

The RSPH guide to commissioning for health improvement

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Foreword

The move of public health into local authorities on April 1, 2013 created a new working environment for commissioners, public health practitioners and providers in England. Yet the public health challenges remain the same. Research published by the RSPH in February this year suggests that public health teams remain optimistic about the opportunities to improve public health in the local authority environment but are concerned in the short term about their ability to make a difference.¹ Health inequalities still abound, with the most deprived people in society still experiencing the worst health, including mental health.² There can be no doubt that if health inequalities are to be successfully addressed and the public's health improved, the causes of poor health need to be the targets for intervention and commissioners are key to making this happen.

This guide aims to provide a wider perspective, about commissioning across a broad arena and not just about services in isolation. Commissioning for health improvement cannot be effective if issues are seen in silos but each service should be a strategic step towards a better, healthier society where health equity is seen as a matter of social justice.

When we began to develop this guide and talk to practitioners, Health and Wellbeing Boards were in their very early days and therefore this guide focuses on practical issues for commissioning for health improvement and does not focus on Health and Wellbeing Boards or the important role of local councils in the development of new services and ways of working. The Social Value Act of 2012 does bring a statutory requirement for public authorities to have regard for the wider economic, social and environmental wellbeing in contracting and this along with the establishment and settling in of Health and Wellbeing Boards should have a significant and positive impact on the health improvement landscape and we look forward to exploring this in future reports.

We believe that models and approaches to population health which support commissioning to address the social determinants of health have much to offer and we hope that this guide will make commissioners and providers of services excited about the potential impact they can have on improving the public's health, while providing practical illustrations of how to commission effectively.

We would like to thank Richard Shircore, lead author and Graham Rushbrook who facilitated conversations with key stakeholders for their contributions to this work. We are also grateful to our steering group members and reviewers for all their support on this project. Their commitment and passion for the topic shines through the pages of this guide.



Shirley Cramer CBE

Chief Executive, RSPH

1. Department for Work and Pensions & Department for Education. A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives. April 2011. Cm 8061.

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Preface

In December 2009, the RSPH published its first commissioning guide focusing on the promotion of health and reducing health inequalities. Reflecting the policy language and concepts of the day the guide talked of: the NHS, health promotion, “world class commissioners”, the “commissioning cycle” and of occupational groups such as health promotion staff. The NHS covered health, both personal and community, and although local authorities were mentioned as partners, they were seen as relatively junior partners in the quest for health improvement.

With the transition of public health in England from the NHS to local authorities in April 2013, it was clear that a new commissioning guide was needed to reflect this change specifically as it related to health improvement. The RSPH put together a reference group including public health professionals, commissioners, providers and academics to consult on the focus and role of a new guide. Very early on in our discussions it became clear that the new guide would need to make sense of the system changes by focussing on the professional and technical responsibilities of those commissioning for health improvement, as well as those who advise and monitor them.

As such the initial focus of this guide is on local authority commissioners. However as is illustrated in the section on integrated commissioning, the greatest gains will come from all commissioners (CCGs/adult social care) taking the opportunity to work differently to achieve better outcomes. This guide will not be a simple restatement of past practice. The contextual shift of public health into local authorities means that new opportunities and new challenges are present. We need to minimize the challenges and maximise the opportunities.

However, in the face of such change not all consequences are knowable. As Donald Rumsfeld so eloquently put it: “there are also unknown unknowns. There are things we don’t know we don’t know.”¹ Hopefully this guide to commissioning health improvement will help ensure that the unknowns are fewer and the knowns better understood.

Richard Shircore FRSPH

Lead Author



Preface

When the RSPH asked if it was time to produce new guidance for commissioners, I was surprised to think how quickly the world had changed. World class commissioning belonged to another administration and primary care trusts and their responsibility for public health delivery was moving house. You could say it was going home.

The RSPH wanted this guidance to be more than a check list for commissioners, recognising that the responsibility for delivering commissioned services and the experiences of those using them are all part of a broader picture of public health. In 2004, Wanless told us of the need to “fully engage” and yet there was still a sense that commissioning was something done to people rather than with or for them. With these thoughts in mind, the RSPH set about starting a conversation with a range of interested and interesting groups of people. Membership was iterative and certainly not exhaustive. What was essential was that the guidance reflected health and social care and public health practice, not just medical and clinical perspectives. National representation came from PHE and some nationally recognised charities. Some were commissioners in local authorities, some in the NHS. Charitable organisations that had a political view as well as provider expertise were identified, not least for their wealth of evidence of the experiences of the public and the research that they conduct. The RSPH sought advice from workforce representatives, member organisations and a range of service providers in the public and private sector.

I was delighted to be asked to facilitate these conversations. What has been produced extends beyond these discussions and provides a snapshot of evidence and practice which it is hoped will be useful to all those involved in commissioning processes. Central to the guidance is a theme that it is vital we don't forget, namely that good commissioning and good public health practice are happy partners and not warring neighbours. Having said that these were conversations, and remembering that the RSPH prides itself as the voice of public health, I hope you find this guidance both useful and informative and see it as a starting point for more joined up thinking, planning, commissioning and delivery, and even more conversations.

Graham Rushbrook FRSPH

Conversation Facilitator

1 Introduction

1.1 The new landscape for public health

In working on this guide one is struck by how much has changed over the last few years. Local authorities, that in 2009 were junior partners in public health now host public health departments and operate health and wellbeing boards which determine local priorities and actions. The NHS is now solely a commissioning body with a restricted range of specialist public health functions. Other former NHS agencies such as primary care trusts (PCTs) no longer exist and their functions have been spread across clinical commissioning groups (CCGs), local authorities and provider organisations. Reading current public health and health improvement policy documents there is no mention of specific occupational groups such as health promotion staff – the exception being directors of public health.

What we do have is a new lexicon of names, titles and functions: Public Health England, NHS England, formerly known as the NHS Commissioning Board, Health and Wellbeing boards, Health Watch and a raft of others (see Appendix 1). All of which means changes to ways of working and to commissioning structures.

Under the NHS, the dominant mode of health care activity was via the “professional to the patient”. Much activity labelled public health still operates at this individual level. Local authorities however are less engaged with this way of operating. Their natural location is the ward, the parish, the borough, the county. The natural focus of local authorities is not the “professional to the patient”, but the group and the community. This offers a radical new perspective on improving health in a locality.

Another important change is that, while the implicit operating model of the NHS was to seek a cure for the presenting condition, local authorities have a different way of measuring success. Local authorities are rooted in improving the social context of their populations. Much of this guide will be focused on how local authorities can maximise this opportunity.

It is clear that in this new public health landscape we are dealing with both ethical and organisational issues. Ethically, the marked disparity of health experience across localities and communities presents a public health challenge; organisationally, the shift of public health to local authorities has created a radical new system still experiencing ongoing change.

As a nation we also have financial and economic challenges. We need to compete internationally and create the wealth to maintain the health of our nation at a time of an increasing and aging population. Both developments will increase demand for health and social care services. We need to prevent, inhibit or at least delay the onset of illness and keep our population active and independent for as long as possible. This is where commissioning for health improvement becomes vitally important.

Footnote

- a. Health improvement can be called a variety of terms. The most common being: health improvement, health promotion, public health. However activities such as community development, community regeneration have significant health improvement aspects.
- b. The Health and Social Care Act (April 2012) returned the bulk of public health to the control of local authorities.

This guide has been written to assist commissioners in the development of strategic and tactical approaches for commissioning health improvement^a programmes in line with their statutory requirements under the 2012 Health and Social Care Act.^b

However, while our primary audience may be local authority commissioners, the responsibility for improving health outcomes cannot sit here alone, and it is vital that all parts of the system, including those working within the NHS and providers of services are aware of the practical implications of improving health in the new system.

This guide has been written with both individuals new to commissioning and those with greater experience in mind. For the former, we hope it will serve as a user-friendly roadmap to the processes involved and the key considerations that will determine whether commissions are successful at improving health in a locality. For the latter we hope the guide will serve as an encouragement that the new public health environment has great potential for addressing health inequalities and improving health, and that through commissioning for health improvement outcomes, good health can be supported and encouraged in the communities we all serve.

A key development of the reforms has been to free up the opportunity for non-governmental agencies to bid for work. We therefore hope that this guide will help providers understand the challenges and opportunities they face and how to best demonstrate the values and skills to become effective in health improvement practice.

In particular, attention is drawn to the strategic importance of local people coming together with health and social welfare professionals to decide the future they want. There needs to be a collective vision of where communities want to go and what it will look and feel like to live there. This guide supports the idea of the “fully engaged scenario” of Wanless² and it mirrors the Ottawa Charter³ recommendations for public participation and empowerment.

There is of course a moral imperative to all this. An individual’s health state is a major determinant of their own life chances and in consequence, a major determinant of the life chances of those with whom they are in contact. In England, we have a huge burden of avoidable illness and disability. This burden is a limit to the individual, as well as their families, community and ultimately the nation. We have the knowledge to make things better – we just need to put it into practice. We hope this guide is a positive step in this direction.

