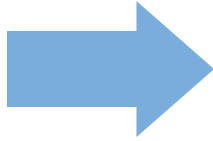
1. Architect of the local health system
2. Active engagement of partners
3. Understanding provider economics
4. Relentless focus on health outcomes
5. Commissioning behavioural change within the population
6. Recognising the need to transform themselves and develop new capabilities<sup>16</sup>

### World Class Commissioning competences are health promotion competences

The 11 competencies for World Class Commissioning are closely aligned to the theory and practice of specialised health promotion, especially WCC competencies 2 and 3:

- Working collaboratively with community partners to commission services that optimise health gains and reduce health inequalities
- Proactively build continuous and meaningful engagement with the public and users to shape services and improve health

16. Claire Whittington, Deputy Director, Commissioning, Department of Health, [www.dh.gov.uk/worldclasscommissioning](http://www.dh.gov.uk/worldclasscommissioning)



**SCORE YOURSELF ON THE APPLICATION OF WCC COMPETENCIES TO HEALTH PROMOTION**

**World Class Commissioning competencies - as applied to Health and Well-Being**

World class commissioning competencies	Application to promoting health and well-being	Current development score 0 = Not started 1 = Limited 3 = Operational
1. Are recognised as the local leader of the NHS	1. Able to gain trust and cooperation with a range of potential partners	
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities	2. Able to assess accurately the contribution of potential partners 3. Ability to support growth of local capacity	
3. Proactively seek and build continuous meaningful engagement with the public and patients, to shape services and improve health	4. Alert and sensitive to local issues 5. Able to use a range of different types of language registers	
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation	6. Able to make positive use of local populations and groupings 7. Able to discern difference between “means” and “ends” in programme development 8. Knows when to ask for professional advice 9. Knows how to utilize professional advice	
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements	10. Able to interpret epidemiological and other social data to make assessments of strategic direction and goals 11. Understands the concept of the “learning organisation” and can build self monitoring into programme and activities	
6. Prioritise investment according to local needs, service requirements and the values of the NHS	12. Appreciates how to use public money to build social capital 13. Values personal, organisational, and community learning	
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes	14. Able to use public money to facilitate growth of learning in local organisations and groups and develop local providers	
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration	15. Ability to think and act strategically and operationally to evolve programmes in the light of experience	
9. Secure procurement skills that ensure robust and viable contracts	16. Carries out research and assessments of potential suppliers and agencies as to their capacity to fulfil contracts and to act in public benefit	
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes	17. Appreciates the need for clear effective Governance structures for effective programme development, implementation, delivery and monitoring	
11. Make sound financial investments to ensure sustainable development and value for money	18. Is able to commission to build social capital	
<b>Total score (max 54)</b>		

# 3. Approaches and Options

## Contents

1. The commissioning journey
2. Systematic project planning
3. Specialised health promotion and social marketing advice
4. Ready-made or developmental responses
5. The ethics of commissioning to promote health and well-being
6. The importance of theory
7. Specific tools and techniques to assist commissioning
8. Building provider capacity and capability

## 3.1 The Commissioning Journey

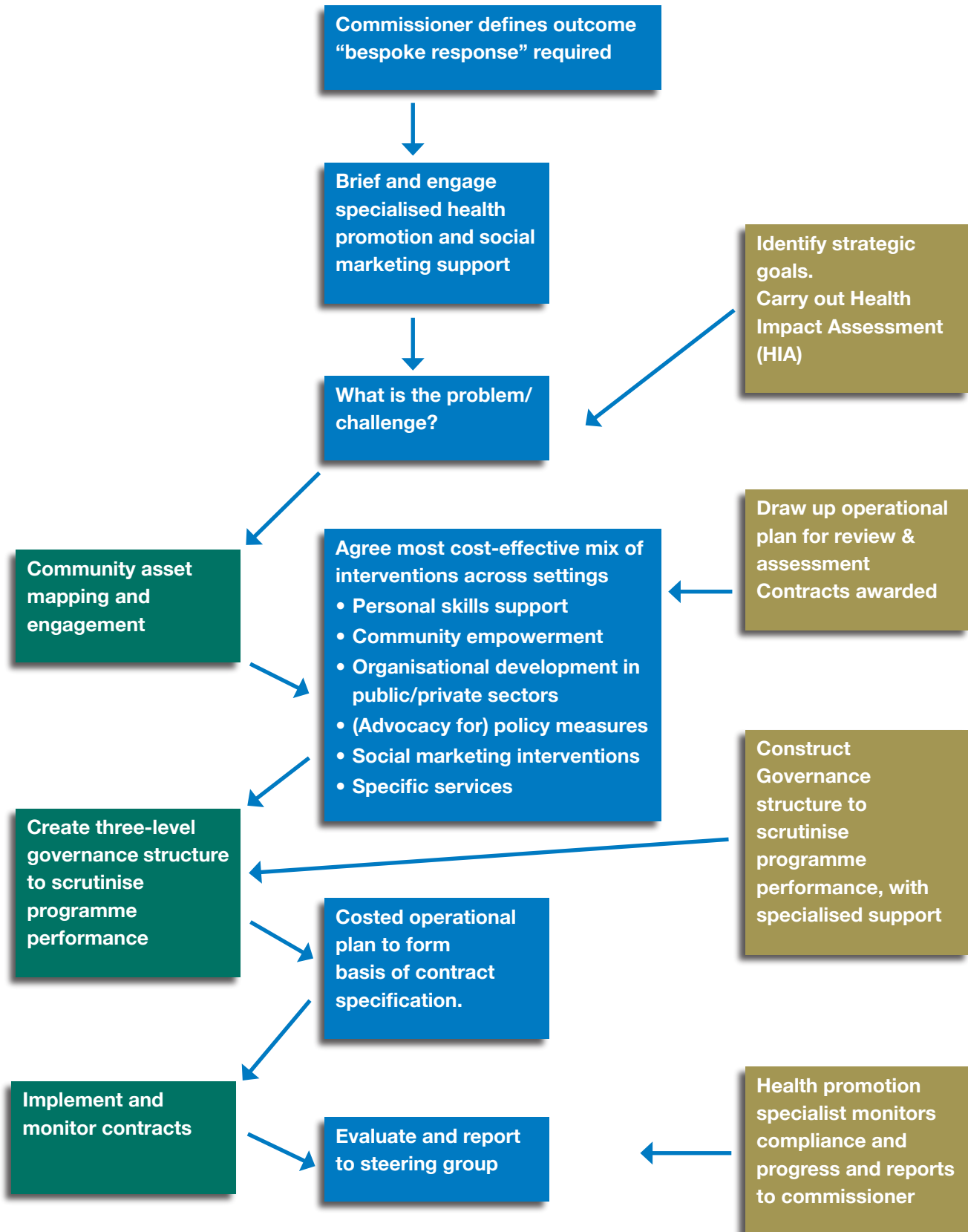
### Processes are very important

Section 2 described the characteristics of effective programmes and interventions to promote health and well-being. This section offers support on HOW to set about commissioning your programme. Section 4 focuses specifically on governance and risk management.

### Tailor the processes to your situation

There is not a single “correct” way of commissioning. We make a number of suggestions here for your consideration. It is important is to get the principles right and to have robust processes. We must then tailor our approaches to our own time and resources, and the context in which we are working. To start us off, the diagram below summarises the whole commissioning journey for promoting health and well-being.

