



# Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

## Response from the Faculty of Public Health to the Department of Health's consultation on a *Commissioning framework for health and well-being*

### Introduction

The Faculty of Public Health is an authoritative public health body which aims to advance the health of the population through three key areas of work: health improvement; service improvement and health protection. In addition to maintaining professional and educational standards, the Faculty advocates on key public health issues and provides practical information and guidance for public health professionals.

The Faculty welcomes the opportunity to respond to the questions in this consultative document. As well as providing responses to specific questions posed by the consultation we have also offered some general observations on the framework as a whole, and also for particular sections.

### General comments

1. Welcome this as important policy framework for increasing emphasis on health and wellbeing through commissioning powers and the joint approach by the Department of Health and Department for Communities and Local Government.
2. Effective action through partnership can be hard to deliver in practice, and has not been helped by recent reorganisations (not just NHS): a period of stability is needed.
3. Valuable and welcome focus on mental and social well-being, alongside physical well-being.
4. Important to encourage commissioners to actively engage with the framework.
5. Consideration also has to be given to decommissioning, particularly where there is evidence from a joint strategic needs assessment (JSNA) to support this.
6. The consultation document appears at times to confuse issues of inequality with equity (fair shares).
7. It is useful to see the 'best value' concept extended to healthcare, but may not sit well with patients, public and elected members in this context.
8. Barriers to change are mentioned (p.13) but not fully explored. Additional barriers to be considered include:
  - Lack of acceptable evidence base for many public health interventions and programmes;
  - Inadequate investment in health improvement (*Choosing Health* funding, even where retained, is small compared with investment in downstream healthcare programmes);
  - Conflicting targets and perverse incentives;
  - Focus on health inequalities rather than inequities may perversely widen inequalities;
  - Difficulty in influencing determinants of good health, for example with housing;
  - Data quality poor, particularly at community level; at transition points; in non-traditional commissioning settings;
  - Lack of in-depth understanding of organisational cultures;
  - Lack of understanding of costs and benefits of real investment in upstream preventive initiatives;
  - Immaturity of certain key partnership relationships.

### People at the centre of commissioning

General comments:

9. 'Choice' needs to be widened to incorporate self care, the third sector providers, and true alternatives (or additions) to traditional management.
10. Traditionally it has been very hard to engage young people in longer term health improvement; services need to be more tailored to young people and take an holistic approach.
11. Very difficult to get the truly objective patient voice; the NHS is so ubiquitous that everyone has been influenced by past experiences.

12. Enabling people to achieve healthy lifestyles and behaviours requires recognition of the role played by sociocultural influences and environments – as demonstrated by the ‘Three Es model for lifestyle change’ – see Appendix 1. Commissioning should also be used not only to encourage health behaviour and self-management but also to empower people to make healthier choices (eg. lifeskills, advocacy) supported through the creation of a physical, social and economic environment which supports healthy choices. This requires the commitment of local authority commissioning to underpin community safety, implement town planning, leisure, education as well as social care and the third sector.

***Q1: Are these measures sufficient to enable people to take greater control of decisions about their health and care? What further action could central government take?***

Without greatly improved ‘health and well-being literacy’ people are unable to take greater control of decisions about their health and care; inadequate choice is available for true alternatives to traditional delivery of healthcare interventions in primary/secondary/community settings.

Considerably greater investment in health and well-being is needed, along with a drive for deeper integration of such services across health and social care.

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

Social marketing techniques would help to understand those groups who do not routinely use local services.

Understanding the needs of populations and individuals

General comments:

13. Joint needs assessment is an advance on ‘silos’ based approaches – but will still only be as good as the underlying data.
14. A better understanding of hard-to-reach and seldom-heard groups is required, perhaps facilitated through social marketing techniques.
15. Extension of the care programme approach to long term conditions would be excellent, especially if also included a drive to engage voluntary/third sector providers.
16. Statutory requirement for JSNA is welcome and could potentially provide a valuable evidence-base for Local Area Agreements (LAAs) and SCS action plans, with enhanced ownership and buy-in.