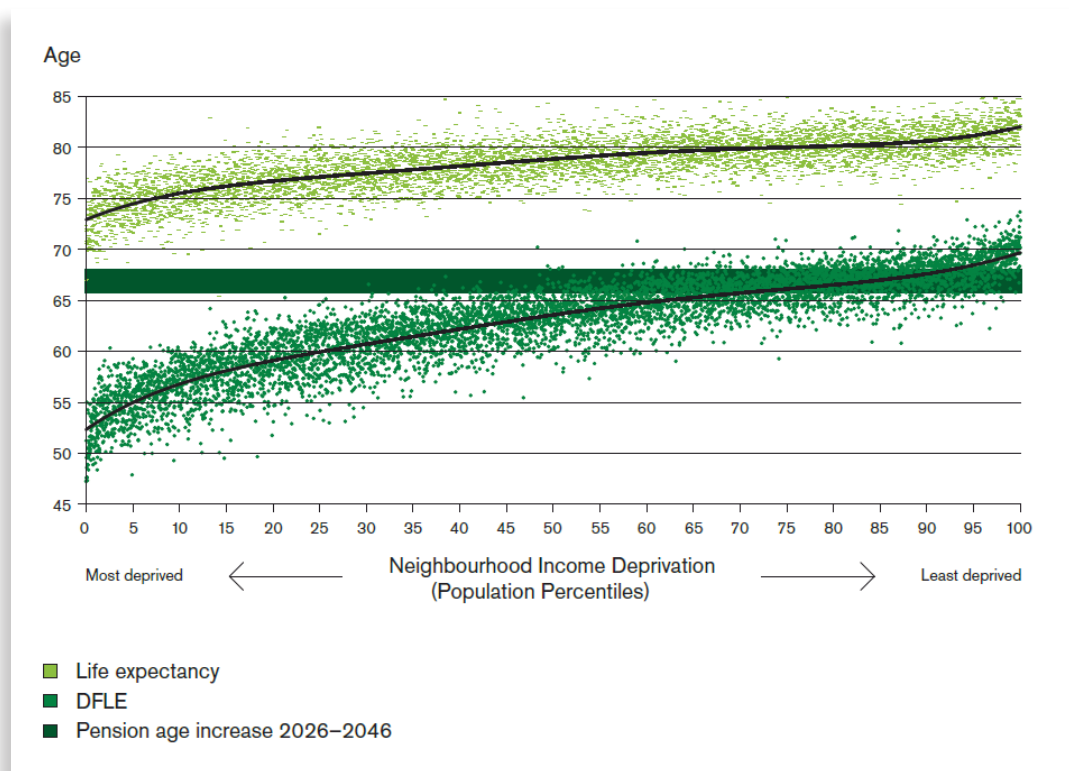
1.2 The change drivers

This guide is written in the knowledge of specific policy drivers. The most important being:

- The Marmot Review⁴ which highlights the disparity of life expectancy between individuals and communities
- Healthy Lives, Healthy People⁵ which details the transfer of primary public health responsibilities to local authorities
- The Localism Agenda⁶ which gives councils more freedom to work together with others in new ways to drive down costs. It seeks to give them increased confidence to do innovative things to meet local needs.



The graph below included with kind permission from the Marmot Review, details the very real health challenge that needs to be addressed.⁴ It shows that those living in the most deprived areas experience the earliest onset of life-limiting illness and can expect to die significantly earlier than those living in the least deprived areas. This report hopes to highlight how commissioning for health improvement can help to tackle these health inequalities.



DFLE - refers to Disability Free Life Expectancy.



1.3 How to use this guide

We hope that this guide will present a helpful overview of both how to commission for health improvement, and the reasons why it is so important to our nation's health. Our approach may appear simplistic, but we have sought to stick to plain English and highlight common ground rather than areas of contention. We have also included a glossary at the back of the guide to help further explain some of the terms used.

The guide can be used in different ways depending on your needs:

- As a professional handbook describing processes, perspectives and methods for commissioning effective and high quality responses to health inequalities.
- As a travel guide. It will show 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 on quality commissioning for promoting health and wellbeing.
- As a checklist for action and resources – e.g. to clarify roles and relationships between commissioners and providers.
- As an ethical guide – the absolute ethical requirement for health improvement is to “do no harm” (see Appendix 2). Evidence abounds of poor practice having a detrimental and damaging effect on the public.

2 Health improvement in the new system

2.1 Why health improvement is crucial to disadvantaged groups/individuals

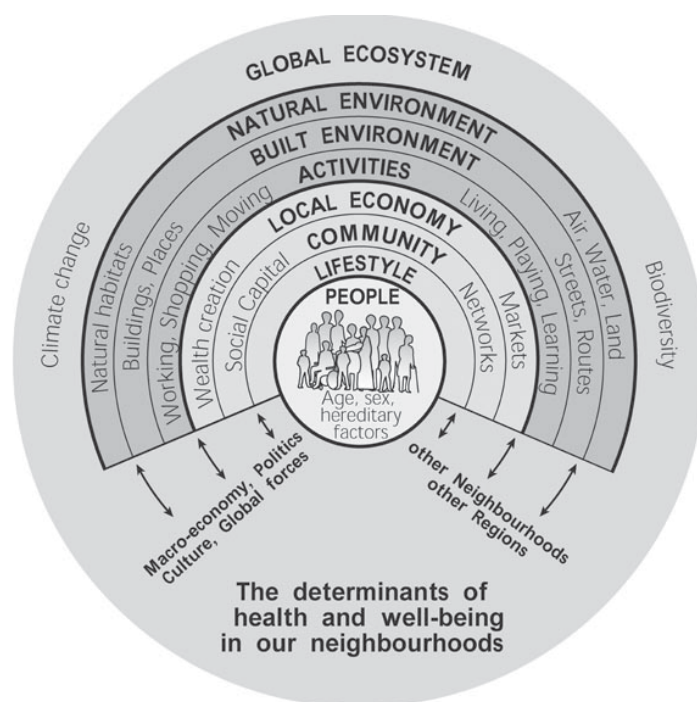
Commissioning for health improvement is not preventative healthcare by another name. It requires a particular form of approach and understanding of how to promote health as opposed to treating or preventing disease or illness.

The rationale of health improvement is that for those living with disadvantage, preventing illness does not significantly improve their life chances. They face multiple disadvantages as measured by risk factors. Thus removing one risk e.g. stopping smoking, does not in itself impact very much on their overall risk of premature death and disability.⁷ It is essential to raise those social aspects of life that promote and enhance health status and wellbeing.

2.2 The determinants of health

Dahlgren and Whitehead's social model of health (below) describes how populations are affected by a range of influences. At the outer edges is the global ecosystem (e.g. global warming). Further in sits the natural environment, the built environment, personal activities, the local economy, immediate community and then personal lifestyles and people themselves. Thus health is produced by a broad range of determinants, and it is unequal distribution of these determinants give rise to health inequity – avoidable health inequalities. The recent Marmot report on the social determinants of health in Europe⁸ highlights that addressing health inequalities is, at its core, about tackling the “causes of the causes”: the living and working conditions that give rise to health inequalities, as well as, even further upstream, the inequities in power, money and resources that create the unequal conditions in the first place.

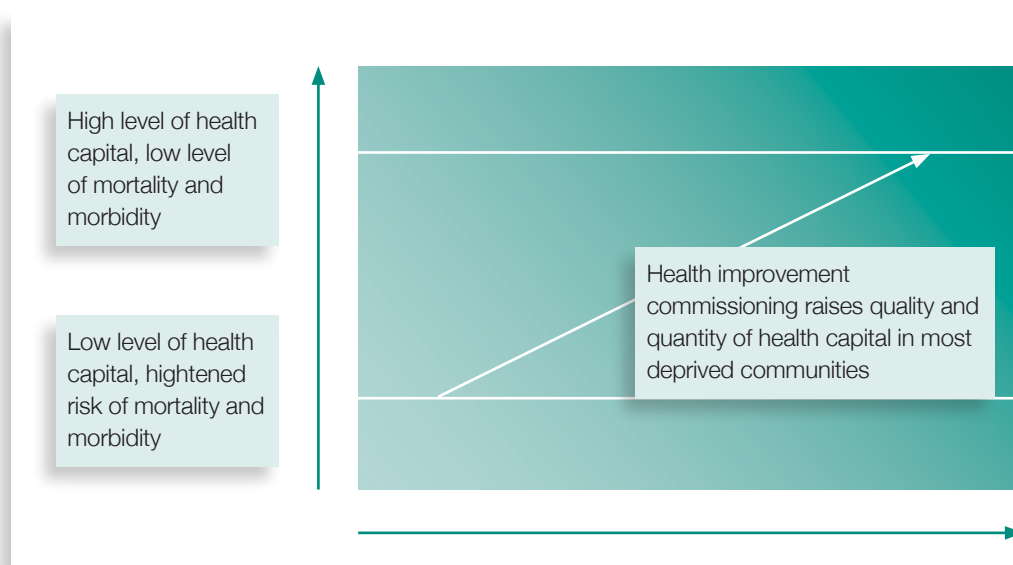
Local authorities, due to their wider scope and responsibilities, are better placed than the NHS with its largely clinical orientation, to address a broad range of determinants, such as lifestyles, community, local economy and activities. They therefore are in a privileged position to really understand behaviour in its context and to embed effective interventions building on this local understanding within existing and new services in order to tackle health inequalities.