## Promoting health and well-being – the commissioning journey



## 3.2 Systematic project planning

### The stages of project planning

Programmes need to be carefully planned to be effective and efficient. There are well-established processes in public health and service commissioning which precede the procurement stage:

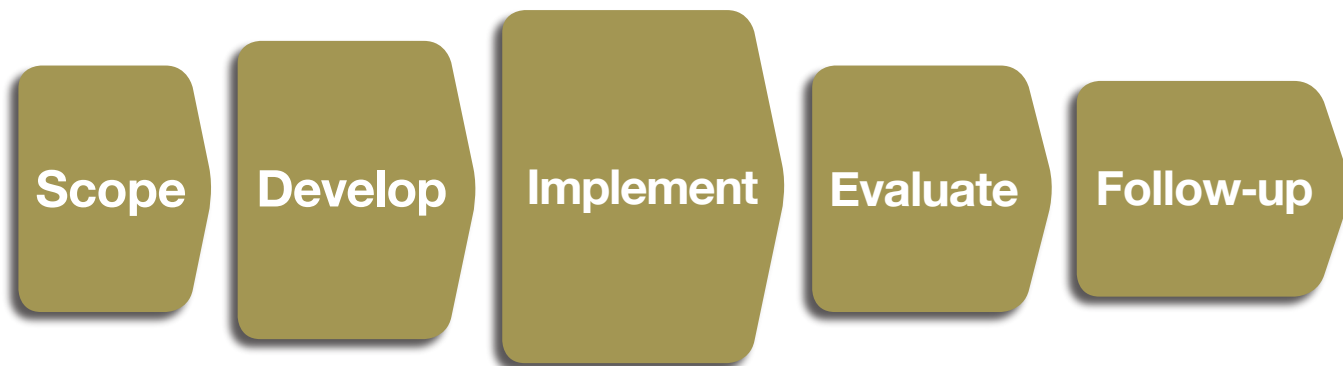
- Assessing needs
- Reviewing current service provision
- Identifying gaps and deciding priorities
- Specifying services and making the business case

A similar logical process is set out in the Department of Health guidance *Transforming Community Services*:<sup>1</sup>

1. Review current state
2. Prioritise need
3. Plan
4. Design future state
5. Implement service change
6. Transition and monitor

*The Total Process Planning Framework* (Blair-Stevens and French, 2006) is a tried and tested framework which can be used at strategic or operational level as part of the commissioning process.

### Total Process Planning [TPP] Framework



**A systematic and staged process** For further information see <http://www.nsmcentre.org.uk>

#### Commissioning the scoping stage first improves effectiveness

These project planning processes assist with defining clear aims and objectives and helping to ensure that the programme or intervention we commission will fulfil them. Spending time and resources on effective scoping is a critical success factor. It is often sensible to commission the scoping phase first and thoroughly analyse it before making decisions about the design of the programme.

1. *Transforming Community Services & World Class Commissioning*, Jan 2009 Department of Health

## **The Procurement Guide for Social Marketing Services**

The National Social Marketing Centre has published the *Procurement Guide* for Social Marketing Services (2009) which provides support with the procurement of specialist providers for social marketing. This Guide does not discuss in detail the procurement of specialist providers for health promotion, but the NSMC's guide has useful information relevant to both health promotion and social marketing on procuring tenders for different stages of a project.

### **3.3 Specialised health promotion and social marketing advice**

#### **Specialised health promotion staff**

Health promotion is undertaken by a wide range of staff in many different roles in the NHS, local government, the NGO sector and the private sector. Specialised health promotion staff can work with you to commission services. They are employed by Primary Care Trusts (health promotion teams and/or public health departments), local authorities, some non-governmental organisations, specialist university departments and independent health promotion consultancies. Alternatively ask the Royal Society for Public Health for advice.

**Health promotion specialists may not have that job title:** they have a wide range of titles such as health improvement and public health development.

#### **Specialised social marketing staff**

Increasingly specialist social marketers are being employed across the public and third sectors, and particularly within the health sector at national and SHA and PCT levels. Such staff can come from a wide range of academic and professional backgrounds, they can also be located in different parts of organisations e.g. they may be within a specific programme or project topic area, or within the communications or marketing function of the organisation. Some will be familiar with established health promotion and public health, while others may come from the communications and marketing side. Either way they should be able to help in looking at ways that social marketing techniques and approaches can be integrated into both strategic planning and operational development and delivery.

The National Social Marketing Centre, which works to build capacity and skills in social marketing, currently has ten Regional Development Managers (one for each Strategic Health Authority area) working to help PCTs and SHAs understand and integrate social marketing approaches into relevant strategic programmes. They will be able to provide guidance on where to find specialist advice at the strategic or operational level, from particular individuals or dedicated agencies. They can also provide advice and support for relevant commissioning and procurement.

#### **Involving specialists in your commissioning**

We suggest involving one or more experienced and qualified health promotion specialists and social marketers to work with you in designing your programme, and be a key member(s) of your team. They should have a high level of professional and technical knowledge in engaging communities and in organisational and behavioural change to improve health. There is much to be gained from developing an informal working relationship between commissioners and health promotion and social marketing specialists prior to more formal working.

**How specialists can help**

Health promotion and social marketing specialists can:

1. Advise and comment on the collection and assessment of health and population intelligence
2. Assess and report on local conditions likely to impact on the best commissioning response to the health problem you have identified
3. Advise on (scoping research to) understand people's and communities' needs, engagement and mobilisation, insight into what motivates and moves people
4. Advise on (scoping research to) achieve the best possible targeting and segmentation of the population for your programme or intervention
5. Recommend the most appropriate and tested theories
6. Advise on the mix of methods, both strategic and operational, to achieve the outcomes you specify in specific settings
7. Draft a full operational planning brief for the chosen programme or intervention
8. Guide drafting of service specifications
9. Carry out a Health Impact Assessment (HIA), community asset mapping and/or health equity audit (see below)

**What specialists will need from you**

To be of best value to you, health promotion and social marketing specialists need:

- To be involved from an early stage
- To have an early statement of your aims as a commissioner – open to amendment as the scoping work proceeds
- To be involved in decision making on operational aims and objectives
- To have ethical principles (see below) acknowledged and integrated into operational plans

**Qualifications and experience of health promotion specialists**

As a general guide a health promotion specialist is expected to have:

- An M.Sc. in health promotion or equivalent
- A track record in health promotion theory and methods, publications and reports – ask to see their CV
- Membership of the UK Public Health Register, Royal Society for Public Health and/or Faculty of Public Health
- High level capability in operational planning

Health promotion specialists may also have:

- Professional teaching experience in health promotion or an allied field
- Evidence of involvement in a range of health promotion or social welfare agencies and activities, either voluntary or paid
- Well developed problem-solving skills in relating theories and methods to local conditions

### Qualifications and experience of social marketing specialists

As yet social marketing is still at an early stage of development in the UK. Academic and professional courses and related qualifications are only just beginning to be developed. However a set of social marketing national occupational standards (NOS) have been established which cover different aspects of the role. These have now been formally agreed and launched by the Marketing and Sales Standards Setting Body (MSSSB).

They cover five key areas relevant to social marketing related work:

- Carrying out research
- Establishing and evaluating strategies
- Managing activities
- Delivering interventions
- Promoting and continuously improving social marketing related work

There are many existing qualifications that cover specific aspects of these standards. Work is currently underway in academic and professional contexts to look at relevant qualifications and accreditation systems. In the meantime, the NSMC runs core training for people wishing to work as social marketing associates.

## 3.4 Ready-made or developmental responses

### Off the shelf or tailor-made programmes

A key early decision is whether commissioning aims are best served by the purchase of a “ready-made” response or a “developmental” response, where a programme is tailor-made to local requirements and/or conditions. Specialised health promotion and social marketing advice will help with this important decision.

### Adaptation to the local context and local ownership

In most cases, “off-the-shelf” or “ready-made” commissioning solutions are likely to require some adaptation to respond to local needs and resources, and equally importantly to enable local ownership and participation by the community which, as we have seen in section 2, are directly linked to successful outcomes.

