

# Commissioning for better health outcomes

September 2016

# Foreword

Councils have a critical role to play in securing good health outcomes for the communities they serve. In the context of an ageing population with increasing complex long term conditions, the need to address emergent concerns such as obesity and oral health, coupled with a picture of health inequalities across the country, this is a significant challenge.

Councils, working with partners in health, housing, leisure and the voluntary and community sector, among others, have risen to this challenge and are taking innovative approaches to how they improve the health of their citizens, some examples of which you will see in this guide. Council leaders are encouraging locally delivered solutions that lie at the core of localism. These solutions are based on an understanding of the needs of local communities. They build on local community assets, drawing together communities and partners to develop a joined up, multi-faceted approach to improving health.

Commissioners are vital in the process of making the most of collective resources to improve health outcomes. We acknowledge that commissioners are experiencing a period of change. Citizens are no longer seen as passive recipients of services but enablers of their own good health, supported by the communities around them. The role of commissioning has changed from identifying and procuring services for individuals to bringing people together to enable citizens to live a fulfilling and independent life for as long as possible.

We have developed this guide with commissioners from councils and partner organisations, building on existing learning and resources and sharing new and innovative practice developed by those working to improve public health. We hope that it will help to support change and enable commissioners to have even more of a positive impact on the health of the communities they serve.



**Councillor David Simmonds**

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# Introduction

Councils were given responsibility for public health in April 2013. The initial focus was on ensuring a safe transition of staff, services and contracts – and getting these into good shape. Now, three years on, many councils are moving to a phase of transformation with health being embedded in everything the council does, including its commissioning.

Investing in prevention and better health outcomes can be part of the solution to the challenges of increasing levels of need along with shrinking budgets. Effective preventative interventions can reduce health and social care costs and the need for welfare benefits. Better health can also enhance resilience, employment and social outcomes.

The financial climate for councils and their partners is becoming increasingly tough, making it ever more important to get the best outcomes from the scarce resources available. Effective commissioning is one of the levers that councils can use to make the most of the resources they and their partners have.

This guidance is based around a set of principles that make for good commissioning. These were developed from a scoping workshop with public health and procurement staff, consultation with delegates at the Local Government Association (LGA) and Association of Directors of Public Health (ADPH) conference and from the lessons emerging from the case studies included in this report.

The case studies have been chosen to illustrate positive approaches to commissioning being taken across the country to address a wide range of public health challenges.

Common to all of the examples was the enthusiasm for working in the council environment, the opportunities it had brought to make better links between programmes and the mutual respect that had been built up between colleagues from different professional backgrounds. Many also pointed to the value of political leadership of the health agenda and the critical role elected members played in ensuring momentum in difficult times.

# The role of councils in improving health outcomes

The Health and Social Care Act 2012 gave councils new duties to improve the health of local people. They formally took on responsibility for public health in April 2013. The focus initially was on ensuring a safe transition. Three years on, councils are increasingly looking to transform the way that they and partners work to improve the health of local people. Effective commissioning is one of the levers they have to deliver transformation.

## **Duties of councils under the Health and Social Care Act 2012**

- duty on upper tier and unitary authorities to improve the health of local people
- duty to have regard to guidance including the Public Health Outcomes Framework
- regulations specify:
  - National Child Measurement Programme
  - NHS Health Checks
  - sexual health services
  - provision of public health advice to CCGs
  - information and advice on health protection
  - some of the Healthy Child Programme is now also mandated following 0-5s transfer in October 2015.

These functions are supported by a ring-fenced public health grant until 2018/19 when funding from retained business rates is due to replace the current local authority funding system. Public health services that are part of the comprehensive health service are governed by NHS constitution and so, for example, must be provided free at point of use.

Investing in prevention and better health outcomes can be part of the solution to the conundrum faced by councils of how to meet increasing need with reducing funding. Helping people to stay healthy can reduce health and social care costs along with the need for welfare benefits. Better health can enhance resilience, employment and social outcomes thus keeping people independent and reducing dependence on services.