Commissioning for health improvement requires commissioners to focus unrelentingly on the modifiable determinants of health.⁹ It is not about waiting until people are already ill and commissioning reactively, but about seeking to create a better society for all, where commissioning proactively seeks to improve individuals' life chances, reduce social inequalities and, as a result, support health. The determinants of health are described and further developed in the Ottawa charter for public health³ and the table below highlights their breadth:

Condition	Examples
Peace	Community safety, domestic violence
Shelter	Adequate housing
Built environment	Access to green spaces, safe roads
Education	Basic literacy and numeracy, opportunity for self development
Food	Affordable food, adequate nutrition, secure food chain
Income	Money or access to adequate resources
A stable eco-system	Hygiene, clean water, waste management
Sustainable resources	Power, personal supplies
Social justice and equity	The ability to participate in democratic process free from arbitrary arrest, bullying or harassment

Modifiable determinants of health are the bedrock upon which all positive health status rests. By investing in improving them, the shift upwards illustrated on the below graph can be achieved:

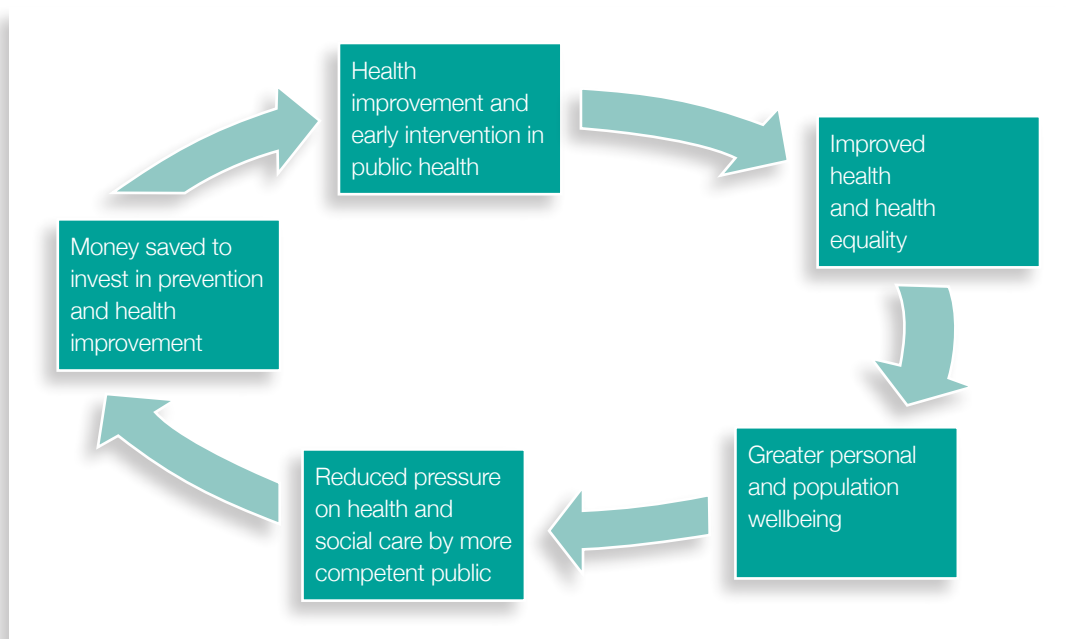




2.3 Health improvement and cost

In times of reduced public expenditure it is important to flag up the economic benefits of health improvement. The economic as well as the personal case for considered, thoughtful and effective health improvement is unchallengeable. Getting things “right first time” is the cheapest way of doing anything and has lasting value. Getting health improvement right has been described as a ‘virtuous cycle’ and is illustrated by the below diagram reproduced with kind permission from the Local Government Association.¹⁰

The virtuous cycle of public health



The above can work if the drive of health improvement is towards the “fully engaged scenario” where individuals take responsibility for their own health.² However, the cycle will grind to a halt if communities are regarded as passive recipients of services, and communities will only engage if they can “own” the changes taking place. Health improvement initiatives need to be co-produced with the communities in which they are taking place.

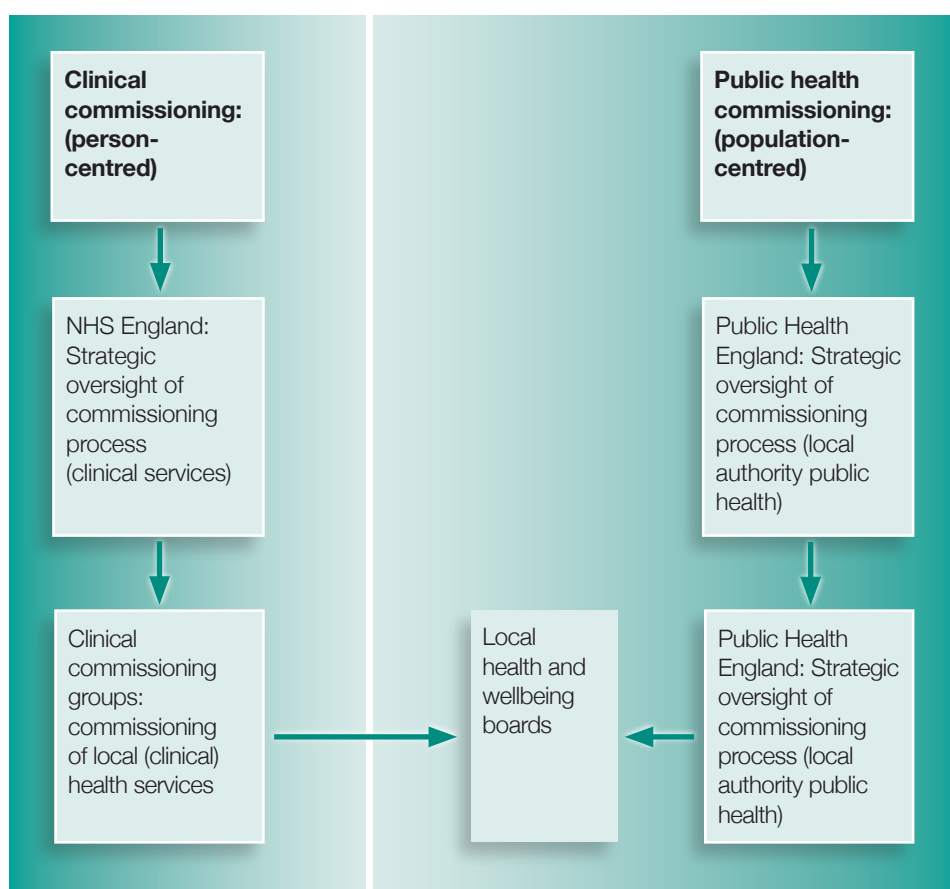


2.4 Who does what in commissioning for health improvement?

Below is a simplified diagram of the new responsibility structure for commissioning health and wellbeing.

Public health commissioning in England – who does what for health improvement

(see Appendix 1 for definitions)



At time of writing the following are designated as local authority public health commissioning responsibilities:¹¹

- Tobacco control
- Alcohol and drug misuse services
- Public health services for children (5-19 years)
- National child measurement programme
- Obesity programme
- Nutrition initiatives
- Physical activity
- NHS health check assessments
- Public mental health
- Dental public health
- Accident injury prevention
- Population level interventions to reduce birth defects
- Behavioural programmes to reduce cancer and long term conditions
- Workplace health
- Sexual health services
- Initiatives to reduce mortality from seasonal issues (cold/heat deaths)
- Health protection including protection from environmental risks
- Community safety
- Tackling social exclusion

Of these responsibilities, several are mandated by the Secretary of State: appropriate access to sexual health services; putting plans in place to protect the health of the population; the National Child Measurement Programme; NHS Health Check assessment; and elements of the Healthy Child Programme. Local authorities are also mandated to provide population healthcare advice to the NHS.¹² It is also important to note that responsibility for public health commissioning for 0-5 year olds will transfer from NHS England to local authorities on 1 October 2015.



In addition to understanding commissioning responsibilities, it is important that those new to commissioning health programmes appreciate how health care is organised.