Here are three examples to illustrate the difference between ready-made and developmental responses in responding to local circumstances:

#### Case example 1 **Healthy eating – 5 a day**

Research from social marketing studies of eating patterns and beliefs shows that programmes and services need to respond carefully to diverse public views and understanding of what constitutes “healthy eating” and how attitudes to food are influenced by social roles such as parenting. Such factors must be incorporated into the local response.



## Case example 2 Reducing smoking

### Ready-made response – Smoking cessation services

If there is a clear need for a stand-alone smoking cessation service then you can use Department of Health guidance:

<http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Tobacco/index.htm>

Also NICE public health guidance <http://guidance.nice.org.uk/PH10> which is a smoking cessation bespoke support tool.

Specialised health promotion and social marketing advice will help to ensure that the service is tailored and targeted appropriately to your local needs.

### Developmental response – Reducing tobacco consumption

If local evidence suggests that reducing tobacco consumption requires more than the provision of a smoking cessation service, then specialised health promotion and social marketing advice needs to be brought in to support the commissioning of a locally-specific, multi-factorial response tackling identified determinants of smoking behaviour. This might mean working in schools and workplaces, with retailers, with young people in various settings, with pregnant women and young parents - a broader approach to promote positive health.

## Case example 3 Sexual health – Sexually transmitted infections (STIs)

Data from adjoining local authority wards might show high levels of STIs in both: further scoping research will establish the nature and characteristics of the populations in the two wards.

Let us imagine that one ward has a concentration of female drug users, a high proportion of whom are recent migrants involved in the sex trade. The other ward has more young people, most of whom attend two local community colleges.

The commissioning response is very different in these two wards. In the first, logical partners would be community safety and immigrant welfare organisations. For the second schools- and college-based programmes linked to social inclusion and community and/or personal development would be appropriate.

## 3.5 The ethics of commissioning to promote health and well-being

### Ethical questions are part of commissioning

Ethically-based practice is as important as evidence-based practice. Values are important to the way that we think and act. What should we be doing? For whom should we be doing it? Who should decide and how? These questions are fundamental to the commissioning and practice of health promotion. This section highlights some of the values and principles underpinning health promotion practice.<sup>2</sup>

2. For more information and a full statement of ethical principles, see Shaping the Future of Health Promotion with SHEPS Cymru (2009) A Framework for Ethical Health Promotion. [www.rsph.org.uk/healthpromotion](http://www.rsph.org.uk/healthpromotion)

### **Ethical differences between clinical settings and working with populations**

Bioethics tends to focus on the relationship between individuals and clinicians. Health promotion extends beyond clinical settings and is concerned with programmes that affect whole populations. This raises a number of ethical issues, in particular, the responsibility and authority of the state (and agents acting on behalf of the state), whose policies affect people's lives.

### **Some core values in health promotion**

Ethical health improvement is effective health improvement. Health is a fundamental human right, and is holistic, encompassing physical, mental and social well-being. Self-actualisation is central to health and well-being. It follows therefore that equity, empowerment and participation are core values.

### **Some ethical conflicts in promoting health and well-being**

Some of the ethical conflicts that affect commissioning programmes include:

- How to simultaneously do good and avoid doing harm
- State responsibility and the protection of personal autonomy
- Sacrificing the rights of some in the interest of welfare overall
- The greatest good for the greatest number or reducing health inequalities

### **Two statements to debate<sup>3</sup>**

To bring ethical principles alive, you could debate the following two statements with colleagues. What issues do you think are raised by each statement? What aspects of these statements do you support? What would you change?

**Statement 1:** "Everyone knows what things are bad for them - smoking, lack of exercise, too much alcohol and a poor diet – and all of us have equal access to publicly funded education and healthcare. People should be allowed to make their own choices, and do what makes them happy as long as it doesn't hurt anyone else. Health promotion is just an extension of the 'nanny state'. Why should the state tell people how to live their lives? Autonomy and freedom are the central building blocks of a healthy society and are fundamental to personal well-being."

**Statement 2:** "People do make personal choices, but these do not occur in a vacuum: they are influenced by other people and the environment. Health should be ensured through political and state intervention to address all of the factors affecting health and well-being. Variations in health are due to fundamental socio-economic and environmental inequalities that exist in society. The state must ensure that public institutions, third sector and commercial organisation engage with communities to take collective action in relation to health determinants."

### **Developing a code of practice for social marketing**

The National Social Marketing Centre is consulting on a draft code of conduct. It has published a report on social marketing ethics, which discusses ethical frameworks and ethical issues in targeting and makes recommendations for the development of a code.<sup>4</sup>

3. With acknowledgements to Will Beer, SHEPS Cymru

4. Eagle, Lynn (2009) Social Marketing Ethics. Report Prepared for the National Social Marketing Centre. [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

## 3.6 The importance of theory

### The benefits of theory

Programmes and interventions planned, implemented, monitored and evaluated with the benefit of a theory base are more likely to succeed than those developed without an underpinning theoretical perspective.<sup>5</sup> The benefits of careful consideration of theory include:<sup>6</sup>

- Use of theory allows commissioners to make predictions regarding impact and results
- Using the right theory can help to ensure that interventions actually reach and have a demonstrable impact on individuals, communities and organisations
- Use of theory assists monitoring and evaluation as it enables comparison between expected and observed results
- Theories and models are in themselves an important form of evidence. Theory needs to be integrated into the evidence base, alongside evaluations and other research-based evidence, the academic literature and national policy

### Choose theories appropriate to your aims

Programmes should be informed by established theory that is relevant to the type of intervention planned. There are several approaches and models which are commonly used to guide programme development and implementation and these can be adapted to fit most interventions. Specialised health promotion and social marketing advice will assist with the selection of the most appropriate theory/ies for your health problem, matching theory to your desired outcomes.

5. US National Cancer Institute (2005). Theory at a Glance: A Guide for Health Promotion Practice (second edition). U.S. Department of Health and Human Services, National Institutes of Health. [www.cancer.gov/theory/pdf](http://www.cancer.gov/theory/pdf)

6. See Shaping the Future of Health Promotion, "Why Theory Matters", [www.rsph.org.uk/healthpromotion](http://www.rsph.org.uk/healthpromotion); and Nutbeam, D., Harris, E., Theory in a Nutshell: A practitioner's guide to commonly used theories and models in health promotion. National Centre for Health Promotion, Sydney

## Four types of theory

### Explanatory theory

Explanatory theory describes the reasons why a problem exists, e.g. why young people take up smoking. It helps to ensure that all relevant factors are identified, such as the personal, environmental, social and behavioural determinants of the problem. There are several different explanatory theories to choose from.

### Community development theory

Community development draws on several important theories concerned with the building of groups, inter-sectoral collaboration, the building of social capital and organisational change.

### Change theory

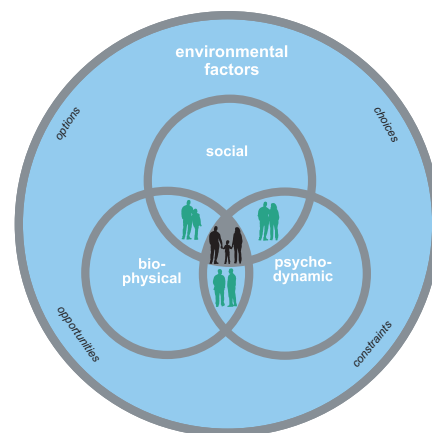
Change theory guides the development of interventions and assists evaluation. One change theory that is widely known is the diffusion of innovations theory.

### Behavioural theory

Behavioural theory is used in health promotion and social marketing, taking into account the four primary domains within the Integrated Theory Framework (Blair-Stevens 2005).