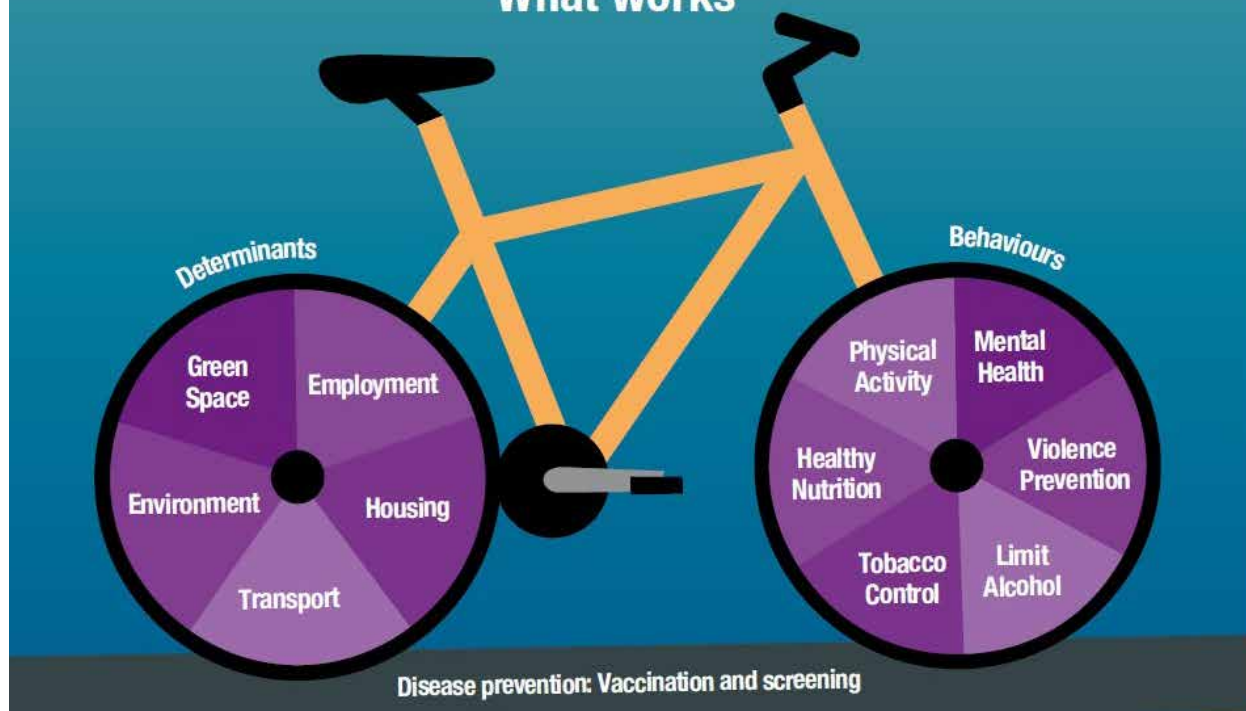
The influences on health go well beyond the delivery of specific services set out in legislation, hence the focus on commissioning for better outcomes in this guidance (see diagram overleaf). To address a complex issue like obesity or giving children the best start in life, many different approaches may need to be coordinated to produce the best impact. This could include the provision of services to support individuals, designing programmes to create healthier environments and building additional social value into a construction project, for example.

Commissioning for better health outcomes stretches well beyond using the public health ring-fenced grant to purchasing specific services to using all the resources that a system has at its disposal to have the biggest impact on outcomes.

## Public health can be part of the solution:

Investment in prevention reduces health costs and lowers welfare benefits  
Promoting health and well-being enhances resilience, employment and social outcomes

### What works



### The benefits of investing in effective public health

Source: WHO (2013a)

Outcomes can be measured using the national outcome frameworks for the NHS, public health and adult social care<sup>1</sup>. Using these outcome measures councils and partners are able to benchmark performance as an approach to making improvements. The NHS Outcomes Framework sets out the outcomes and corresponding indicators that will be used to hold NHS England to account for improvements in health outcomes.

The public health outcomes framework 2013 to 2016 concentrates on:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities.

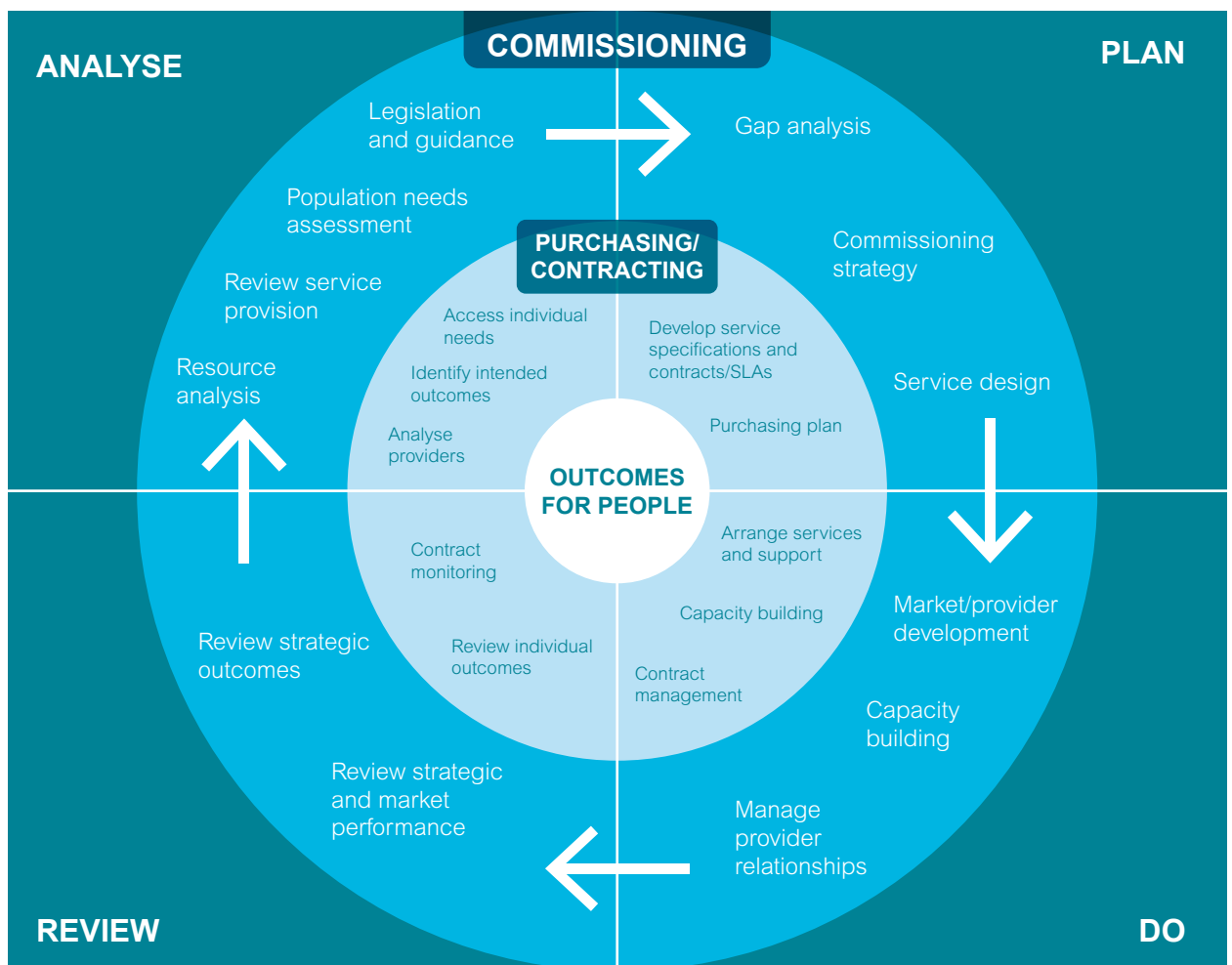
The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people.