***Q3. Will the approach set out here and in the supporting Annex A help commissioners to undertake (a) an assessment of an individual's needs, (b) an assessment of the needs of particular groups or communities and (c) Joint Strategic Needs Assessments?***

There is an increasingly blurred role between commissioners and public health practitioners. JSNA should provide a ‘high-level’ picture of population-level need, against which individual needs can be assessed by educated commissioners. Commissioners themselves are unlikely to have full skill-set to assess needs of groups or communities dispassionately. Another approach is to assess the needs for specific interventions or services.

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

JSNA needs to be closely linked to LAA action planning, and to drive the increasing integration of PH delivery across PCTs and local authorities. Closer working between commissioners and public health specialists around the needs for specific services or specific population groups is essential for greater impact.

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

Yes, provided relationships are mature enough for meaningful interpretation and dialogue.

**Sharing and using information more effectively**

General comments:

17. IT systems are not necessarily at same stage of development across key partnership stakeholders.
18. Organisations need to develop an understanding of confidentiality and data sharing issues; ignorance still prevents sufficient sharing of information. Excellent multi-agency protocols exist, but need true experts to develop and drive.
19. Caldicott Guardian function does not always sit with the director of public health.

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

Effective commissioning needs to ensure effective sharing of information is facilitated.

***Q7. Is the legal position with regard to information and data sharing for the purposes of commissioning clearly set out here? Is there any need to review the current rules (including primary and secondary legislation, audit processes, etc.) in order to facilitate information and data sharing?***

There is considerable confusion around information governance in primary care; some longstanding practices (cancer registries) and some newer initiatives (QoF-driven disease registers) do not stand up to information scrutiny.

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

Where guardianship is clear the arrangements for information sharing ought to be straightforward. However, looked after and accommodated children might present a more complex issue.

***Q9. Would it be helpful for the Department of Health to work with other government departments and national stakeholders to develop a set of common principles to help underpin local agreements?***

Good examples already exist, and could be shared/endorsed at DH level to achieve this rapidly.

**Assuring high quality providers for all services**

General comments:

20. A wider and more innovative range of providers would be very valuable.
21. Provision tailored towards prevention/early intervention/maximisation of health and well-being is welcome.
22. Role of the primary care trust (PCT) as provider needs to be further thought through.
23. Traditionally the third sector has been inadequately used by both patients and professionals: this stems from lack of understanding (and possibly a certain mistrust) of this very different way of working. It will take some time, and probably considerable investment, to reverse this view. This is a very sensitive area as the flexibility and responsiveness of the third sector needs somehow to be retained.

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

These proposals alone are unlikely to widen the range of commissioned providers, especially in the context of practice based commissioning. .

***Q11. Should the Department develop one contract template for out-of-hospital services (except GMS and PMS) or one for each of the main service segments (e.g. mental health, long-term conditions, etc)?***

A flexible model contract would be helpful, which could then be adapted to local needs.

**Recognising the interdependence between work, health and well-being**

General comments:

24. Positive impact of work on health is important, and usually under-appreciated.
25. Many work sectors lack effective occupational health support.
26. Valuable read-across to *Choosing Health* implementation.
27. The public sector is a major employer, however, health issues there are very different from the private sector.
28. The framework makes no mention of volunteering as valuable pathway to employment.
29. Health trainers could have been promoted within this section.

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

There are not sufficient incentives for commissioners to improve health and wellbeing as yet; the incentives for employers ought to be obvious.

**Developing incentives for commissioning for health and well-being**

General comments:

30. Practice based commissioning is unlikely to improve overall consistency of commissioning.
31. There is the practice of investing 'NHS money' on support for self-care and non-health interventions. Whilst this is often sensible and occasionally evidence-based, it often gets very poor media coverage. Proactive media assistance here would be helpful.
32. The patient still needs to be considered in the family/community setting by both primary and secondary care providers; this remains inconsistent.
33. Primary care incentivisation, however achieved, may not result in long term shift in behaviour as benefits are not necessarily immediately obvious.
34. In health economies with significant financial difficulty, it is impossible to achieve investment in health and social wellbeing.