The Integrated Theory Framework covers four core overlapping and interacting domains as listed and represented diagrammatically here:

- 1: Bio-physical
- 2: Psychological
- 3: Social
- 4: Environmental / Ecological

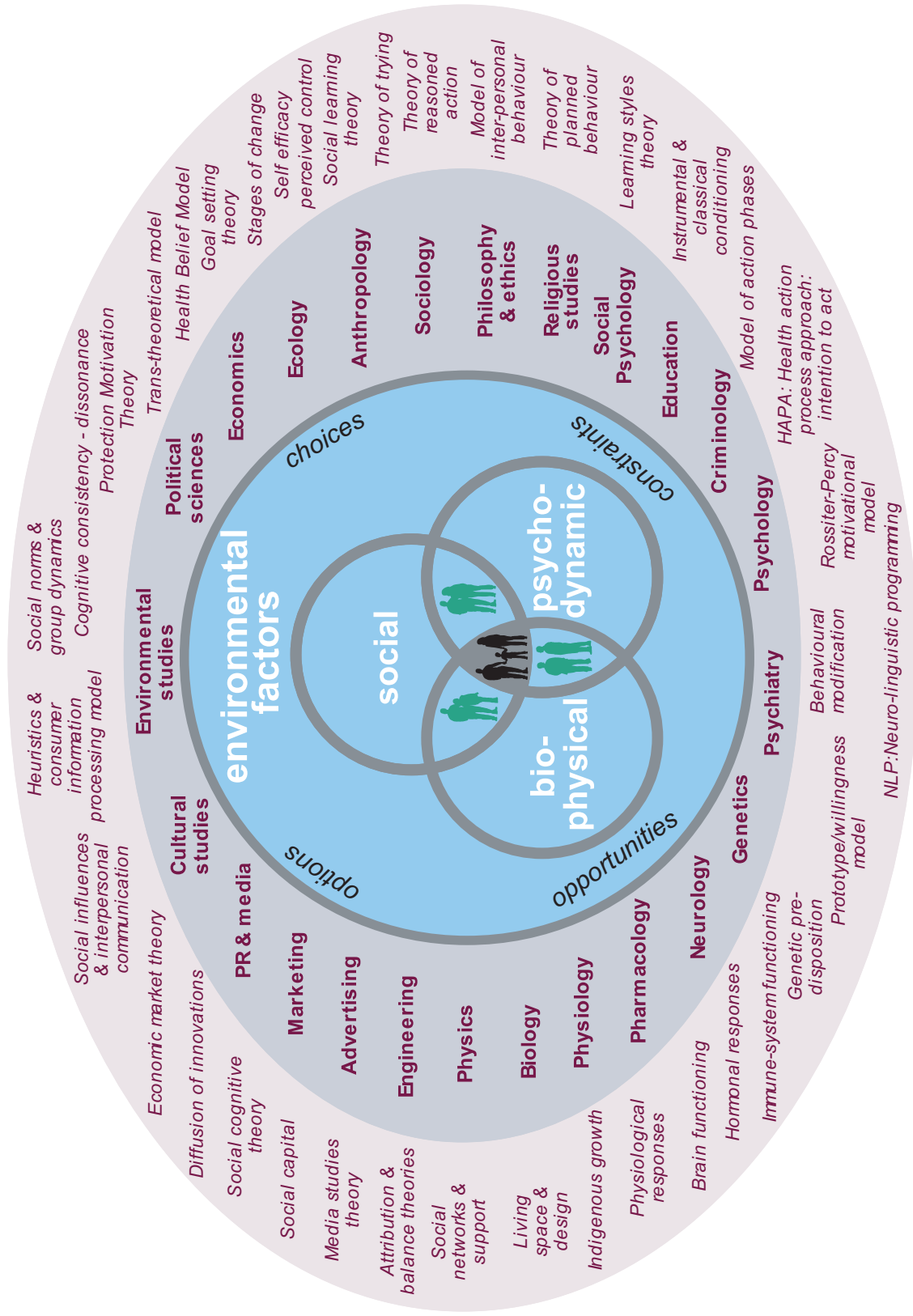


## The Integrated Theory Framework

The Integrated Theory Framework can be used to help review and assess which theories might be relevant to particular behavioural challenges. It provides a practical tool for helping manage the complexity. Key principles include:

- Valuing a diverse range of academic and professional disciplines that can potentially contribute theory and ideas to inform work
- Avoiding over reliance on one single professional discipline or perspective
- Avoiding unquestioned use of the same behaviour theory for every behavioural challenge
- Keeping the assessment of options focused on the ‘utility’ of the particular theory to the specific individual, social and societal context.

Examples of the huge range of different disciplines that can contribute to understanding are shown below, along with illustrative examples of some of the many different theories that exist.



With Kind Permission of the National Social Marketing Centre [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

## 3.7 Specific tools and techniques to assist commissioning

### Community Asset Mapping

Community asset mapping identifies the structures and resources within communities and local organisations that can be built upon to develop a strong, lasting programme of health improvement. Community asset mapping is as important as needs assessment. Health promotion specialists locally will be able to provide help.

The WHO website gives practical examples of community asset mapping and techniques in respect of HIV/AIDS. The method is adaptable for other conditions and situations.

See [www.who.int/entity/hiv/pub/imai/om\\_4\\_community.pdf](http://www.who.int/entity/hiv/pub/imai/om_4_community.pdf)

### Health Impact Assessment

Health Impact Assessment (HIA) is a systematic process to ensure that the potential health effects of policies are fully considered. It can also help in assessing models of service or programme delivery, helping to evaluate the environmental, health and well-being impacts of programmes and developments. HIA can also aid monitoring and evaluation by allowing an element of pre and post assessment of activity.

HIA has been successfully used on policies as wide-ranging as air quality, rural development, housing, social care, transport and mental health. [www.hiagateway.org.uk](http://www.hiagateway.org.uk) provides a resource of evidence, case studies, tools and an interactive forum about all aspects of HIA, and also SEA.<sup>7</sup>

Specialised health promotion staff can initiate, implement and assess the results of HIA.

A judgement needs to be made regarding the scope and depth of an HIA. Its rigour must be commensurate with the requirements of the commissioner's investment. It is unlikely a "rapid" HIA would be adequate for major programmes.

### Health Equity Audit

Health Equity Audit (HEA) is a tool used to identify and address inequalities, focusing on how fairly resources are distributed in relation to the health needs of different groups. HEA enables a systematic review of inequities in ill-health or in access to effective services. It can be used to:

- Inform commissioning to make services more accessible and appropriate
- Provide evidence to show whether local health needs are being met
- Encourage community involvement by providing information on inequities in services that allows groups to lobby for improved resource allocation

For more information see: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4084138](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138)

7. SEA is Strategic Environmental Assessment. It enacts a EU Directive requiring formal assessment for a wide range of plans and programmes (e.g. spatial, transport and waste) of the likely significant effects on the environment of implementing the plan, including effects on population and human health. The assessment is used to influence the wider determinants of health, health inequalities and sustainability

### 3.8 Building provider capacity and capability

Commissioners need to be satisfied that the providers they choose have or gain the knowledge and skills to be effective in the delivery and monitoring of programmes.

The “market” for the provision of quality health promotion services is under-developed in some areas of the country. Commissioners have an important role in stimulating the market to develop a choice of providers (see World Class Commissioning competency 7). Some health promotion providers may need support with professional training and education to deliver programmes to the levels and standards set by commissioners.

Training and education will in some circumstances be a good investment for commissioners, as it will avoid programme failure by enabling providers to adhere to commissioner-specified methods and monitor their own performance without constant oversight.