<sup>1</sup> <https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks>

# What is commissioning?

Commissioning is a term that is used differently by different people, and is often used as shorthand for procurement or contracting which are only part of the process. There are many different commissioning models and the language associated with commissioning differs across sectors which can add to the confusion. When talking about commissioning with partners it can be time well spent to explore what everyone actually means.

The Cabinet Office Commissioning Academy defines commissioning as the effective design and delivery of policies and services – so it is much wider than procuring services from an external provider. This definition works well for public health challenges that are complex, where there is no single silver bullet that will solve the issue, and where prevention and early intervention at a population level are often more cost effective than providing more expensive treatment services to deal with the consequences of unhealthy environments and behaviours.



## A commissioning model

Source: Institute of Public Care, Oxford Brookes University

The Institute of Public Care model above shows commissioning as a complete process from understanding needs in the population, developing a strategy and designing the intervention, working with providers and reviewing performance. The procurement activities are inextricably linked with the overall procurement process and are needed at all stages of the commissioning process, not just during tendering for a service. The desired outcomes for the population are central to the whole process.

The Commissioning Academy framework asks a series of questions linked to the stages of the commissioning cycle:

- What's the question?
- Get to know and work with your customers
- Define the outcomes and priorities
- What will it look like?
- How will you get there?
- Measure the impact.

They recommend spending significant time working with partners on the first two questions – being clear on the issue that needs to be addressed and understanding what will work for the people the intervention is intended to help – as this will increase the chances of a successful intervention being commissioned and potentially save resources in the longer term.



# Principles for good commissioning

The range of work that councils are undertaking to transform the health of their populations is wide and varied. But some key themes and principles are emerging for what makes commissioning most effective.

These principles have been developed from a focus group of public health and procurement professionals, from discussions with delegates at the LGA/ADPH Annual Public Health Conference and from the lessons emerging from the case studies included in the report.

1. Act as system leaders to build the right culture, relationships and partnerships
2. Have a clear focus on outcomes
3. Take time to understand what is driving population behaviour
4. Invest strategically and for the longer term
5. Work with communities and build on assets
6. Work with providers as partners and shape the market
7. Commission across systems and for whole pathways from prevention to care
8. Use evidence of what works and build new evidence through evaluation.

## 1. Act as system leaders to build the right culture, relationships and partnerships

Commissioning is sometimes regarded as a narrow activity focused on securing services from external providers. All of our case studies included some form of tender process but more importantly they were developed in the context of a wider strategy sitting within a wider system. To commission effectively different parts of the local system (and often wider) need to be brought together to identify the best solutions to complex issues. Building a culture of trust and strong relationships is critical to success.

Some of our case studies illustrate clearly how bringing different people into the conversation has led to more innovative approaches being developed.

**Devon** drew on the skills of their digital transformation, social marketing and communications teams in developing their public-focused commissioning approach.

**Cheshire East** are investing their energy in working with their new provider for 0-5s services post-contract award to develop closer integration between health and early years services.

All were convinced that a team approach, valuing different skills and perspectives made for more effective outcomes.

## 2. Have a clear focus on outcomes

Building a clear, shared understanding of why something is important and what you are aiming to achieve helps to maintain focus and momentum for the longer term. Elected members play an important role in determining and maintaining the emphasis on priority issues and outcomes.

**London** has defined clear health outcomes for its city wide sexual health transformation programme.

**Leicestershire** used the Public Health Outcomes Framework to identify fuel poverty and reducing excess winter deaths as priority outcomes.

**Devon** designed their procurement process to enable co-development of outcomes and outputs with the successful provider.

**Cheshire East** is linking financial incentives to the achievement of desired outcomes

## 3. Take time to understand what is driving population behaviour

The Commissioning Academy emphasises that spending time on the early parts of the commissioning process by understanding the issue being addressed and what works for specific communities is vital to the success of the whole process.

**Devon** used Mosaic analysis to segment their population into different groups and then worked with focus groups drawn from these groups to understand how they would best engage with lifestyle services.

**Liverpool** used behavioural insight to design their campaign to reduce the sale of alcohol to people who were drunk.

**Halton** and **Cheshire East** used in depth work from their Joint Strategic Needs Assessment (JSNA) and the Director of Public Health (DPH) Annual Report in the design of their services for children.

