FROM TRANSITION TO TRANSFORMATION IN PUBLIC HEALTH

Resource Sheet 5

Strategic planning and commissioning across partnerships

Key messages

Health and wellbeing boards are the key vehicle for system transformation.

Marmot Review principles should be at the heart of health and wellbeing strategies.

Establish shared priorities, actions and outcomes in the joint health and wellbeing strategy and align these with organisational plans in councils, CCGs and other partners.

This resource considers how public health in local authorities can influence wider partnerships through a range of issues connected with strategic planning and commissioning:

- the development of Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategies (JHWS)
- public health support to clinical commissioning groups (CCGs)
- interaction between public health and local authority commissioning
- collaboration across local authorities.

Messages and suggestions are based on discussions with the wide range of people from local government and public health who were involved in the snapshot.

Joint Strategic Needs Assessment

Directors of Public Health generally lead or jointly lead the local change programmes aimed at partnership planning and integration across local partnerships. The influence of public health is therefore central to the development of health and wellbeing boards (HWB), JSNA and JHWS. Areas are currently working to improve their JSNAs, with the following being common developments.
• Including an assessment of assets, such as community resources, not just of need.
• JSNA publicly available on a website with the facility to drill down into layers of data (e.g. not solely a printed document).
• Wider stakeholder ownership, including voluntary and community sectors and council/NHS staff.
• Broadening to topics not previously covered e.g. housing, transport, and the local economy.
• Including qualitative information, such as people’s experience of services or local areas.
• Providing locality profiles.

In Blackburn with Darwen an exercise is being piloted to map neighbourhood services from voluntary, community and public services onto GP practices to improve links and referral pathways. This sort of activity also has the potential to bring together key local players who have regular face to face contact with individuals and communities – councillors and GPs – in a shared agenda for health improvement.

In Wakefield an asset based pilot process\(^1\) for JSNA resulted in many lessons about approaches, tools and methodologies. For example, close working with the newly emerging Priority Neighbourhood teams (virtual multi agency teams formed to tackle issues in the 12 most deprived neighbourhoods) so that new toolkits are systematically trialled and adopted in frontline work.

Areas are also making sure that JSNA is no longer a standalone assessment of need but has clear connections to the planning or commissioning activity that it supports. Measures are being taken to improve the quality of products so that JSNA moves beyond presentation of data to analysis, prioritisation, and recommendations for evidence-based interventions. Several of the case study areas operate local observatories or intelligence units, sometimes involving other partners such as the police.

The Public health outcomes framework\(^2\), which includes indicators relating to the wider determinants of health and to health improvement, and has a new emphasis on shared indicators with the refreshed NHS outcomes framework\(^3\), will need to be built into the JSNA and JHWS, alongside the Adult social care outcomes framework\(^4\). The Department of Health indicates that further development to align the frameworks will take place. Many areas are identifying their own set of complementary indicators from the national frameworks, plus local indicators, to establish a local performance framework for the JHWS.

**Joint health and wellbeing strategies**

In terms of JHWS, most areas are linking priorities, objectives, actions and outcomes to the principles and evidence base in the Marmot report (see in particular chapter six) and these are also feeding down into council corporate objectives and actions. In some areas work is also starting to align JHWS with emerging CCG plans and with
the organisational plans of other partners, such as the police, transport and the voluntary and community sectors. In this way, community strategy, total place, community budget, and localism approaches are being built upon – see, for example, diagram of Luton model. This approach can be assisted by public health specialists being assigned to support organisations to develop their potential for health improvement.

In some areas, partnerships are working on integrated business planning or joint commissioning models, in which activity to improve health outcomes are mapped across expenditure from a range of partners, such as transport or education, in community budget arrangements. Making best use of system-wide resources will be an ever more vital role for public health in future. In many areas, public health is focused on identifying evidence-based early interventions and preventative measures to tackle poor health and health inequalities.

In Blackburn with Darwen, public health has been central to an integrated business planning model with the council and other partners such as the police, the independent sector and local GPs. This involves needs assessment, cost benefit analysis and the evidence base for intervention. So far the model is in place for two areas: housing (addressing poor standard rentals) and domestic violence.
The commissioning cycle illustrates the link between needs assessment, strategy, commissioning and outcomes.

The commissioning cycle

- Monitor, review and evaluate services and re-commission and de-commission where appropriate (Tool: Outcomes Framework)
- Identify need of local community, services and resources available (Tool: JSNA)
- Develop services through procurement and service agreements (Tool: Commissioning Plan)
- Decide priorities and specify services and outcomes to meet priority needs (Tool: JHWS)

Clinical Commissioning Groups

Public health is providing support to clinical commissioning groups in a number ways including, for example, assigning staff for several days a week and providing analysis and specialist advice as part of an agreed work programme. In some areas, public health offers of support to CCGs have been signed off for 2012-13, and in others they are in draft form. These are being refreshed in light of the 2011 DH factsheet[^5] Public Health Advice to NHS Commissioners. Draft guidance on the core offer was issued in February 2012[^6].

In Salford, the public health team will be part of an integrated commissioning hub providing intelligence, research, policy and strategy. The aim is to have broad capacity to support future development and commissioning activity for the council, and potentially across integrated commissioning structures. The hub will offer strategic population data and analysis support to the CCG. An Integrated Commissioning Board is being established to be the commissioning arm for the health and wellbeing board. The ICB will work with an emphasis on prevention and early intervention and will oversee existing and future integrated arrangements such as Section 75 pooled budgets.