Commissioners should also ensure that providers are able to engage with the competences and accreditation processes relating to public health. The core document is the UK Public Health Skills and Career Framework (2008).<sup>8</sup>

8. PHRU/Skills for Health (2008) The Public Health Skills and Career Framework [http://www.phru.nhs.uk/Doc\\_Links/PHSkills&CareerFramework\\_Launchdoc\\_April08.pdf](http://www.phru.nhs.uk/Doc_Links/PHSkills&CareerFramework_Launchdoc_April08.pdf)

# 4. Governance and Risk Management

## Contents

1. Who is responsible for what
2. The importance of programme governance
3. Governance structure
4. Risk management

### 4.1 Who is responsible for what in World Class Commissioning

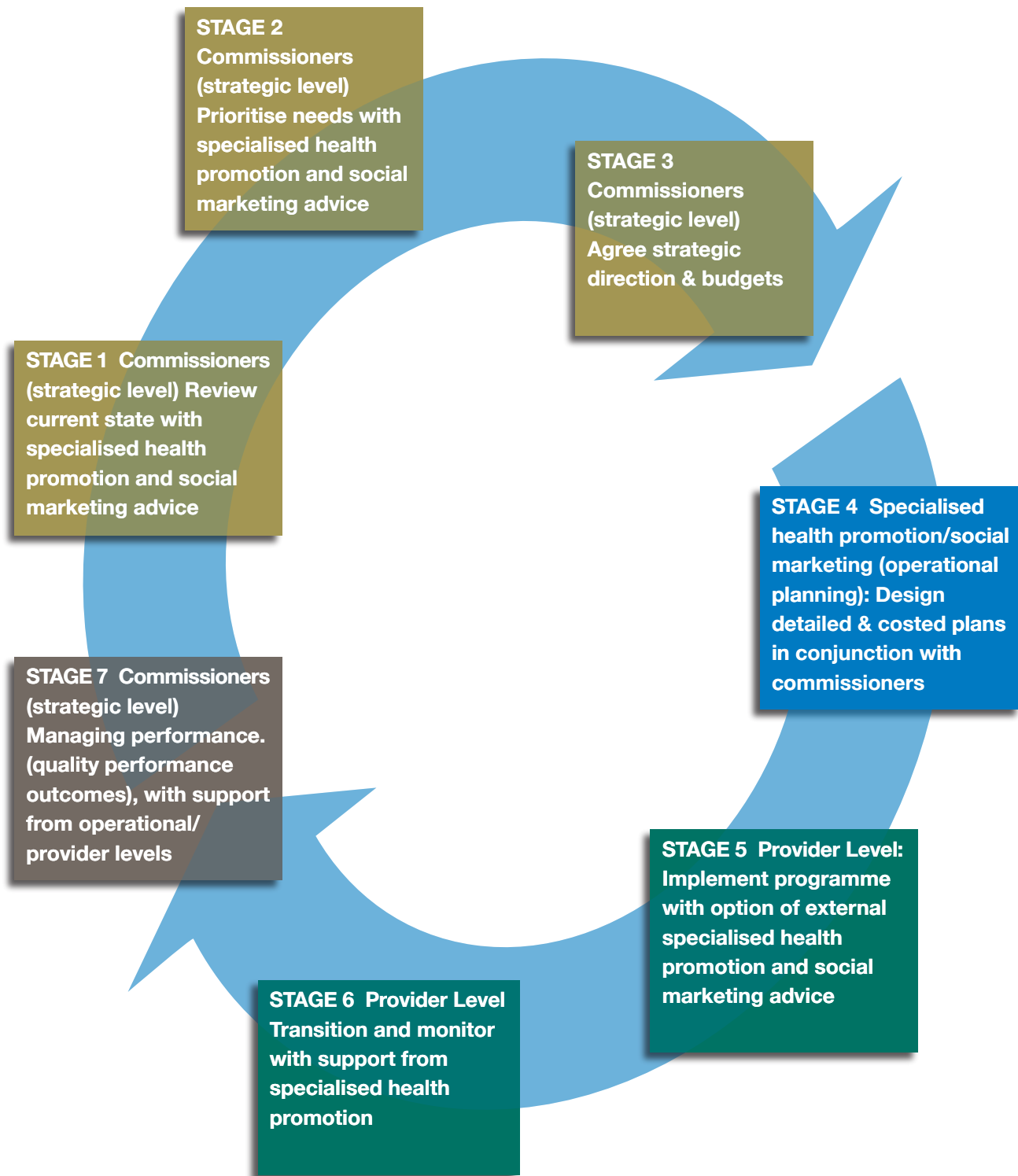
Health promotion and social marketing programmes require detailed operational planning for successful implementation. The chart below summarises the process of developing a programme, although this must be tailored to local conditions, time and resources.

In **Appendix 2** is a **template for developing an operational plan** – see stage 4 in the commissioning cycle.

In **Appendix 3** is a worked example of a **service specification**



## The Commissioning Cycle



**Key:**

- Strategic level (Commissioner)
- Operational level – Specialised health promotion and social marketing advice
- Provider level

Note: The references to strategic, operational and provider levels are organisational terms only. Each level is of equal value. Each is dependent on the other. *It is not a hierarchy of importance.*

## 4.2 The importance of programme governance

### Clear levels of responsibility

Governance is about levels of responsibility in decision-making. In this context the term has a wider meaning than Clinical Governance.<sup>1</sup>

Governance in this context describes the totality of the management process from the initial scoping and design of what needs to be done strategically, for example scoping research to provide insight into people's and community needs, community asset mapping, epidemiological needs assessments, Health Impact Assessments and service specifications, through to the management of the delivery and oversight processes – operational resource allocation, budgeting, HR, and monitoring and evaluation.