## 4. Invest strategically and for the longer term

Complex population health issues are unlikely to be solved overnight by single interventions. Commissioners will usually need to build up a network of policies, programmes and services that together have the desired impact. Sustaining effort and impact over the long term is important to success and this may not be best served by recommissioning services every two to three years.

**Essex** worked with their procurement team to secure a long-term co-design partner for their programme to work with young people in managing risk. Their model also enables them to generate commercial revenue that can be used to support the local programme.

**London** are developing a pan London sexual health transformation programme. Long term contracts are being put in place to enable providers to make the investment needed to transform the service delivery model.

## 5. Work with communities and build on assets

This can lead to a better understanding of the issues facing communities and what approaches are likely to work. Working with the assets that communities hold such as skills and networks within the community as well as facilities can lead to more sustainable solutions and avoid creating dependency on services.

**Devon** worked with focus groups drawn from different population groups to develop their integrated lifestyle service.

**Essex** and **Halton** have built strong relationships with schools and built their capacity to address risk-taking by young people and mental health issues.

## 6. Work with providers as partners and shape the market

It is a myth that commissioners should keep a clear separation from providers. Whilst it is important to treat all potential providers fairly throughout a tender process, innovative approaches can be achieved through engaging a range of potential providers in the design of services and through working collaboratively with them once a contract has been awarded.

**Devon** held a discovery day and market days to encourage providers to develop more innovative responses to their tender for lifestyle services.

**Halton** held market development days and encouraged collaborative bids from providers.

**Cheshire East** are working collaboratively with their community 0-5s provider post contract award to develop more integrated services.

## 7. Commission across systems and for whole pathways from prevention to care

A commissioned programme does not exist in isolation. Many of our case studies identified how they had created links to other related programmes to maximise reach and impact. They also identified how it was important to plan for the whole pathway from prevention through to treatment.

**Leicestershire** has built links from its Warm Homes, Healthy Homes programme to other housing support and created multiple referral routes into the service. Securing funding for housing improvements will increase the impact of the programme.

**Halton** has brought together previously separate prevention, early help and treatment approaches to develop an integrated children and adolescent mental health service (CAMHS).

**Cheshire East** is bringing council children's services together with the 0-5s healthy child programme to deliver more integrated services.

**Wolverhampton** has needed to identify and plan for increased treatment workload arising from a latent TB screening service. Their voluntary sector partner has been critical to ensuring patients continue with treatment.

## 8. Use evidence of what works and build new evidence through evaluation

The resources section of this guidance provides links to a wealth of evidence of what works to improve outcomes. Good commissioners will make the best use of what is already available and also evaluate their work to add to the evidence base.

**Wolverhampton** used national evidence to identify that screening for latent TB was an effective intervention, and evaluated their pilot programme to identify how their local at risk population could be reached most effectively and supported through their treatment.

**Liverpool** used international evidence to identify a promising intervention for reducing heavy drinking in city centres. They independently evaluated their campaign to inform future local commissioning.

**Devon** retained a specialist stop smoking service as a component of their integrated lifestyle service having reviewed the evidence.

Effective commissioning depends on being really clear about the issue to be addressed and bringing the right team together to identify the most cost-effective solutions. Our case studies show the benefits of working with the public, services users and providers as partners, and also the benefits of bringing together the skills and experience of a wide range of council officers and elected members with the shared goal of improving health.

# Case studies

# Commissioning an integrated 0-5s service in **Cheshire East**

Councils formally took on commissioning responsibility for the 0-5s Healthy Child Programme in October 2015. Cheshire East Council re-procured its services for children aged 0-5 ahead of the formal transfer with a view to working with the new service provider to transform services and better integrate them with council in-house early help provision and children's centres. They have consciously adopted a partnership approach to transformation with their provider, aiming to achieve systematic change and build on good practice that had been there in isolated pockets previously.

## What approach was taken?

Cheshire East Public Health team worked with NHS England to re-commission the 0-5 services following the same timeline as Cheshire East's re-commissioning of 5-19 services. The service specification followed the national model, adapted to ensure local needs were addressed. This was informed by the JSNA, the Director of Public Health's (DPH) Annual Report, and joint work with the Children's Directorate. Joint market engagement events were held with NHS England. The procurement was carried out by Cheshire East Council. The assessment panel for the bids consisted of representatives from NHS England (Quality and Immunisation and Vaccination Lead), the council's public health team and children's services staff, a CCG representative and a local GP.

A transformation group comprising public health, the community trust provider, council prevention and early help services and children's centres is leading the ongoing work.

Their main focus has been on making practical changes that will support a more integrated service. This has included workshops involving council and NHS staff working together to build relationships and identify local priorities based on national guidance.

The priorities identified are transition to parenthood, parental mental health, child mental health and the two-and-a-half year review. The group have started work on the co-location of services and making better use of the estate available across the children's centres and NHS properties.

Progress on integrating IT has been slower but they are looking to implement common systems across the NHS and council for the universal offer and safeguarding work.

The transformation group are now focusing on the important steps along the parent's journey, five of which are the mandatory health checks. The journey identifies roles within the system, what information, advice and guidance should be available at each stage and when additional targeted support is needed. The aim is for the service to be more systematic with active follow-up of families that have not engaged, as well as better information-sharing between professionals. Work on mental health has engaged the two maternity providers for the area and has made progress connecting up pathways, strengthening onward referral and improving access to peer support services.

The group are beginning to engage parents with the development of the parent journey and to work with the Council for Voluntary Service to strengthen the qualitative information from parents in the JSNA.