[^5]: Public Health Advice to NHS Commissioners
[^6]: Draft guidance
In the context of wider commissioning support to CCGs, PCT clusters have developed their initial prospectus documents for independent commissioning support services which have been assessed by SHA clusters; PCT clusters must produce business plans for the services by the end of March 2012. There is likely to be a range of different sizes and types of commissioning support service across the country. There may also be potential for local authorities to play a role in providing commissioning support for some integrated services. This is a fast changing agenda of which local authorities, public health and health and wellbeing boards will wish to keep abreast to ensure that public health support to CCGs fits clearly and effectively into this picture. Further operational guidance on these matters is expected.

Details are still emerging about how the NHS Commissioning Board, Public Health England, CCGs and local authorities will work together on their various commissioning responsibilities, and this is another area on which local partners will need to keep up to date.

Under the auspices of Haringey Health and Wellbeing Board and its executive, the council is developing its public health commissioning offer to the NHS, for example by exploring the option of direct line management by the Council of commissioning support staff. There will also be a public health input into joint commissioning. The details of how this will work will be determined in 2012.

In Blackburn with Darwen, discussion will take place about extending the role of the CCG to become an integrated clinical commissioning group – this would include adult social care and public health commissioning and would also tackle the social determinants of health.

**Council commissioning and contracting**

Oxfordshire public health team is hoping to draw on the local authority’s expertise of contracting with many large and small providers, including those in the voluntary and community sectors; in a joint initiative with the Clinical Commissioning Group, a contract has just been signed with Age UK to co-ordinate preventive work with older people. The public health team also envisages further joint work with the district councils to invest in local providers around obesity reduction and encouraging better nutrition and exercise.

In terms of direct commissioning, councils are seen as having considerable experience in commissioning and contracting, and as able to be more flexible when contracting with small and medium providers than the NHS. Bringing together public health skills in analysis with council expertise in commissioning is seen as having great potential for added value, particularly since councils are increasingly interested in evidence-based interventions to make the best use of limited funds.
This expertise will also be helpful in understanding what needs to be done to manage the transfer of any public health contracts running beyond April 2013, within the expected national guidance on contract transition.

As well as providing opportunities for flexible approaches to public health commissioning, there is potential in using contracts to promote public health. Some areas are already doing this, for example, through requirements to promote health in home care or care home contracts. Through discussion with providers, this could be extended to include more specific public health interventions such as ‘making every contact count’. Working with CCGs, this could also be a way of extending public health activity in NHS providers – some PCTs already include health improvement measures in their provider contracts.

Regional and sub regional collaboration

There is a rich tradition of public health and local authorities working together on a regional or sub regional basis, generally through associations or networks of councils and with regional public health involvement. Joint work includes strategic planning e.g. health inequalities strategies; lobbying e.g. how alcohol is priced, promoted and sold; and delivery of some services e.g. emergency planning and response.

A consistent message from the snapshot was that this work was highly valued. Although some of the regional support mechanisms were changing, there was every intention that councils would work together to make sure it continued, and the transfer of public health responsibilities was seen as a way in making further progress.

Areas were also looking to new developments, such as supporting health and wellbeing boards to work together through networking arrangements. Some councils with a history of joint work across a larger area are also starting to discuss whether any functions could be shared – for example observatory type approaches. Generally, such discussions are at an early stage of sharing ideas. There were also examples of councils who had collaborated previously who were reconsidering such arrangements due to differing priorities for public health.

The Association of North East Councils set up an Improving Health task and finish group to consider what needed to be done to maintain successful joint working as set out in the 25-year, regional Better Health, Fairer Health strategy. Recommendations included that local authorities should recognise the ambitions set out in the regional strategy as a valid statement of themes they will need to consider in discharging their public health functions; also, the regional chief executives group, the leaders and elected mayors group and health and wellbeing chairs should give early consideration to the scope for working at different spatial levels and in different ways to make a greater impact through working collectively.

For further information on collaboration see Resource Sheet 6.

Questions for councils and public health to consider
How is public health being reflected in JSNA and JHWS, for example are Marmot report principles used?

Does the JSNA involve all the relevant stakeholders (from across the council, health and other partners) in understanding public health priorities, and formulating recommendations?

Can a line be traced from JSNA through JHWS to specific actions by the council, CCGs and a wide range of partners to address the relevant determinants of health?

Is there a local performance measurement framework for the JHWS?

What role is public health taking to ensure that budget planning reflects an increasing investment in prevention/upstream action?

What measure are in place to ensure that there is a good local understanding of the respective public health commissioning roles of the council, CCG(s), the HWB, the NHS Commissioning Board and Public Health England?

Is the council involved in discussions about independent commissioning support services for CCGs?

How will existing contractual arrangements for public health programmes/projects be overseen during and after the transition?

What arrangements are/will be in place for supporting future public health commissioning?

Is the council and public health engaged in regional or sub regional collaborations, and are such developments considered at the local HWB?

February 2012

---

1 Wakefield asset-based JSNA pilot


4 Department of Health, 2011, Adult social care outcomes framework.