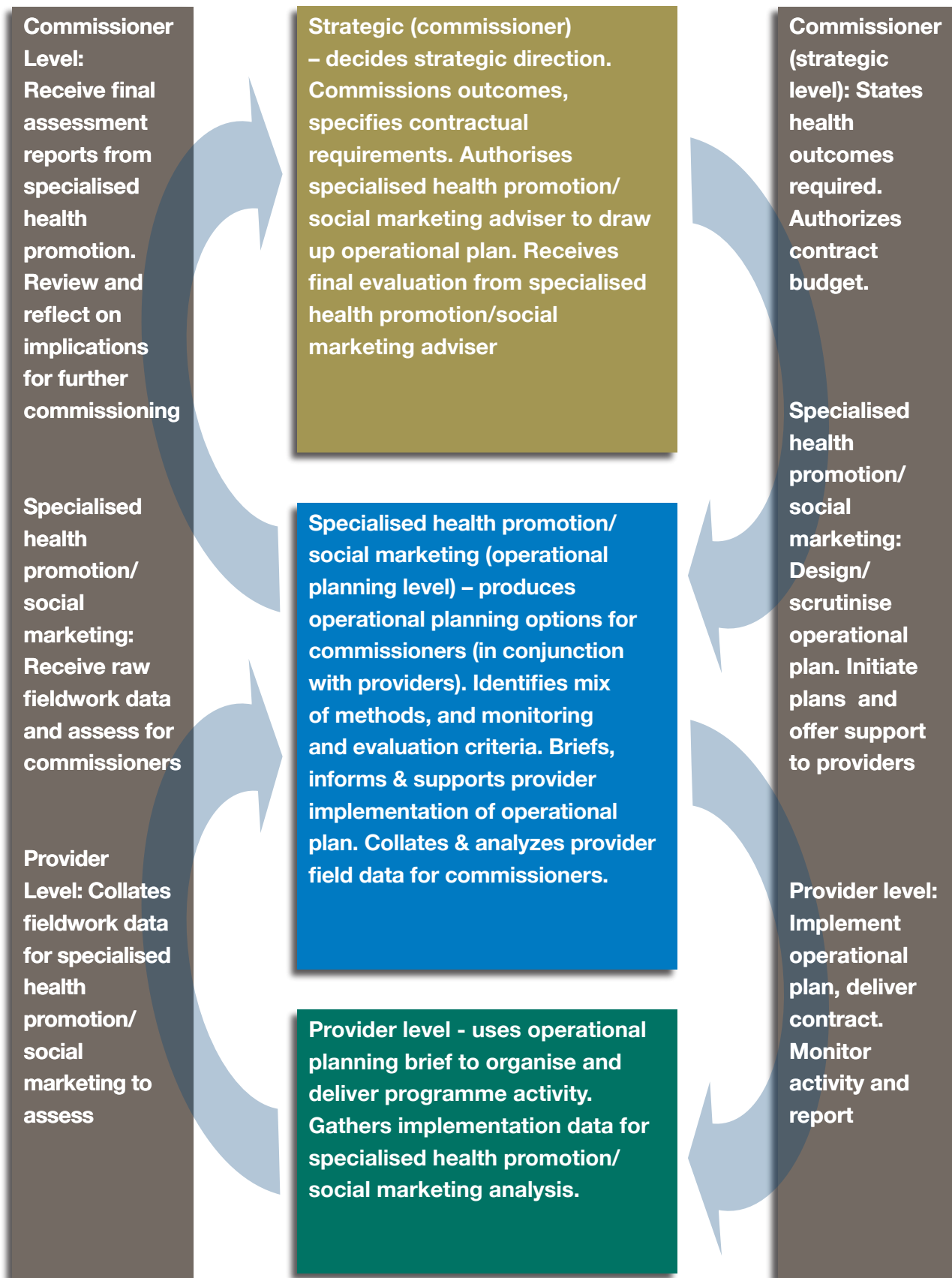
### Overseeing the total process

Although the commissioning process splits the assessment (initial) function from the delivery (secondary) function, commissioners need governance structures that can oversee the total process. They should also ensure that their providers have governance structures that are “fit for purpose”.

The diagram below illustrates the governance structure for the delivery of programmes to promote health and well-being.

1. Private Action, Public Benefit: A Review of the Wider Not-for-Profit Sector (Strategy Unit Report), Chartered Institute for Public Finance and Accountancy (Dec 2002) [http://www.cipfa.org.uk/pt/pt\\_details\\_r.cfm?news\\_id=15215](http://www.cipfa.org.uk/pt/pt_details_r.cfm?news_id=15215)

### 4.3 Governance structure for commissioning health improvement



For further information, see Private Action, Public Benefit: A Review of the Wider Not-for-Profit Sector (Strategy Unit Report), Chartered Institute for Public Finance and Accountancy (Dec 2002) [http://www.cipfa.org.uk/pt/pt\\_details\\_r.cfm?news\\_id=15215](http://www.cipfa.org.uk/pt/pt_details_r.cfm?news_id=15215)

## Case example of effective governance

### National Healthy Schools Programme<sup>1</sup>

#### Implementation

The strategic decision to improve health within schools was made at Government level (Departments of Health and Education). Outline goals and budgets were transmitted to Primary Care Trust level. PCT public health and health promotion departments took on the operational planning role of matching strategic goals to local needs and conditions. The field level delivery (provider function) was undertaken by local schools with specialised health promotion support, to the criteria previously agreed with the Government.

#### Monitoring and evaluation

The raw monitoring and evaluation data from the schools was then collated by the PCT health promotion services prior to transmission back to Government.

The National Health Schools programme operates at a national level. However the divisions of responsibility and action are equally applicable to local level. The scale is smaller but the process and division of labour remain the same.

## 4.4 Risk management

Commissioning requires the management of risk associated with contractual relationships.<sup>2</sup>

#### Risks include:

- **External** – exposure to outside influences, outside the control of the parties concerned e.g. funding cuts
- **Operational** – the risks associated with the actual running of the programmes, e.g. loss of key staff
- **Assumptive risk** – this is related to the judgements made for the total programme or service.

Operational and assumptive risks can be managed by using problem-solving approaches, with timely and effective use of specialised health promotion and social marketing advice and support. Real-time monitoring and review is essential to ensure timely responses to emerging issues.

1. <http://resources.healthyschools.gov.uk/p/static/aboutus>

2. Tennant J. (2008), Guide to Financial Management. Profile books in conjunction with The Economist. UK

# 5. Criteria for Self-Assessment

## Contents

1. Criteria for the promotion of health and well-being
2. Social marketing national criteria

It is taken for granted that elements such as strategic planning, partnership working and evaluation are undertaken, as they would be in any form of commissioning, so these are not included in the criteria below.

### **5.1 Self-assessment criteria for the promotion of health and well-being**

These criteria are provisional and will be updated to reflect the outcome of the National Social Marketing Centre/Royal Society for Public Health/Public Health Resource Unit Delphi consultation on health promotion and social marketing mentioned in Section 1. The criteria are essential elements to look for in a programme or intervention, to assess whether it is based on health promotion theory and practice.

## Self-Assessment Checklist

Criteria	What to look for	Yes Score 1	No/ Not known Score 0
<b>1 Whole system approach: Determinants of health addressed</b>	Programmes are clearly focused on the cultural, social, economic and environmental conditions that influence people's health, as well as individual lifestyles  Action to reduce greenhouse gas emissions is integrated into programmes, recognising that what is good for the climate is good for health		
<b>2 Holistic view of health</b>	Encompassing physical health, mental health well-being and quality of life simultaneously		
<b>3 People as partners</b>	People are positively engaged in the programme development and implementation. Their resources are respected and they are empowered to participate		
<b>4 Communities nurtured</b>	What is already going on in communities is fed and nurtured  Power and control are given to communities		
<b>5 Social networks supported</b>	Social networks (known as social capital) are engaged and developed to promote health and to ensure long-term success		
<b>6 Ethics</b>	Programmes are grounded in an appropriate ethical framework		
<b>7 Theory</b>	Theory is used transparently to inform and guide development, and theoretical assumptions tested as part of the process		
<b>8 Methods mix</b>	Use of a mix of methods relevant to the local situation and based on theory		
<b>9 Settings</b>	Use of a range of different settings for interventions relevant to the local situation		
<b>10 Social marketing integrated</b>	Social marketing and health promotion interventions are commissioned together as a single integrated programme (see below)		
<b>11 Scoping</b>	Detailed scoping of the health problem and solutions  Contextual understanding developed in detail		
<b>12 Governance</b>	Governance structures have clear decision-making processes for aims and objectives, strategy, operational planning, resource allocation, operational implementation support, and monitoring		
<b>13 Specialist advice</b>	Specialised health promotion and social marketing advice is used during the commissioning process		
<b>14 Provider support</b>	Programmes and initiatives are delivered by appropriately qualified and experienced staff Support is provided for provider education and development, if necessary		
	<b>Score</b>		

## 5.2 Social marketing national criteria

Criteria	What to look for
<b>1 Customer orientation</b>	A broad and robust understanding of the customer is developed, which focuses on understanding their lives in the round Formative consumer/market research used
<b>2 Behaviour</b>	A broad and robust behavioural analysis undertaken Intervention clearly focused on specific behaviours Specific actionable and measurable behavioural goals and key indicators
<b>3 Theory</b>	Is behavioural theory-based and informed – draws from an integrated theory framework Theory is used transparently to inform and guide development Theoretical assumptions tested as part of the process
<b>4 Insight</b>	Based on developing a deeper 'insight' approach – focusing on what 'moves and motivates' Drills down from a wider understanding of the customer to focus on identifying key factors and issues relevant to positively influencing particular behaviour
<b>5 Exchange</b>	Incorporates an 'exchange' analysis. Understanding what the person has to give to get the benefits proposed Analysis of the perceived/actual costs versus perceived/actual benefits
<b>6 Competition</b>	Incorporates a 'competition' analysis to understand what competes for the time and attention of the audience Both internal and external competition considered and addressed
<b>7 Segmentation</b>	Uses a developed segmentation approach (not just targeting) – avoids blanket approaches Deeper segmented approaches that focus on what 'moves and motivates' the relevant audience Interventions directly tailored to specific audience segments
<b>8 Methods mix</b>	Identifies an appropriate mix of methods Intervention mix = strategic SM Marketing mix = operational SM Avoids reliance on single methods or approaches used in isolation

From: French, Blair-Stevens (2006), adapted from original benchmark criteria developed by Andreasen (2002)

See: [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk) for more information

# 6. Appendices

## Contents

- Appendix 1 Frequently asked questions
- Appendix 2 Operational planning template
- Appendix 3 Service specification – worked example

## Appendix 1 Frequently Asked Questions

### 1 What is health promotion?

The strategic definition of health promotion is “the process of enabling people to increase control over and to improve their health” (WHO 1985).