Incentive payments (of up to 5 per cent of the contract value) have been built into the contract with the provider and these have been linked to Key Performance Indicators (KPIs). Early payments are related to the establishment of the service, however, in future years they will be more closely aligned to improvements in health outcomes.

## What impact did it have?

Relationships are already much improved both at management level and between frontline council and NHS staff, creating a productive environment for transformation. Staff are increasingly working from co-located venues and opportunities to make more cost-effective use of property have been identified.

Baseline data for services was limited but there is a desire to work towards a more outcomes based contract. Early KPI's specified in the contract were linked to the process of getting the new service into place. For next year, this will shift to progress on the service priorities such as establishing a baseline position for mental health.

The increased profile for children's and parental mental health needs has led to this being a focus for joint work on healthy schools.

## What has been learned?

Establishing a culture of openness and investing in the relationship with the new provider has been vital. There are a limited number of providers in this market and the style of leadership, capacity to work with partners and openness to transform services are important discriminators between providers.

Working on relationships is helping to create a sense of "we are all in this together" to make the biggest impact, rather than the "us and them" culture. Seeing providers as colleagues in the system rather than having a purely contractual relationship has helped with this.

Frontline staff transferred from the previous provider and it has been particularly important to ensure they feel engaged in the transformation. The workshops were a useful start to this, but different types of engagement with more local teams may have been better. Commissioning staff have also spent time shadowing frontline staff which has helped build trust and for them to understand local needs better.

The DPH Annual Report was important in illustrating the impact of parental and child mental health on longer term outcomes. This helped with understanding the issue and getting it higher on the agenda.

Partnership governance and strong elected member leadership have helped keep the focus on transformation and integration and ensure that links are made with other related programmes. The transformation group works within the frameworks provided by the Health and Wellbeing Board and the Children's Trust and is linked to the Joint Commissioning Leadership team.

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### Further information

DPH Annual Report 2013/14

[www.cheshireeast.gov.uk/PDF/Annual-Public-Health-Report-2014-FINAL.pdf](http://www.cheshireeast.gov.uk/PDF/Annual-Public-Health-Report-2014-FINAL.pdf)



# Commissioning a new Healthy Lifestyle Service for **Devon**

Devon, like many areas, had commissioned individual lifestyle services to support lifestyle change, eg smoking cessation and weight management services, for many years. These services were largely commissioned from NHS providers on the basis of funding available and outputs rather than outcomes. Services were reaching a small proportion of those who could potentially benefit – with 3 per cent of current smokers accessing the service each year for example.

When public health transferred to the council, elected members took the view that as these services had never been subject to market testing they should be retendered to ensure the most cost-effective services were in place. It also came at a time when the Five Year Forward View was calling for a radical upgrade in prevention and the council was reviewing its role as a commissioner, enabler and connector. The public health team took the opportunity to review the whole approach to delivery of these services, rather than simply tweaking the existing service specifications and retendering. There were risks associated with this, but the risk of not changing was seen to be greater.

## What approach was taken?

The design principles for the new model were that the user should be at the centre of the service, and there should be a focus on outcomes and earlier intervention.

The public health team were fortunate to have a social marketing lead within the team and, with the move to the council, they were able to make strong links with people who they had not worked with previously such as the digital technology lead and staff running the community directory. This led to different conversations and much greater potential for integration and innovation.

Starting from the perspective of the user was important. This approach was initially shaped using Mosaic analysis of population data to define three key groups to work with – Inform Me, Enable Me, Support Me.



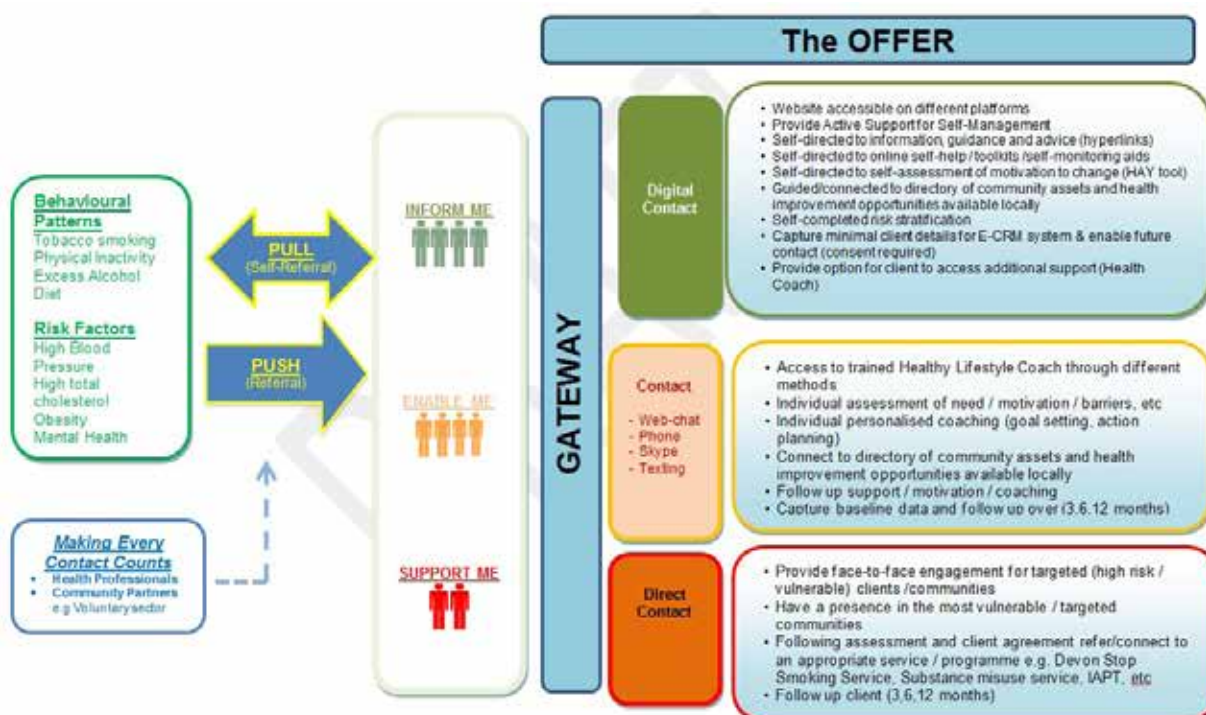
The council then held a “discovery day” involving about 100 local people and organisations. The focus was an open exploration of what could be done to reduce premature deaths and long term conditions rather than homing in on what services were needed. Discussions were geared around “personas” that had been developed to represent the key Mosaic population groups. This led to a different, more innovative, conversation with providers who would traditionally have been asked to respond to a detailed service specification.