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

Investment in research to enhance evidence base for this approach and greater incentivisation (NICE, QoF, appraisals).

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

Personalised budgets and better data linkage.

***Q15. What considerations do you see in increasing the use of single audit arrangements for pooled budgets?***

Audit improves ownership so would need to involve all contributors to pooled budgets. Difficulties in tracking organisational investment right back to outcome might be serious disincentive to this approach.

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

Children are frequent users of primary care services, but usually for primary care-based services. Knowledge and experience of children/young people commissioning issues is therefore likely to be weak, even at practice consortium level. 'Expert' consortia might need to be created to act as bridge between CT and primary/other sector provision. Families could hold budgets, as older people now do for social care.

**Local accountability**

General comments:

35. Alignment of performance management mechanisms across key partner organisations would be helpful.
36. Community empowerment would be welcomed and is likely to create additional benefits through increased engagement.
37. JSNA and SCS should drive LAA local outcome indicators and targets.
38. Local strategic partnerships (LSPs) need greater legal foundation.
39. PCT prospectuses are an ambitious proposal (as described here) but for whom are they intended?

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

In two tier authorities the hierarchical relationship between the LAA and the LSPs has not been adequately described or agreed. As commissioning becomes increasingly a joint strategic agenda at the local level, accountability for the resultant joint provision needs to be jointly and adequately measured/owned.

***Q18. Should a local authority have some say in the capital investment plans of a PCT (and vice versa) to ensure they support more integrated service delivery, where appropriate?***

Joint delivery is the ultimate end point in this journey so it is logical that some joint capital expenditure will happen, especially if this drives more closely integrated service delivery. There are good examples of this already.

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

Metrics would need to reflect local and national issues, be driven by DH/Strategic Health Authority (SHA) strategic priorities, by the LAA and the SCS, and by the business plans, processes and priorities of the key local stakeholders, including the PCT, the LA(s) and the third sector.

**Capability and leadership**

General comments:

40. Commissioning capability within primary care is weak for traditional health care, and considerably weaker for the health and social well-being agenda;

41. The relationship between PH and commissioning at the PCT level needs to be further clarified; and with Las as joint commissioning becomes more commonplace;
42. FFP assessments may not give due consideration to health and well-being issues, since these are often lower profile within PCT settings;
43. National accreditation for development programmes is welcomed;
44. PBC unlikely to focus on commissioning for health and well-being initially; this needs to be powerfully incentivised.

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

Commissioning for health and wellbeing requires considerable understanding of strategic need at population level but there is currently little incentive (other than commercial) for primary care performers to develop this. This is unlikely to yield service development best tailored to the defined needs of the wider population- especially as practices/consortia will be considering a different size of population.

**Joint Strategic Needs Assessment**

General comments:

45. A really good idea!
46. Will enhance widespread local ownership of population health priorities;
47. Do need to minimise risk of inadvertent widening of health inequalities;
48. Must link closely to other local population drivers for better health and well-being: LAA and SCS in particular.
49. Should be 'live' project, rather than 'dead' document!
50. Should make best use of innovative and dynamic formats;
51. Population projections can use widely differing models, so will need to be defined closely;

***Q21. How might Joint Strategic Needs Assessments inform other aspects of community planning?***

JSNA should be tailored to local priorities, which would necessarily extend beyond health. There are risks that scarce public health resources might be spread even more thinly with resultant lack of focus.

***Q22. What could be added in to Tables 1 and 2?***

- Conceptions, as well as births
- Population pyramids
- Educational metrics
- Sexually transmitted infections
- Childhood obesity data
- Mental health data, difficult to capture suicide rates/antidepressant prescribing
- Long term conditions data
- Looked after children

***Q23. What is the most efficient way to provide the necessary information and analysis to commissioners?***

This is dependent on the type of commissioning questions asked.