This is underpinned by a further statement of the WHO: “This perspective is derived from a conception of ‘health’ as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities”.<sup>1</sup>

An academic definition is: “The study of and the study of the response to, the modifiable determinants of health or illness”.<sup>2</sup>

### 2 What are primary, secondary and tertiary prevention?

Primary prevention seeks to avoid onset of illness by the detection of high risk groups and advice on healthy living, e.g. screening programmes, balanced diets, as well as policies concerning a health-promoting environment, e.g. housing, healthy workplaces. Primary prevention overlaps considerably with health promotion.

Secondary prevention seeks to shorten episodes and the duration of illness, e.g. smoking cessation for asthmatics.

Tertiary prevention seeks to limit disability or incapacity,<sup>3</sup> for example physical exercise as part of cardiac rehabilitation.

### 3 Where can I get specialised health promotion and social marketing support?

Specialised health promotion staff are employed by Primary Care Trusts (health promotion teams and/or public health departments), local authorities, some non-governmental organisations, specialist University departments, independent health promotion consultancies or ask the Royal Society for Public Health for advice.

1. Ewles L. and Simnett I (2005) Promoting Health a Practical Guide, Bailliere Tindall

2. Wylie A, Thompson S. Establishing health promotion in the modern medical curriculum: a case study. Medical Teacher 2007;29

3. Naidoo J & Wills J 2005, Health Promotion Foundations for Practice, Bailliere Tindall. UK



Specialist social marketers come from a diverse range of disciplines. To date, the following sectors have been particularly involved: academic; research and development; public health and health promotion; environment; communications and marketing. In the future it is hoped to establish a formal accreditation and qualification system but in the meantime the National Social Marketing Centre has established an initial Associates scheme and helped train and assess a core group of independent consultants. The National Social Marketing Centre also currently has ten Regional Development and Support Managers (one per Strategic Health Authority) who can provide advice and guidance on securing expertise and skills and potentially contribute to the commissioning and procuring process. There are also a number of lists being set up by bodies like the Central Office of Information or some regional offices (NSMC) which have individuals or agencies with expertise or skills in this area.

#### **4 What should I look for in health promotion and social marketing specialists?**

A competent health promotion specialist is expected to have a higher degree in health promotion, a verifiable track record in: programme and service design (linked to problem solving); application of theory and methods; monitoring and evaluation; operational planning; and partnership working.

Academic qualifications in social marketing are only just beginning to be developed and so most social marketers are unlikely to have a dedicated social marketing qualification. However the list of areas covered in the social marketing National Occupational Standards (NOS) provides a useful starting point to assess experience and skills. Many of the specific areas included will have dedicated academic qualifications that can be considered (eg research methods). The social marketing NOS covers five key areas of practice:

- A: Carrying out research
- B: Establishing and evaluating strategies
- C: Managing activities
- D: Delivering interventions
- E: Promoting and continuously improving social marketing related work

#### **5 What is social capital?**

Social capital refers to investment in the social fabric of society. It is characterised by communities with high levels of trust, effective community networks for the exchange of information, ideas and practical help.<sup>4</sup>

It also refers to social cohesion and the cumulative experiences of relationships, with both those known to us and those who are strangers. Characterised by mutual trust, acceptance, approval and respect.<sup>5</sup> There is a strong evidence base linking people's participation in networks and social structures with positive mental and physical health.

4. Ewles L, Simnett I (2005) Promoting Health a Practice Guide, Bailliere Tindall

5. Naidoo J & Wills J. (2005), Health Promotion – Foundations for Practice. Bailliere Tindall

## **6 What are the determinants of health and/or disease?**

The determinants of health are listed by the World Health Organisation<sup>6</sup> as:

- the social and economic environment
- the physical environment
- the person's individual characteristics and behaviours

Health promotion interventions focus not only on individual behaviour, but on the environment – social, economic and physical.

## **7 What is the difference between an aim and an objective?**

An aim is the ultimate achievement or goal desired, after all activity involved in its attainment has ceased.

An objective is the necessary steps required to achieve the stated aim. Commissioning objectives will always be tactical in pursuit of the strategic aim.

6. <http://www.who.int/hia/evidence/doh/en/>

## Appendix 2 Operational Planning Template

<b>1 Title:</b>	Programme Name (Unique).
<b>2 Aim/s:</b>	The ultimate result desired.
<b>3 Objectives:</b>	Key steps to achieving the aim.
<b>4 Timings:</b>	Start time? End time? Duration?
<b>5 Location/s:</b>	Where? Settings approach? Geographical? Population? etc.
<b>6 Population/s:</b>	General public, social excluded, young people, older people? Who? Define.
<b>7 Evaluation Methods/ Processes/Outcomes:</b>	What is going to be measured, how, when, by whom?
<b>8 Methodology (Theory):</b>	What philosophy of health underpins our approach? (What will make the difference?)
<b>9 Methods:</b>	How shall we carry out the methodology?
<b>10 Liaison Issues:</b>	Who else needs to know? When, for what purpose?
<b>11 Personnel:</b>	Who else is involved? What is their role, Who are they (+ contact details).
<b>12 Resources:</b>	What equipment, materials, capital, personnel and revenue are required?
<b>13 Needs Assessment:</b>	What evidence supports choice of methodology?
<b>14 Contextual Understanding:</b>	What do we know about the lives of the target population and the assets of communities?
<b>14 Key Messages:</b>	Can we define the key concepts to be used?
<b>15 Design Concepts:</b>	Can we define the style of operation?
<b>16 Risk Assessment and Ethics - personal, professional and public.</b>	What risks do we run? Are any known? Can they be managed? Ethical standards-whose?

*The key quality criterion of an effective Operational Plan is that each element is congruent with every other element.*

## Appendix 3 Service Specification - Worked Example

### SERVICE SPECIFICATION

#### Worked Example

<b>Service</b>	<b>Child Obesity Reduction Programme “ACWREP” (Anytown Community Weight Reduction Programme)</b>
<b>Commissioner Lead</b>	<b>J Smith</b>
<b>Provider Lead</b>	<b>S Brown Chief Executive: AAI, (Action Against Inactivity)</b>
<b>Period</b>	<b>1st April 2010 – 31st March 2013</b>

#### 1. Purpose

**1.1 Aims:** The Anytown PCT wishes to commission a focused community based weight reduction programme for the Chapel Street area of Anytown.