They also held focus groups drawn from the ‘Persona’ population groups following the discovery day. Again the conversation was quite different as instead of asking questions about where and when people would access services they discussed what was important to them in their lives – what made them happy, who they talk to and who is important in their lives. They found the three groups were very different in their needs with the Inform Me group being motivated to change and reacting well to self-help, whereas those in the Support Me group wanted face-to-face interaction and didn’t really trust the NHS, for example.

The outputs from the focus group and the discovery day were fed into a market warming day with potential service providers. This was a well attended event with over 30 providers from public, private and voluntary sectors – far more than would typically get engaged in more traditional procurement approaches. The questions providers were asked were deliberately open – how would they reach these people and what would they offer?

As a result, the specification for the service has been constructed differently to give more scope for working collaboratively with providers to shape and define outcomes and outputs after the contract has been awarded.

There will be an online digital service, as well as telephone and texting service to reach and support Inform Me and Enable Me individuals as well as services that reach out into specific communities providing face-to-face advice and support to those who need more support (Support Me). A targeted specialist stop smoking service has also been retained as part of the offer given strong evidence of effectiveness. High level outcomes have been included in the specification but there is a commitment to co-production with providers post award.



**The integrated lifestyle service model for Devon**

Source: Devon County Council



Links have also been made with national programmes such as the Public Health England's One You campaign which also targets people in mid-life and, through the community directory, links them to community assets such as local rambling groups.

## What impact did it have?

The tendering process closed at the beginning of April 2016 so it is too early to identify health outcomes that have been achieved. However, the approach has already been successful in attracting different providers into the marketplace and introducing a more collaborative approach to commissioning.

There has been wide interest across the council and among partners in building on the approach for other programmes. The council, in collaboration with the South West Forum made a bid to the Cabinet Office for funding to test how social value can be better embedded within the commissioning process. The funding enabled the authority to work with the South West Forum to ensure social value was a prominent narrative within the commissioning process, including being explicitly written into the service specification and tender questioning.

## What has been learned?

For the different approach to work, it has been important to be open as a commissioner, which meant letting go of the notion of being custodian of all the answers.

Putting the user at the centre was critical to setting the tone for the whole process.

Using evidence and data effectively helped shape the commissioning process. For example, data showing how few people who could benefit were accessing current services helped shift the focus to how do we engage with people who don't use services.

Mosaic data helped define characteristics of groups that providers could design services around. NICE evidence supported effectiveness of specialist stop smoking services which were retained as part of the model.

As with any new and different approach there was inevitably some nervousness about the level of risk involved. Acknowledging the challenges of taking a more radical approach and involving people early in the process helped to reduce anxiety in the system, as did having allies who bought into the approach from the start. It was also important to emphasise the risk of not changing and getting sub-optimal outcomes was actually greater than the risk of change. Involvement of the chair of the HWB and the inclusion of Healthwatch has helped to ensure leadership and support across the system.

It is important to bring the market with you. The discovery day and market-warming day helped attract providers and to bring them on a shared journey.

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# Risk-Avert – a schools-based programme to help young people build resilience and manage risk in **Essex**

Essex is a large, diverse county with a population of 1.4 million. It has 12 district/borough/city councils, two neighbouring unitary councils (Southend on Sea and Thurrock) and, before the transition of public health to councils in 2013, was served by five primary care trusts (PCTs). The move of public health into the council enabled stronger links with children's services and between drug and alcohol, sexual health and mental health commissioners. It also presented an opportunity to commission programmes across the whole county at scale.

Essex had a history of commissioning school-based programmes to address specific risks that young people may encounter, such as drugs and alcohol. These were mainly one-off programmes commissioned using small pots of money. Evidence of sustained impact was often lacking. They identified a need for a more sustainable approach that was embedded in the way that schools work and addressed the underlying reasons that led to a range of risk-taking behaviours.

## What approach was taken?

In 2013, the initial concept was submitted to the Safer Essex Partnership (the Pan Essex Community Safety Partnership) who provided set up funding. A steering group involving the Police and Crime Commissioner, the Safer Essex Partnership, public health and health partners scoped out what they wanted to achieve with the programme. They worked with the procurement team to commission a co-design partner who would work with them to create and evaluate the programme.