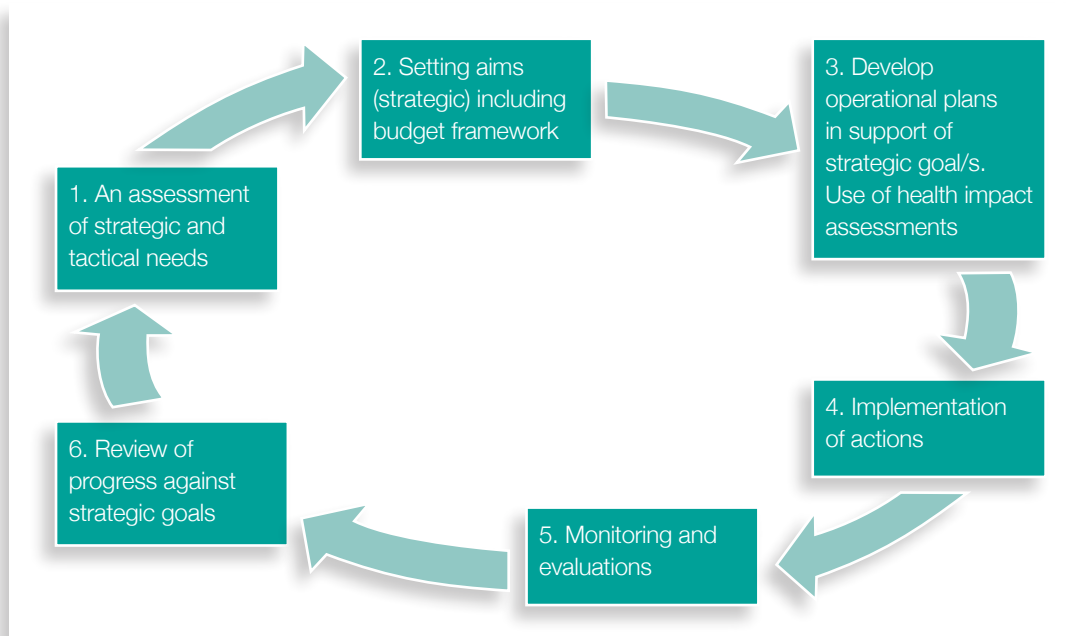
- 1 Health improvement** – operates in the community and focuses on creating the conditions that promote healthy lives and aspirations
- 2 Primary prevention** – seeks to avoid onset of illness/disability by the detection of high risk groups and advice on healthy living – e.g. screening programmes, advice on balanced diets
- 3 Secondary prevention** – seeks to shorten episodes and the duration of illness, e.g. smoking cessation for asthmatics
- 4 Tertiary prevention** – seeks to limit disability or incapacity¹³ for example physical exercise as part of cardiac rehabilitation.

Benefits to the whole population can only be obtained by focusing on health improvement approaches.

3 Commissioning practice for health improvement

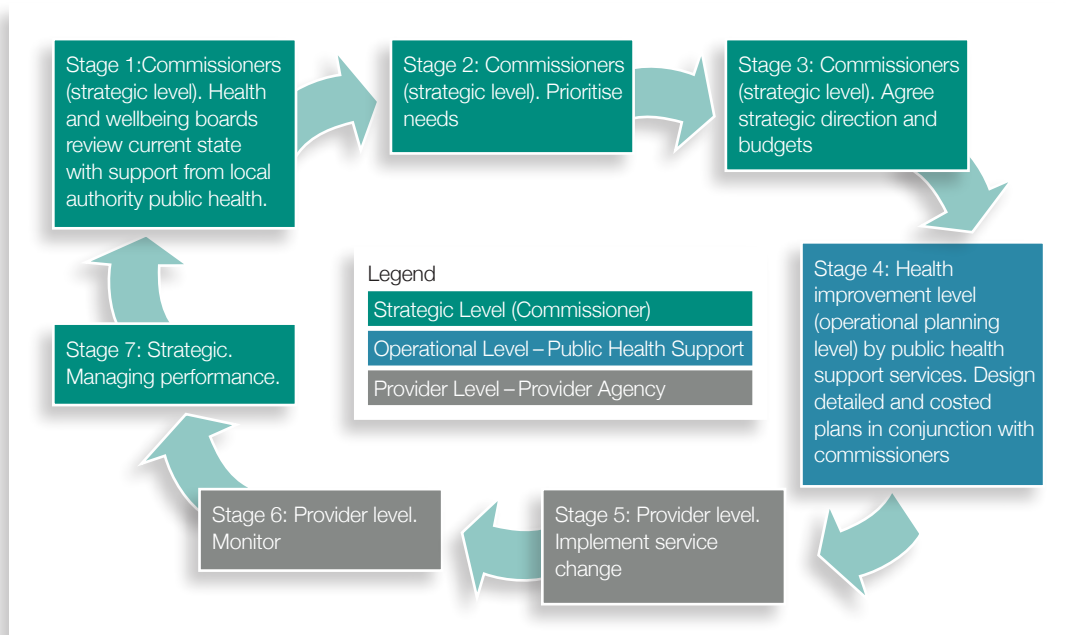
3.1 The commissioning cycle

The flow chart¹⁴ below adapted from McCarthy, traces the process of developing a health improvement programme.



This section will seek to guide you through each of these processes.

It is also useful to see how roles are split as illustrated by the below chart. Commissioners set strategy, commissioning support oversee contract implementation and monitoring, providers deliver agreed service.



3.2 Assessing need

3.2.1 Joint strategic needs assessments (JSNAs)^c

Two key fundamentals for commissioning are first deciding on the nature of the health challenges to be addressed, and secondly deciding how best to respond and who should implement it. Joint strategic needs assessments (JSNAs) are accepted as an essential element in assessing local needs.

A JSNA involves collecting and analysing data on the health state of a population and assessing the results to understand which aspects of health (and social care) need attention – and what may be safely left alone. The results of a JSNA should be of significant help in guiding commissioners in understanding the needs of the local community. JSNAs like other forms of research can be done well or badly. Poor JSNAs can be limited in scope and/or dominated by self interested professional or pressure groups. In such an instance the scope of the JSNA will be narrow and limited – the very antithesis of what health improvement requires.

The move of public health into local authorities gives the option to broaden the participation of JSNAs with respect to public engagement. This move reflects a shift in public health from practice dominated by a professional agenda based on public health needs, to a more collaborative approach between professionals and the public. Such a development must coincide with broadening the scope of the JSNA into those areas that include the modifiable determinants of health – educational attainment, local economy, built environment, leisure and parks/open space, food supply, community safety and sustainability.

Commissioners should seek to involve and engage the local public in the development of JSNAs. This is important for health improvement where local knowledge is very important. To begin with this approach will be more time consuming and demanding. However it key to ensuring that the JSNA is accurate and insightful.

3.2.2 Community asset mapping¹⁵

A community asset map will identify the structures and resources that communities and local organisations have that can be built upon to develop a strong, lasting programme of health improvement. Community asset mapping is just as important as a relevant needs assessment. Such an approach focuses on what is right with a locality rather than simply focusing on its deficits. Such information is not just of use to commissioners for health improvement but of significant value to all commissioners looking at specific populations, such as GPs wishing to improve their practice population's health. The assets of individuals (e.g. skills, knowledge, networks); organisations (e.g. services delivered as well as physical assets such as parks and buildings that they control); physical environment of an area (e.g. green space, transport links); economic assets of an area (where local skills and investment are boosting the local economy – and how this can be increased); and cultural assets (e.g. activities such as music, dance, drama)¹⁵ can be mapped to help understand the strengths of a community that can provide a foundation for health improvement activities.

Footnote

- c JSNAs analyse the health needs of populations to inform and guide commissioning within local authority areas. The JSNA will underpin the health and wellbeing strategies. The NHS and upper-tier local authorities have had a statutory duty to produce an annual JSNA since 2007.



3.3 Strategy and tactics in health improvement commissioning

Having assessed community needs, the setting of a robust, focused and valid strategy is required. In developing a strategy, there must be a clear understanding of the difference between ends and means, between strategy and tactics. Strategic commissioning is about deciding on how the fundamental needs of the community should be addressed e.g. creating the best environment for positive child health over a ten year period within a specific borough or area. This will probably require a collaborative approach involving other agencies and local people.

Tactical commissioning for health improvement is about commissioning shorter term specific activity focusing on an individual issue either to support current standards or dealing with an identified shortcoming.

Defining the difference between strategy and tactics in health improvement

	Means	Ends
Strategy	Policy	Population engagement leading to enhanced social capital and functioning
Tactics	Services / action	Service use and focus on targets

The key components of a sound local strategy:

- A profound, fundamental and measurable goal/outcome that is worth achieving.
- A time frame congruent with the stated goal.
- The organisation accepting that the strategic goal is essential to its own purpose and (as a public service) the risk of failure to achieve it would have serious consequences for itself and the public.
- The presence of public support, commitment and participation.



Health improvement strategy has tended to focus on process issues - the “how” (i.e. the tactical elements), of delivery. This approach to strategy is flawed. As has been previously reported by Wanless,² the cost of chronic illness may make the NHS unaffordable in 30 years. For this reason alone we need to start thinking seriously and profoundly – not just about the “how” of health improvement work but equally importantly about the “what”. What would make a difference to the overall ill-health burden of specific communities in 5-10 years time? The Dahlgren & Whitehead Model (see section 2.2) is widely used to help identify where action could be taken in the pursuit of health improvement. It is worth taking the time to consider your local circumstances and to identify what would increase the social capital^d and assets of your community and increase the life chances of local populations.

Commissioners seeking health improvement should be clear that they have a range of commissioning options. Traditionally, commissioning has been focused on service targets and that has been interpreted as a focus on distinct topics – e.g. smoking, weight loss, exercise. The list of population-based activities handed to local authorities clearly shows this (see section 2.4 for a list) as does the Public Health Outcomes Framework,¹⁶ which focuses heavily on clinical outcomes. This has tended to squeeze out commissioning for those aspects of strategic social and community development that have longer term, positive and sustainable impacts on health states – that is, commissioning for improving community health capacity, capability and sustainability. Much poor health behaviour is rooted in individuals’ behaviour which is influenced by local social customs and norms affecting individual’s opportunities to enact healthy behaviours. Another key factor is the physical environment which through careful management can be altered to enable healthy choices. Local authorities are in a position to work through local councillors and other local representatives to build health enabling communities where healthy behaviours are the norm. The residual effect of intelligent commissioning is often referred to as “legacy value”. The value of commissioning for an enduring health improvement legacy cannot be overstated.