This Service Specification is based on identified needs and requires specific levels of activity. The requirements are that the service is:

- Child and family centred
- Clinically and managerially competent
- Accessible to vulnerable families
- Quality of services are commensurate with or exceeds nationally or locally set standards
- Delivers agreed levels of outcome

**1.2 Evidence Base:** The need for programme has been identified from a range of sources.

- 1 Tackling Child Obesity – First Steps – NAO 2006
- 2 “Tackling Obesity Locally” Anytown PCT Annual Report 2009.
- 3 Hospital Activity Analysis – Anytown Hospital 2007

**1.3 General Overview:** Anytown PCT area covers 45 square miles, and has a number of wards where the levels of deprivation are in the lowest quartile. It is accepted that raised levels of obesity in children have a significant impact on future mortality and morbidity levels. Being overweight also impacts on educational and employment prospects and contributes to under achievement.

**1.4 Objectives:** To halt year on year rise in obesity in primary school children from the given base line data by Dec. 2012.

**1.5 Expected Outcomes:**

- a) It is expected that following 2013 review new objectives will be set to reduce overall weight levels.
- b) Stabilisation in morbidity rates in young people related to known obesity risks
- c) Increased personal and family ability to monitor weight and make autonomous exercise and dietary decisions

## 2. Scope

**2.1 Service Description: The purpose of this programme specification is for the implementation and delivery of the stated programme and its administration, monitoring and evaluation to the stated population within the required geographical location.**

**Vision:** It is expected that within the time frames set out in the Operational Plan, that the year on year increase in excess weight will stabilise. It is expected that the measured level of physical activity in the wards specified will have increased by a statistically significant levels. Our expectation is that there will be a high level of participation in scheme by local residents.

**Principals and Core Components:** Ethical standards will comply with agreed protocol in relation to professional standards, gender, sexuality, race, cultural and faith issues.

**Quality of Service:** Services and programmes will meet agreed standards. Guidance from NICE will be observed where applicable. NSF standards will apply where applicable.

**Access and Availability:** Services will be user friendly and accessible as stated in the Operational Plan. Financial and other monetary barriers to participation will be removed allowing ready access.

**Responsiveness to Need:** Special attention will be paid to the deficits in literacy and language identified during the community research phase. Issues around body image will receive special care and attention. Family and group activity will be important as identified in the Community Assessment.

**Population Needs:** Special attention to be paid to persons and families with Special Needs as identified during the Community Assessment. Children and young people displaying particular talent for sports will be given encouragement and support to develop their talent – if necessary outside the programme area.

**Core Activity:** Physical activity to be promoted as a matter of routine and of a source of enjoyment. This will take the form of street based activities. Parks and other local open spaces to be used for recreational purposes. Alongside physical activity community cooking and food production via renewed Allotment Holders programme to be encouraged.

**Specialist Activity:** Special Needs groups will be given a higher level of 1to1 support and instruction. Children and adults with an identified obesity issue will have access to “fast track” weight management provided by the PCT.

**Referral Conditions to Specialist Support:** Referral for specialist weight management or specialist coaching will be as stated in Operational Plan.

### 2.2 Accessibility/acceptability

Attention will be given to ensuring programme activities and services will be culturally appropriate and personally acceptable and enhancing.

### 2.3 Whole System Relationships

1 The Provider is required to make use of and exploit the benefit of collaborative working with local partners and interested parties.

2 Anytown Borough Council has an active and established team working in the field of Community Exercise and Fitness.

3 Chapel Street Tenants Association – is active in promoting community cohesion and improving the life chances of local people, esp. children.

4 The Anytown Youth and Community Service established a year ago a Community Outreach programme for children and Young People “out of school”.

5 The University of Anytown has expressed interest in supporting programme development by making staff available for ongoing monitoring and evaluation at cost.

6 Professional advice and support from Anytown PCT Health Promotion Service is available to Providers relating to implementation and delivery issues. This is also applied to Anytown PCT Community Dietetics Service.

#### **2.4 Interdependencies**

The Providers must be able to demonstrate cooperation with staff and members of the Borough Council, Tenants Association, the PCT and the University in a timely and positive manner

#### **2.5 Relevant Clinical Networks and Screening Programmes**

There is an expectation that formal links are established with school nursing, and public health department in relation to the child weight measurement programme.

#### **2.6 Sub-contractors**

Because of the specialist nature of the programme specification, it is expected that the selected Provider will deliver services and activity. Sub-contracting is not expected. However sub-contracting is permissible (with agreement from Commissioners) in response to exceptional or unforeseen developments or occurrences.

### **3. Service Delivery**

#### **3.1 Service Model**

The Service Model specified is a dual model of Community Development linked to Informal Community and Personal Education.

#### **3.2 Pathways**

Pathways for client and population involvement are set out in the Operational Plan.

Pathways for referral to specialist support is are set out in the Operational Plan.

### **4. Referral, Access and Acceptance Criteria**

#### **4.1 Geographic coverage/boundaries**

The wards (G, K, L & X) in Anytown Borough Council Area

#### **4.2 Location(s) of Service Delivery**

**Initially K ward Community Hall, L Park and Sports facilities, X school sports facilities.**

**4.3 Days/Hours of operation**

As stated in the Operational Plan, the programme will run to a stated time-table that facilitates activities seven days a week with special activities in spring, summer and autumn.

**4.4 Referral criteria & sources**

Parental referral, self-referral, school referral.

**4.5 Referral route**

Centrally via Provider offices or at delivery centres.

**4.6 Exclusion Criteria**

Participation will only normally be refused if there is a known risk to staff, property or buildings.

**4.7 Response time and prioritisation**

The programme schedule facilitates positive activity and support within at most five days from initial enquiry. It is expected that 50% of referrals will be able to access activity and support within 72 hours.

**5. Discharge Criteria & Planning****See Operational Plan for full details**

Formal discharge criteria do not apply to this community programme. However monitoring of participation and impact will indicate results/effectiveness.

**6. Self-Care and Patient and Carer Information****See Operational Plan for full details**

The Operational Plan sets out the methodology leading to enhanced self awareness and self management. In support of this, literatures and other resources have been designed to be easily read.

7. Quality and Performance Indicators	Quality and Performance Indicator(s)	Threshold	Method of Measurement	Consequence of Breach
1 HCAI Control	N/A			
2 Service User Experience	Programme overall participation rate	Minimum 50% overall	Participation levels	Review of tactics
3 Improving Service Users & Carers Experience	Level of enjoyment /benefit	50% overall	Participant exit surveys	Review of tactics
4 Unplanned admissions	n/a			
5 Reducing Inequalities	Levels of voluntary activity	+ 20% over one year	Activity surveys	Review of tactics
6 Reducing Barriers	Population accessing programmes to be spread from across ward areas and representative of population mix	Local activity to attract primarily local participants	Post code review of participants	Review of tactics
7 Improving Productivity	n/a			
8 Access	See Box 3			
9 Personalised Care Planning	(Refer to referral agencies for their criteria)			
10 Outcomes	See Box 1.5	20% increase overall on base line data	Epidemiological studies	Review of strategy
<b>Additional Measures for Block Contracts:-</b>				
Staff turnover rates	n/a			
Sickness levels	Levels greater than 10% to be reported to Commissioner			
Agency and bank spend	It is not envisaged that agency or bank staff will be employed except in exceptional circumstances			
Contacts per FTE	n/a			



8. Activity				
Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach	
Already stated above				
<b>Activity Plan</b> As per Operational Plan				
9. Continual Service Improvement Plan				
<p>“Third Party Assessments” (PLC) are authorised to carry out audit and review of process and outcomes and to report to Commissioners and Provider at regular three monthly intervals to facilitate both tactical and strategic re-assessment as required.</p>				
10. Prices & Costs				
10.1 Price				
Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
<b>Block Arrangement/ Cost and Volume Arrangement/National Tariff/Non-Tariff Price_____*</b>		£		£
<b>2009 Quality Payment</b>				
<b>Total</b>	£	£		£

\*delete as appropriate



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