This was a different approach as it was about establishing a long-term partnership with a view to developing a commercially viable entity, rather than commissioning an organisation to simply deliver a short

term programme. The steering group were looking for a partner who provided the right fit, understood their vision, had the skills and experience to develop the programme and establish it as a commercial entity, and was able to work well with the council and wider partners. As this was breaking new ground, the advice of the procurement team, particularly in developing a suitable format for the tender and the subsequent contract was invaluable. The legal team have also been helpful in working through issues about intellectual property and copyright which were important to ensure that the programme retained commercial value.

The successful bidder to become a co-design partner was The Training Effect (TTE). They worked with the steering group to build an initial product that was tested in a small number of schools. The model was refined and has been rolled out across secondary schools in the county. The approach is to screen all pupils in Year 8 for their attitudes towards risk-taking. Those with high scores then take part in a six session programme delivered by teachers in the school. The teachers involved received training in delivery of the programme and will have annual refresher training. They also have access to online resources and support. Wider partners such as the Family Solutions Team (the Essex Troubled Families provider), Pupil Referral Unit and the Police School Liaison team have also been trained so they are familiar with the aims and content of the programme.

Initial set up funding for the programme came from the Safer Essex Partnership. The ongoing funding has been provided from the public health budget, with a longer term aim of making the delivery of the programme in Essex cost-neutral by selling the programme to other local authorities.

The programme has been linked to the existing Healthy Schools Programme that

already had effective links into schools across the county. This has enabled a managed roll-out of the programme over the course of two years, allowing capacity to be built slowly and minimising the need for additional marketing. Schools are represented on the steering group responsible for the ongoing management of the programme.

Given the concerns the team had about the lack of evidence of effectiveness for these types of programmes, they have placed a strong emphasis on evaluation. They have funded a PhD studentship with Essex University and have also commissioned aspects of the evaluation from two other academic partners.

## What impact has it had?

The first evaluation report from the programme shows that it was being successfully delivered in 30 secondary schools reaching around 6,000 pupils. 94 per cent of pupils felt more confident about managing risks and 74 per cent had a more positive relationship with their teacher. 86 per cent of teachers rated their improvement in knowledge of risk-taking behaviour at over eight out of 10.

Awareness of the Risk-Avert brand has developed and gained credibility amongst partners. It is now being used to link up complementary programmes such as addressing hidden harms like child sexual exploitation, a healthy relationships programme aimed at Year 8 pupils, a primary school resource pack, and resources for emotional health and wellbeing.

The programme has been sold to several other local authorities. This external income has offset 20 per cent of the programme costs in Essex already, with the ultimate aim being for the programme to be cost-neutral.

## What has been learned?

It is important to spend time with procurement colleagues so that they understand what is to be achieved across the life of the partnership

to enable them to provide the best advice on suitable vehicles for doing this. In this case, knowing that the longer term aim was to develop a commercially viable product with the partner organisation was important to the way the tender was set up. It is also important to anticipate legal issues such as copyright so that advice can be sought as early in the process as possible.

The council brings valuable contacts to the partnership that make it work, such as access to the healthy schools programme and its established links into schools, making strategic links to other interventions, as well as funding.

Academy groups within Essex have been interested in commissioning the programme for schools they operate elsewhere as they value having access to a quality, evaluated product backed up by support.

Whilst there are multiple providers who were interested in selling off the shelf training programmes for schools, there were only a small number who were interested and able to work with the council in a developmental partnership. Providers will need to become more flexible as councils increasingly look for partnership models.

Effort has had to be put in to keeping the programme at the forefront of organisations' memory to sustain momentum. Elected members and wider partners have been very supportive of the programme and this has been important to sustaining energy and commitment for the longer term.

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### **Further information**

[www.risk-avert.org](http://www.risk-avert.org)

# Commissioning a new children and young people's emotional health and wellbeing service for **Halton**

Halton is a unitary authority in the Liverpool City Region, serving a population with high levels of deprivation and poor health. It is coterminous with NHS Halton CCG and there is a long history of public health teams working collaboratively across Cheshire and Merseyside through Champs Public Health Collaborative.

Local mental health and wellbeing services followed a traditional tiered model with public health responsible for Level 1 and some level 2 services, the Local Authorities Children and Young people's team commissioning some Level 2 provision and the CCG responsible for Level 2 and 3. Services had problems with long waiting times and there was confusion in how to access the most appropriate support, with schools, for example, having only limited access to early intervention. NHS Halton CCG made the decision to recommission the level 2 CAMHS service and this was identified as an opportunity to review all the children's mental health services in the borough to develop a more integrated model which placed an emphasis on promotion, prevention and early intervention to better meet the needs of children and young people. The new model moved away from traditional levels and tiers of service towards the development of an integrated Emotional Health and Wellbeing service that worked across the continuum of need.

## What approach was taken?

The work was carried out under the remit of the Children's Trust and started in the summer of 2014. An integrated commissioning team was formed early on with input from children's services, public health and the CCG. This was critical to the success of the process as it enabled a sense of joint endeavour, working together in the best interests of the local community and getting the most out of the Halton pound.

After their early work, approval to proceed with procurement of a jointly commissioned service was given in October 2014.