Footnote

d See Glossary for professional definition



Examples of legitimate strategic aspirations:

- High level of local population engagement with individual and community health action – interest and action in support of personal and community health capital/assets
- Significant improvement to green environment – providing opportunities for increased physical activity leading to enhanced fitness levels and wellbeing of a given population
- Educational standards within a deprived population on par with those in less deprived areas enabling higher economic activity levels and aspiration

Strategic options need careful consideration for both their intended and unintended consequences. An avoidable error in health improvement commissioning is the idea of focusing solely on the negative aspects that generate the problem or ill health. When commissioning for health improvement the first goal is to support positive elements that counter-weight the negative aspects. Exactly what this means will depend on what is locally “modifiable,” (the degree of leverage) and at what cost/demand.

3.4 Case study: obesity and its determinants

Obesity tends to be discussed within a biological/physiological framework with obesity being explained by the excess of calorie intake over calorie expenditure. This is correct within a biological/physiological perspective. However it does not take into account the determinants of the biological/physiological framework such as personal and community values and norms. Obesity – like other health related challenges tends to be greatest in areas of poor social capital. The table overleaf lists health determinants where intervention related to obesity may be relevant.

Determinants of obesity*	Negative determinant	Positive determinant – helps to build social capital
Physical environment	Limited space for physical activity	1 Accessible physical space available for physical activity – pedestrianisation, cycle routes, playgrounds 2 Make exercise fun and socially rewarding (street activity) 3 Green gyms**
Local culture re: physical activity	Physical activity not valued or enacted	1 Physical activity valued and encouraged, support to youth and sports associations, subsidised sports facilities, taster sessions in sport and leisure
Social environment	Limited community knowledge/understanding of role of food in health	1 Community has high levels of knowledge of interplay of food and health – allotment societies, community cafes, food co-ops
Community safety	No security for cycles or for persons	1 Confidence in security for personal property. Confidence in personal safety at all times. 2 Increased security of built environment, safe storage or cycles at shops, stations, enhanced street lighting
Access to healthy food	Access to food limited to processed foods, limited access to fresh fruit and vegetables	1 Easy access to non-processed foods via shops, markets, allotments or other green initiatives
Socially marginalised	Existence difficult and challenging. Personal energy used in maintaining current existence levels	1 Creation of easy and safe access to opportunities to develop personally and socially e.g. community cafes/ adult learning, tenant association-led developments
Work environment	No opportunity for accessing healthy options	1 Employers create opportunity and ability to access healthy options, meal breaks allowed, space and facilities for cooking and safe food storage (chilled cabinets)

*The listing is indicative only. Local health intelligence would define key determinants. NICE guidelines on a range of health and obesity issues can be accessed at www.nice.org.uk

**Green gyms refer to open spaces where various items of exercise equipment are placed for public use free of charge.

3.5 Commissioning approaches

Once the issues to be addressed are identified and a strategy agreed, the commissioning action needs to move to a different level – an operational level. Using the two decades of experience of the theory and practice of health promotion^e provides the greatest opportunity for improving the overall health of a given population. We know that simply telling people how to live their lives does not improve health. We need to understand the context in which they live, provide the tools and information they need to be empowered to make changes to their lifestyles and enable them to contribute directly to their own health outcomes – not treat them as passive recipients of services.

Sample methods and theories

Selection of health improvement theories and methods	Delivery options	Predicted outcomes	When/where applicable
Community development	Community based activity agencies, e.g. street games, ¹⁹ big local partnerships, ²⁰ re-generation activity.	Increase in social cohesion and group action in support of self determination. Increased health-enhancing provision and opportunity.	Where it is established that the community lacks ability to self-organise in pursuit of own goals and aspirations.
Education: peer-led – informal – formal – experiential – e-learning – community group	Health trainers, community educators e.g. school nurses, health visitors, pharmacists.	To change knowledge and comprehension of individuals, groups, or communities.	Where it is established that a knowledge or comprehension deficit is identified as a major determinant of health inequality.
Behavioural: cognitive motivational	Professional staff	Enhanced capability to change behavioural response pattern and capability	Where it is established that client/group ability to self direct behaviour is inadequate and external support required
Behavioural insights	Community, workforce, health professionals, cross discipline professionals	Change in behavioural outcomes linked to lifestyles and health choices that will lead to improvements in health and wellbeing.	Can be applied to health communications, environmental restructuring, existing systems.

As illustrated above, the range of approaches, methodologies and methods available to commissioners and providers is significant, but to work they need to be applied in a logical and rational manner reflecting the nature of the challenge.

Footnote

- e Two definitions of health promotion are used in this guide. At the strategic level the World Health Organisation has defined it as follows: "Health promotion is the process of enabling people to increase control over and to improve their health".¹⁷ The second definition refers to the professional (tactical) practice of health promotion. "The study of and the study of the response to, the modifiable determinants of health or illness".¹⁸



In clinical situations it is possible to know the exact issue to be addressed and therefore it is possible to commission and match services and facilities with specific issues. This may not be an appropriate response for health improvement. Provision of “services” in isolation rarely contributes to building social capital. Health improvement commissioning instead requires engagement that is deeply connected to ‘problem solving’ in relation to programme and service formulation.

Commissioning for health improvement requires a shift in focus from commissioning for services to commissioning for solutions. The solution may be developments in organisational settings, economic revival, community development (includes skills and training) or policy applications. Critically, commissioning for health improvement will be driven by the needs of the community, enabling the development of a local response, tailor-made to the specific challenge and utilising local resources and capacity building.

For example, having obtained local evidence of need, a locality-specific response that encompasses many factors is likely to be required. If this evidence suggests that there is local support for reducing smoking consumption and that it requires more than the provision of smoking cessation services, action needs to be taken to support the commissioning of a locality specific, multi-factorial response tackling identified determinants of smoking behaviour. This may include reducing exposure to second-hand smoke, decreasing demand for tobacco and reducing tobacco supply - therefore taking a broad approach to promoting positive health and still remaining close to meeting defined local need. Provision of alcohol-related services can also provide an example of the need for multi-factorial approaches. Brighton, for example, has one of the highest hospital admission rates from alcohol and alcohol-related deaths in the UK, and the public health team are seeking to build upon community assets by engaging business, Brighton University and local schools, to address this issue.

In another setting, data from adjoining local authority wards may show high levels of sexually transmitted infections (STIs). If this is the case further study needs to be undertaken to establish the nature and characteristics of the STIs. While one ward may have a high proportion of older female drug users, a high proportion of whom are recent migrants involved in the sex trade, the other may consist of younger people most of whom attend local community colleges. Both may have raised STIs but the style, nature and substance of the health improvement response would be very different. In the former logical partners would be the sex workers themselves, local people, community safety and immigrant welfare organisations, for the latter a college based social media-related programme linked to social inclusion and community and/or personal development.



As well as being location-specific, commissioning should lead to developments that are enduring, have legacy value and are self-sustaining after the original investment has been made.

Young people growing up in poverty have poorer health and fewer life chances than their affluent peers. StreetGames is a youth charity working nationally in over 300 communities, addressing that inequality. The charity uses sport as its tool because sport not only increases physical activity, it can also sustain friendships, build resilience and provide routes into training and employment. Young people who start active have a better chance of staying active and living longer happier lives. Sport addresses both the physical and social determinants of health.

StreetGames' support is available to all areas of deprivation. Lasting change is our mission. This is achieved by working with commissioners and local communities, harnessing people's time as volunteers and providing training. Given the power to do so, young people are adopting a sporting habit for life.

Street Games

The Wanless (2004) description of the Fully Engaged Scenario²² matches this view of health improvement as a community driven activity. Wanless was quite clear that unless authorities create an environment in which the public is active in pursuit of their own health and wellbeing, the cost of treatment of chronic conditions by the NHS will become unsupportable. Fifty years ago, the national health service (NHS) in the United Kingdom consumed around 3.4 per cent of gross domestic product (GDP). Now, public spending on the NHS is nearly two-and-a-half times greater – amounting to 8.2 per cent of GDP and equivalent to seven times more in real terms.²¹ This need to engage the public and encourage behaviours that promote health has been acknowledged by NICE.^{22,23}

The table overleaf gives practical examples of what quality health improvement might look like, highlighting the variety of methods available and focussing on social capital, empowerment and sustainability as key outcomes.