***Q24. How can we ensure that the Joint Strategic Needs Assessments are used effectively?***

By making them readily accessible and ensuring widespread ownership.

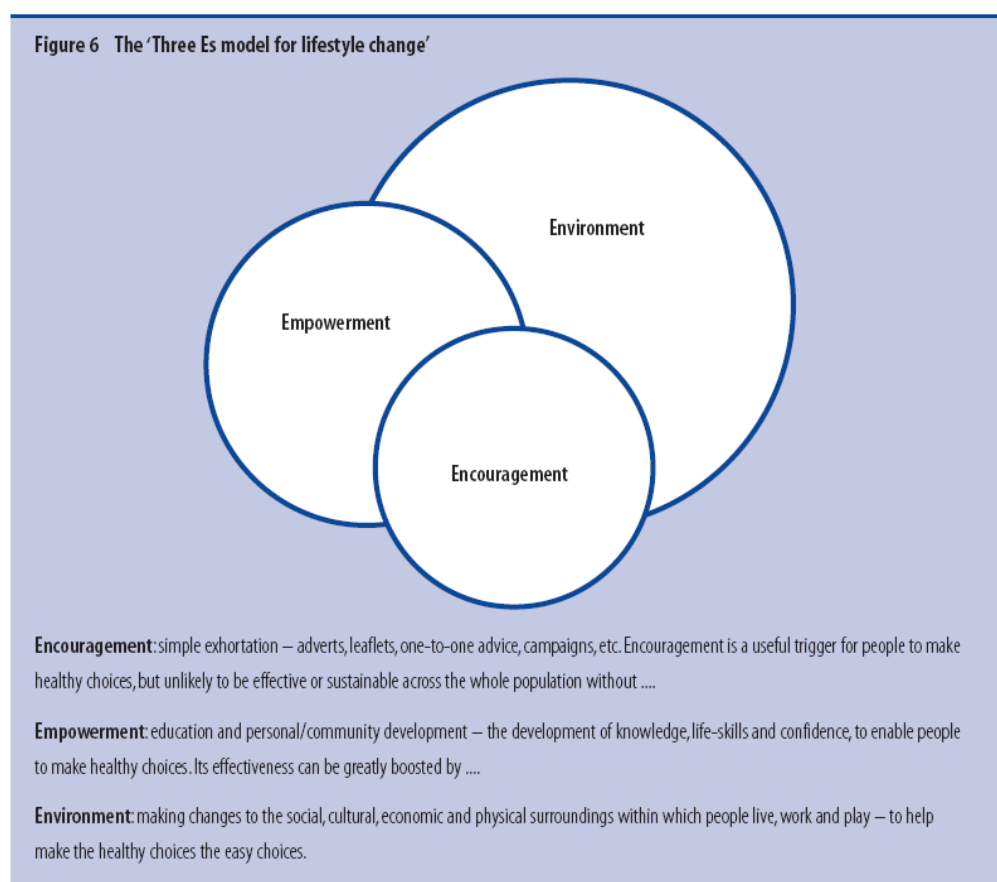
**Q25. Should Joint Strategic Needs Assessments be linked to the three-yearly Local Area Agreement planning cycles, or should timing be left to local discretion (subject to Secretary of State's directions)?**

JSNA should be left as far as possible to local discretion, perhaps with a minimum specification.

**Q26. Will this approach to Joint Strategic Needs Assessment effectively define the needs of children and young people?**

JSNA must be equally effective for all sectors of the population even if this requires tools to be further refined. This may not be achievable immediately, but should be the ultimate goal for joint strategic commissioning, provision and accountability.

## Appendix 1: The 'Three Es Model for Lifestyle Change'



Source: Adapted from Maryon-Davis, 2003<sup>4</sup>