Quality health improvement

Programme/ initiative	Activity	Method	Skills rich	Social capital	Empowerment	Legacy value/ Sustainability
Street activity	Locally based community physical activity (incl. dance)	Trains up local volunteers to lead and develop programme	Significant level of personal development re: health, leadership, organisation and management	High	Builds local talent in deprived areas	Very high. Minimal capital costs for enhanced local activity
Green gyms*	Locally based exercise and fitness equipment	Individuals or groups can assess the equipment as required. Also more organised sessions can be organised	Development of physical fitness and skills	Moderate	Normalises the idea of personal physical exercise. Demystifies exercise	Ongoing legacy value after initial (moderate) capital outlay
Health trainers	Locally trained, salaried individuals support other local people to achieve specific self-defined health goals	By use of 1:1 psycho/social methods of motivation and support. Use of group work if appropriate	Local communities develop personnel with high level of health and behaviour knowledge	Very High	Very High	Ongoing legacy as once trained people are available for others. Local people help demystify health and behaviours. Low financial costs
Community cafe	Supply of low to medium cost healthy food to a specific population	Cafe is operated by local people for local people. Cafe can act as a learning centre for occupational acquisition and as local community hub. Cafe can also be linked to local food supply sources thus further boosting economic development and activity	Very high skills level: finance, health and safety, hygiene, nutrition, personnel management, logistics	Very high Even more so if social hub element is developed	Very high	High level of sustainability if marketing and business case well considered.
Community food and allotment groups	Focus on developing community awareness of nutrition and food chains by growing distributing and encouraging local participation	Community based catering organisation. Involved in lobbying, local food chains, occupational training and development	Skills rich - local campaigning, community advocacy, horticulture, transport, personal and occupational skills development	Very high especially if it supports local celebratory events	Very high	Very high. Impacting on local food/purchasing policies, support to school and other agencies, self sustaining
Community Health hub ¹⁸	Acts as a health "Corner Shop" with local advice on a range of issues. Keeps local and community groups in touch with each and supports mutual support. Pro-active action action would reflect the needs of local community	Community consultations, advocacy, local research, project implementation and management, liaison and facilitation with existing local agencies	Creates opportunities to develop low cost local health opportunities e.g. walking groups, baby sitting courses, local dance options etc	Very high	Very high	Legacy value very high because of the flexibility of provision. Ongoing costs are greater than other options and needs an annual grant or substantive endowment.

*Green gyms refer to open spaces where various items of exercise equipment are placed for public use free of charge.



There are many more examples utilising other options such as support for bicycle and furniture repairs which are community based and which afford opportunities for local people to learn about health, self management and the opportunities that occur when people come together.

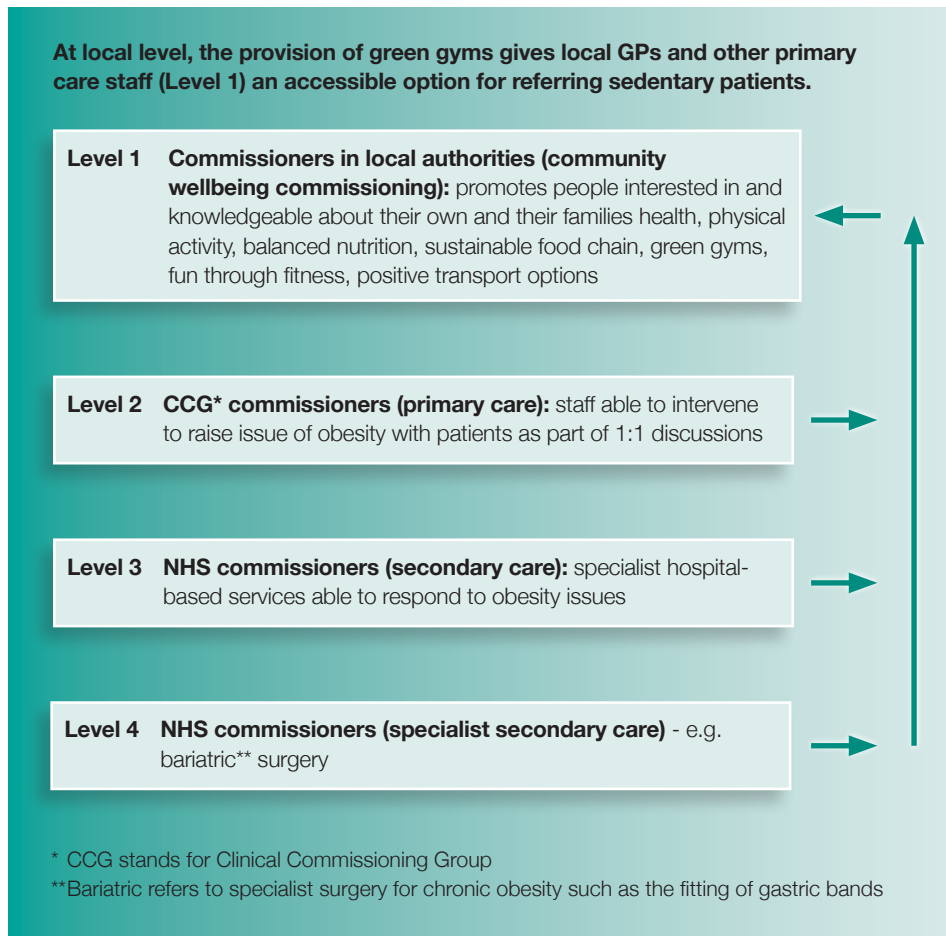
Food is often a starting point for health improvement as it encompasses so much of day to day living and is the bedrock of health behaviours impacting on: weight, physical fitness, personal skills and conviviality, leading to psychological wellbeing. Critically, these types of intervention highlight the importance of focusing on both outcome and process issues. With the above specific health and wellbeing goals are possible e.g. healthy eating and “five a day”. However the process issues of learning new skills that are transferable to other activities is of profound importance. There is nothing to prevent variation and combinations of the above.

Lastly, one very important feature of the health improvement initiatives cited above is that they are designed to be enjoyable and for people to have fun whilst participating. To learn, explore, take risks and try new things requires support, motivation and commitment. Enjoying the experience is one way people can be helped to stick at a challenge and to be successful. Enjoying what you are doing is a natural way of learning. It is to be welcomed and encouraged.

Having assessed need, formed strategy and developed appropriate tactics, the specific aims and objectives of a commission require high level thought and consideration, and technical writing (expression). Without a clear written expression of the ultimate aim of a service or programme it is not possible to progress towards the next stage of effective commissioning. It is essential that the necessary time and resources are spent getting this right.

3.6 Integrated commissioning practice – maximising impact

A key commissioning skill is generating mutual support and synergy between programmes and activities at different levels of intervention. The below diagram highlights how integrated commissioning across four levels of health care can work, using the example of obesity.



The following examples give further insight into the importance of integrated commissioning for health improvement:

Liverpool Community Health is dovetailing prevention with the wide range of clinical services it delivers. We want to demonstrate to commissioners and providers that clinical care provides a fantastic opportunity to help combat the burden of preventable disease for patients, their friends and families. Commissioning for health improvement is therefore broader than just commissioning 'health improvement services', though these are of course, very important.

Commissioning structures may have changed, however, the need for partnership and a shared vision hasn't. Commissioning that actively encourages partnership working with other providers would be welcomed in order to achieve the best possible health improvement outcomes for our populations.

Liverpool Community Health Trust

Social enterprises play an important and growing role in tackling health and social care issues. Innovative in their approach, they are able to offer high quality and forward thinking services that improve and empower communities. Establishing strong working relationships with commissioners and working as a close team is vital if we are going to change the world for the better.

Food Nation

Integrated commissioning across health care is essential if a fully engaged scenario is to be achieved. Furthermore, the next step, integrating health and social care commissioning, is becoming an increasingly important policy driver to tackling the social determinants of health as well as being seen as having the potential to reduce health and social care spending.



3.7 Health impact assessments

Health impact assessments (HIAs)²⁴ are of significant value to commissioners seeking to check the likely or expected benefits of a programme and whether the expenditure is value for money. HIAs can be carried out either prior to a commission to check whether it will work as expected (prospective); during a programme to check on impact (current); or when a programme has ended to assess whether the commission impacted as was intended (retrospective).

An HIA can be defined as a process that uses a range of methods and approaches to help identify and consider the potential – or actual – health and equity impacts of a proposal on a population. Below are some of the principal benefits to be gained from using an HIA.

1. Policy development and analysis
2. Strategy development and planning
3. Programme and/or project development
4. Commissioning or providing services
5. Resource allocation and capital investment
6. Community development and planning
7. Community participation/service user involvement
8. Preparing or assessing funding bids
9. Developing sustainable approaches and initiatives.²⁴

Health impact assessments (HIAs) can also be used to assess various models of service or programme delivery. They can also add value to a service contract by allowing an element of pre and post assessment of activity.

3.8 Other assessment methods

Those new to the concept of commissioning should also be aware of other options for reviewing performance and assessing impact. These are:

- **Audit** - check on whether processes are being performed to set standards and procedures
- **Monitoring** - assessing the operational performance of a programme e.g. numbers attending, throughput of clients
- **Evaluation** - assessing the end result of a commission. Evaluation focuses on assessing whether stated goals/objective were met. Evaluation is not to be confused with a retrospective HIA. A retrospective HIA has a much broader focus which looks beyond specific commissioning objectives.

3.9 Risk and risk management

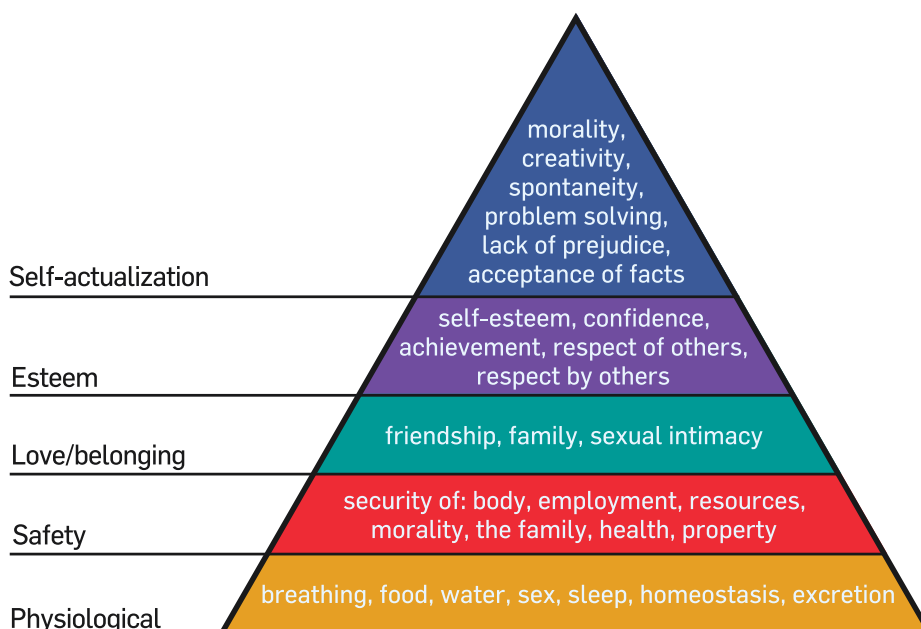
A dominant feature of risk management in public health services has been its preoccupation with the management of operational risk. By this is meant that the focus of risk attention has been on “how the system” operates. This focus on risk management of operational issues masks a fundamental failure to appreciate an even greater risk – namely the risk associated with not having an effective and relevant long term strategy.

Failure to agree a relevant and appropriate strategy with respect to health improvement commissioning will generate its own substantive risk. The risk to be managed is not just about process. It is about strategic goal attainment. In particular that the basic elements of health improvement are relentlessly pursued. The outbreak of measles in South Wales which began in late 2012 is an example of this. The single strategic cause was the low rate of vaccination uptake.

Dr. Marion Lyons, director of health protection for Public Health Wales, has laid the blame for the measles outbreak in Swansea firmly at the feet of a less-than-optimal uptake of the MMR vaccine: “The only reason this outbreak could happen was because not enough young people in Wales were fully vaccinated with two doses of MMR and there is absolutely no guarantee that this could not happen again.”²⁵

Risk is too often seen as monitoring the green, amber and red report forms and focusing on the red to the exclusion of the amber or green. Yet the real risk to sustained health improvement is in not getting the basics right.

One way of viewing risk is to use Maslow’s hierarchy of needs.²⁶ Put simply, the basic elements need to be kept relentlessly in place and act as a firm foundation for further health improvement.



In the example cited above: immunisation and vaccination are related to the bottom two sections, physiological and safety. The key learning point is that all risks need to be managed not just those flagged as red or amber.



3.10 Summary

To summarise section 3, effective, quality health improvement commissioning requires that:

1. The consumer is seen as a “resource” for success rather than a “problem” to be managed;
2. Local people and organisations are given a key role in assessment, planning, delivery and review of activity, programmes and services;
3. There is an understanding of the modifiable determinants of health and disease and how they are used to inform service redesign;
4. Effective assessment of local needs and issues and the identification of the key “modifiable determinants” to be addressed is undertaken. These needs will cover non-medical issues such as the local economy, schooling, community safety or the environment;
5. Social capital, built by developing and participating in social networks and structures, is seen as central to improving people’s health;
6. Partnerships and local control are accepted as key in building sustainable developments;
7. Behavioural science evidence is applied to understand what drives behaviour and which mechanisms can instigate and maintain change; and
8. Real time monitoring and review is undertaken to ensure timely responses to emerging issues.

Two remaining prerequisites of effective commissioning will be considered in the next two sections:

9. Health improvement programmes provided with professional levels of operational planning to ensure successful implementation; and
10. Commitment and interest in developing local provider capacity.

4 Making the most of commissioning support^f

4.1 Working with a public health practitioner^g

Commissioning for health improvement needs to be supported and advised by staff skilled in positive health practice. It is clear that in different parts of the country, local authority commissioning is being carried out by a range of different professionals; in some areas public health practitioners are responsible for commissioning services, in others commissioners have little prior knowledge or experience of public health. Appendix 3 provides a ready-reckoner for commissioning competences.

For the latter group of commissioners, an experienced and qualified public health practitioner will be able to offer a high level of professional and technical knowledge in effecting positive community, organisational and behavioural change for health improvement. To use them to best advantage requires that they are briefed properly and used appropriately. These individuals should know when to bring in specialist behaviour science capability and there is much to be gained from developing an informed, mutual working relationship.

To provide effective support, public health practitioners need:

- To be involved from an early stage
- Access to all relevant data
- To have an indicative statement of commissioner aims – open to amendment in the light of further information.
- To be informed of, and involved in, decision making with regard to operational aims and objectives
- Health improvement ethical frameworks (see Appendix 2) to be acknowledged and integrated into operational plans and activity

Access to specialist public health commissioning support can be obtained from various sources depending on local circumstances. Some commissioners will have support provided by colleagues within public health departments. Other commissioners may wish to take advice externally from the Royal Society for Public Health, or other agencies, including consultancies or specialist university departments.

Footnote:

^f The definition of commissioning support in this section refers to any agency or activity that aides commissioners in their function such as public health practitioners, university departments or independent advisers and consultants. The term commissioning support as used in this context is not to be equated with the specialised commissioning support units operating in support of clinical commissioning groups.

^g While we have used the title public health practitioner, other titles, including public health specialist may be equally appropriate.



4.2 The public health practitioner and the commissioning team

A public health practitioner is a key member of the commissioning team and can aid commissioning by:

1. Advising and commenting on the collection and assessment of health and population intelligence;
2. Assessing and reporting on local conditions likely to impact on “best response”;
3. Recommending “best response” including methodologies/methods;
4. Drafting a full operational planning brief to inform commissioners and providers;
5. Guiding drafting of service specifications; and
6. Carrying out a health impact assessment (HIA).

Effective commissioning requires an assessment of need and the consideration of an appropriate response. The manner and shape of the response is not automatic. Local conditions (resources, staffing, population characteristics etc), will all impact on the decision making.

The value of specialised commissioning support for health improvement can be summarised as follows:²⁷

- 1 Formulating, implementing and monitoring healthy public policy;
- 2 Re-orienting health services to become health-promoting;
- 3 Implementing programmes to improve health for individuals and communities, and across a range of settings, such as workplaces;
- 4 Encouraging environmental measures to improve health;
- 5 Incorporating community development approaches, so that communities are empowered;
- 6 Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes;
- 7 Encouraging appropriate service utilisation, including screening and immunisation services; and
- 8 Delivering health information and education, including the use of social marketing techniques.

5 Developing Provider support

5.1 Supporting provider development

For commissioners, the 2012 Health and Social Care Act further opened up the supply and provision of services to organisations outside the traditional government NHS/local authority public sector. This development created the situation whereby a range of non-public sector agencies could bid for contracts.

In respect to delivery of programmes and initiatives, it is for commissioners to ensure that providers are able to demonstrate the required skill level for the quality delivery of the programmes or services in line with the Darzi recommendations.²⁸ There is a need for a clear and explicit ethical dimension to any health improvement commissioning contract.

Although public health providers come in a variety of types: public, social enterprise, charity, private and public interest company, there need be no difference in ethical standards between the types of organisation. What is paramount are the standards sought by commissioners and the quality of the management of the provider. Appendix 2 provides an ethical checklist that you might find helpful.

The idea of splitting provision of services from the commissioning of services was not only to maximise the return on public money but also to encourage competition and innovation for the benefit of the client/patient. It also needs to be acknowledged that with competition there is a potential challenge and therefore support need, for providers to understand the importance of sharing data and collaborating for the common good.

5.2 What providers need

At this stage in the ongoing development of public health commissioning we are experiencing specific issues around provider engagement with health improvement. There are some established providers – often ex NHS bodies now badged as “trusts”. There are some private contractors of long standing in other areas who have come into the health care field. There are also new providers that are trading arms of charities and lastly there are newly formed social enterprises.

An added complexity is the differing attitudes of commissioners about what constitutes a proper relationship with providers. Initially there was a sense that commissioners and providers needed complete and absolute separation, defined as “arms length”²⁹ commissioning. This was to ensure that providers operated as efficiently as possible and without a high level of bureaucratic burden. Commissioners were to set out a contract brief and providers would tender to the specifications.

While this model may score high on clarity of relationship between providers and commissioners, it has its drawbacks, especially when new systems of collaborative working are being encouraged and developed at a local level.

Health improvement is at its heart a collaborative effort. A significant measure of its success flows from the sense of momentum, optimism and common purpose that carries people forward in making changes. How things feel and are experienced is as important as what actually happens on a day to day basis.

For it to work well, health improvement commissioning requires commissioners and providers to be open, transparent and mutually respectful. This is not always possible when “arms-length commissioning”²⁹ is strictly adhered to as it often fails to support the idea of partnership and co-production.

5.3 Established providers

Established providers need feedback and comment from commissioners. The contracts must provide for an additional cost element to cover administrative costs, equally important is the need to factor in professional development, quality control and monitoring.

A workforce skilled in health improvement is vital but there is concern that the current funding arrangements do not allow adequate training or development of staff. This in turn may seriously damage and undermine long term viability. Staff training and development is a strategic issue that needs to be constantly monitored and impacts directly on strategic success.

5.4 New Providers

Commissioners need to make a decision about their role in supporting new providers. Innovation can come from many sources and new entrants need to be supported and encouraged.

New providers are, by their very nature, frequently starting from small beginnings. However because they often originate from a specific local area with inside knowledge of the population and their needs, they may be at an advantage in engaging with marginalised groups. Put simply, commissioning for health improvement needs to be more than just contract setting. Growth, development and investment in building social capital are also vital considerations.

Commissioners need to be able to critically comment on new providers and their services. If there are clear weaknesses these need to be flagged up. They also need to realise that an effective provider will be in dialogue with their clients and communities. This position gives the provider significant bargaining power. It would be unfortunate for commissioners to cut themselves off from this source of local information and knowledge.

Commissioners must ensure that all providers are given the opportunity to develop and gain the knowledge and skills to be effective in the delivery and monitoring of health promotion programmes. Commissioners should ensure that providers are knowledgeable of, and able to engage with, the accreditation process relating to public health competences. The core document is the UK Public Health Skills and Career Framework, launched in April 2008.³⁰



6 Conclusion

For those committed to improving health and wellbeing, the introduction and resulting implementation of the Health and Social Care Act is an opportunity not to be missed. The move of public health to local authorities does allow a real opportunity to “fully engage” with communities for better health and opportunity.

For commissioners in public health, and especially health improvement, their work is starting to look and feel very different from when it was commissioned by the NHS. With the NHS the dominant commissioning model of health improvement was rooted in the medical model of professionals defining the needs of communities and therefore the needs of community members.

This commissioning guide has taken the opportunity to champion ways of commissioning work for local communities that regularise changes in approach and thinking, reflecting different ways of working and a new language of: *mutuality, joint decision making, sustainability, creation of social capital and assets, and legacy value*. Ways of working whereby health professionals are commissioned to *facilitate and support local development*, rather than to define and prescribe for others. In short, to improve the fundamental determinants of health of the local population.

The opportunity exists for commissioned health improvement to feel different, with communities engaged in activities they have helped direct and which address their wellbeing concerns. These opportunities will be rich in *skills based development, personal and community challenge, as well as being enjoyable and fun*. Local people, at whatever level of competency, will be seen as part of the solution to local health needs rather than as a problem to be managed.

Professionals however do need to take the lead to engage, facilitate and support. Commissioners will need to give thought as to how they will engage meaningfully with local communities and groups.

Commissioners will also need to develop a robust, clear and mutually agreed strategy for health improvement. Programmes and developments need to tackle the core determinants of health. As such commissioners for health improvement need to be as interested in local school performance as they are the level and quality of community safety.

Get the basics right and the rest will follow.



7 Appendices

Appendix 1: **Definitions of new agencies following 2012 Health and Social Care Act**

1. **Public Health England** is a new national body that aims to deliver specialist public health services and advice to national and local government. It also coordinates nationwide health protection work, such as vaccination programmes and supports the development of national public health campaigns
2. **Clinical commissioning groups** (CCGs) consist of GP's, other health professionals and lay members and are responsible for commissioning services for their local community from any service provider which meets NHS standards and costs. They are expected to work with local organisations and partners to design services which meet the needs of the local population
3. **NHS England** (formerly the NHS Commissioning Board) was established as an independent body to support CCGs and is responsible for allocating resources across the NHS and commissioning certain services, including GP practices.
4. **Health and wellbeing boards** were established under the Health and Social Care Act 2012 as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.
5. Under the old NHS system, there were a wide range of **NHS health trusts** (including primary care trusts) managing NHS hospital care, community care and mental health services in England. With the new system, primary care trusts have been abolished and all remaining NHS trusts were expected to become foundation trusts or become part of an existing NHS Foundation Trust by April 2014. Foundation trusts are independent legal entities and are accountable to local people, who can become members and governors. They are self-governing organisations that are no-longer performance managed by health authorities and have financial freedoms to raise capital from both the public and private sectors. They can retain financial surpluses to invest in the delivery of new NHS services.

Appendix 2: **Principles of Ethical Practice of Public Health**

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate for, or work for the empowerment of, disenfranchised community members, ensuring that the basic resources and conditions necessary for health are accessible to all people in the community.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Reproduced with kind permission from Thomas, J.C., Sage, M., Dillenberg, J., Guillory, V.J. (2002). A Code of Ethics for Public Health. American Journal of Public Health 92(7): 1057–1059. Publisher: American Public Health Association.

Appendix 3: Commissioning competencies – ready reckoner

Commissioning competencies	Application to health improvement/promotion activity	Current position score Not started 0 Limited 1 Operational 3
1. Willing to take on the local health improvement role	1. Able to gain trust and cooperation with local people and potential partners 2. Understands the added value to be gained from integrated commissioning	
2. Is ethically aware of the requirements of health improvement	3. Ensures high standards of ethical behaviour from providers	
3. Work collaboratively with local people, and community partners to develop local economy and environment that that optimise health gains and reductions in health inequalities	4. Able to assess accurately the potential contribution of partners 5. Ability to support growth of local capacity	
4. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health	6. Alert to and sensitive to local issues 7. Able to use a range of language registers 8. Ability to make positive use of local populations and groupings	
5. Lead continuous and meaningful engagement with clinical commissioning groups to create integrated commissioning pathways, collaborate on strategy, drive quality, service design and resource utilisation	9. Ability to discern difference between “means” and “ends” 10. Knows when to ask for professional advice 11. Knows how to utilize professional advice	
6. Manage knowledge and undertake robust and regular needs assessments (e.g., JSNAs) that establish a full understanding of current and future local health needs and requirements	12. Ability to interpret epidemiological and other social data to make assessments of strategic direction and goals 13. Understands the concept of the “learning organisation” and can build self monitoring into programme and activities	
7. Prioritise investment according to local needs	14. Appreciates how to use public money to build social capital 15. Values personal, organisational, and community learning	
8. Effectively analyse and manage the provider market to meet demand and secure health and wellbeing outcomes	16. Able to use public money to facilitate growth of learning in local organisations and groups	
9. Promote and specify continuous improvements in quality and outcomes using appropriate process and outcome based contracts	17. Ability to think and act strategically & operationally to evolve programmes in the light of experience	
10. Secure procurement skills that ensure robust and viable contracts	18. Carries out research and assessments of potential suppliers and agencies as to their capacity to fulfil contract and to act in public benefit	
11. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes	19. Appreciates the need for clear effective governance structures for effective programme development, implementation, delivery and monitoring	
12. Make sound financial investments to ensure sustainable development and value for money	20. Is able to commission for social capital building	
13. Demonstrate ability to utilise behavioural science to apply evidence based behaviour change interventions to improve health outcomes	21. Understands the applicability of behavioural science to improve health outcomes 22. Ability to conduct behavioural analysis and understand behaviour in context 23. Identify appropriate behaviour change interventions and evidence based techniques 24. Ability to effectively evaluate behavioural outcomes	
	Total score (max 72)	

Appendix 4: **Frequently asked questions/glossary**

1. What is health improvement?

Two definitions are used in this guide. Each refers to distinct phases of application.

The strategic definition of health promotion is the process of enabling people to increase control over and to improve their health. 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”*.³¹

The professional and tactical definition used is; *“The study of and the study of the response to, the modifiable determinants of health or illness.”*³²

2. What is public health commissioning?

The Department of Health defines commissioning as “the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.”³³

3. Where can I get specialist public health commissioning support?

Professional advice and support can be accessed from local authority public health departments, independent health improvement/promotion specialists, the Royal Society for Public Health or specialist university departments.

4. What should I look for in a public health practitioner/specialist?

A competent public health practitioner is expected to have a higher degree in health promotion or public health, 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.

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 networks for the exchange of communication, ideas and practical help.³¹ It also refers to social cohesion and the cumulative experiences of relationships, with both those known to us and those who are strangers that are characterised by mutual trust, acceptance, approval and respect”.¹³ There is a strong evidence base linking people’s participation in networks and social structures with positive mental and physical health.

6. What is benchmarking?

Benchmarking in this context refer to those attributes or characteristics of an organisation that demonstrate it fitness to operate. In commercial terms this is referred to as the “licence to trade”.



7. What are the determinants of health and/or disease?

The determinants of health are listed by the World Health Organisation⁹ as:

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

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

8. What is legacy value?

Legacy value is the residual value of a tactical commission. Effective commissioning can be identified by the observed residual impact/legacy of the commission. For example, one can commission a local exercise programme using an external specialist which may be effective while the external experts are there. However the programme will probably fail in the longer term as no legacy has been left. Alternatively one can commission for a legacy value and commission an organisation that trains local people to carry on the scheme after the funding ends – thus leaving a local legacy that can continue the good work.

9. 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. Commissioning aims will always be strategic.

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

Appendix 4: **Further reading**

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We have also made additional commissioning resources available on our website at www.rsph.org.uk/commissioning



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