Halton had already developed a specific JSNA for children and young people and this was used as the starting point to understand in more depth the differing needs across age groups. Additional work was done jointly with the neighbouring boroughs of Cheshire West and Chester and Warrington to further understand the specific needs of young people involved with the youth offending service.

There was early and continued engagement of young people in the process through engagement events with the Youth Parliament and school councils, an online survey and so on. Providers in the NHS and third sector were also actively involved in the process through a series of engagement events.

What emerged was a broad, system wide approach to children and young people's emotional and mental health and wellbeing and the development of an Emotional Health and Wellbeing Plan. The plan focused attention on getting the right help in the right place, and had an emphasis on prevention, early identification and access to services. This in turn led to a service specification that, as well as providing a targeted service for young people with high levels of need, also included a community and schools programme that had a wider reach and a strong emphasis on promoting positive mental health, prevention and early intervention.

The integrated Emotional Health and Wellbeing service specification included both school and community based social and emotional wellbeing training for front line staff (including teachers, GPs, school nurses and social care staff), specialist counselling and therapeutic interventions, the targeted youth offer provided by the council's youth service and public health early intervention and mental health awareness programmes.

In addition there was a realisation that the service needed to capitalise on new methods of engaging with young people through the provision of online resources and support, such as online counselling.

Following a comprehensive procurement process, a contract was awarded in summer 2015 to the Five Boroughs Partnership NHS Foundation Trust, (the local NHS mental health provider) working in partnership with Kooth, a third sector organisation with expertise in working with schools and providing online support to young people. As well as providing the new service, the provider was also able to integrate its existing Level 3 specialist provision into the local offer. This enabled a much wider reach than previously possible which focused on the needs of the child and operated a “no wrong front door” policy.

## What impact has it had?

The new integrated approach to working has transformed what was previously a collection of loosely affiliated commissioners and service providers into a focused and dynamic team with a true commitment to working together to improve the emotional health and wellbeing of young people in Halton. The service has been operational for less than a year and is already starting to make a real difference. Waiting times have reduced and more children are able to access help and support than ever before.

The new service has been able to facilitate professional support networks and has provided “twilight” training sessions to staff in schools to increase their awareness and confidence in mental health issues. Kooth is also developing additional in school provision as well as an innovative approach to online support.

Links have also been made with other health pathways such as that for healthy weight, enabling children with a high BMI to have specialist support including cognitive behavioural therapy, as well as self-harm and eating disorder services, crisis resolution and mindfulness.

The quality and depth of the partnership that has been built also provided a strong platform for Halton to submit a proposal for the National CAMHS Transformation Fund. They were selected as a national pilot site for the Schools Link programme, a new initiative designed to provide additional training and resources for schools and to improve the liaison with local services.

## What has been learned?

Establishing an integrated commissioning team early in the process and ensuring there was support from the Children’s Trust and elected members was critically important. The team developed a strong partnership from working together which enabled it to adapt effectively to changing circumstances. During the procurement process, the council experienced a surge in numbers of children requiring care which meant that the service specification and the funding available for the CAMHS tender had to be rapidly reviewed. The strength of the partnership meant that a difficult situation could be discussed and resolved constructively without unduly delaying the tender.

The CCG is the major funder of the service, but they utilised the council’s procurement team for the tender process as they recognised the value brought by the local knowledge and skills of the team.

Working with young people to design the service helped to develop a service which was much more geared to their needs. The positive experience from the CAMHS procurement process has meant that young people have since been more closely involved in the design and tendering process for other services, such as the new school nursing service.

Involving providers and potential third sector partners with insights into the needs of children and their families through “soft” market testing is invaluable. The best people to design a service are those who have experience of delivering services. Creating an environment where good quality co-production can thrive is a key role for the commissioner to ensure that services meet the needs and aspirations of local people.

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# Warm Homes, Healthy Homes in **Leicestershire**

Health in Leicestershire is generally better than the national average, however two indicators in the Public Health Outcomes Framework (PHOF) stand out as needing attention— fuel poverty and excess winter deaths. With elected member support, it was decided that public health should lead the development of a sustainable approach to tackling fuel poverty in the county. The council's work on affordable warmth had previously been led by adult social care using short term pots of funding that were coming to an end. The consultant in public health, who is leading the programme, came into public health with extensive experience of working on housing and fuel poverty in the voluntary sector.

## What approach was taken?

Reducing excess winter deaths had been identified as a strategic priority by the HWB, informed by the JSNA and the DPH Annual Report. NICE guidance had also been published on reducing excess winter deaths and illness. Unlike many health issues, there is not a strong link between deprivation and excess winter death, and in Leicestershire many older people live in large, difficult to heat homes.

External funding sources had come to an end and so £100,000 of public health funding was identified to support the programme. The public health team worked with colleagues in adult social care and housing colleagues based in district councils to develop a healthy housing referral service. The service was put out to tender and awarded to the Papworth Trust in partnership with National Energy Action (NEA), the national fuel poverty charity. The initial programme provided a range of routes of referral into the service, including via First Contact Plus, the council's referral hub for a range of services. The team at Papworth Trust provided basic energy advice and more complex cases were referred onto a caseworker. In many cases, people were able to afford to pay for improvements but needed advice to identify what needed doing

and on reliable tradespeople. The team have also provided awareness and training for professionals working with vulnerable people to help them identify who would benefit from a referral into the service.

They have also now embedded the scheme into the Lightbulb Project, which is funded by DCLG Transformation Funding, and is working to integrate the various housing support services provided by the county and the seven district councils into a coherent offer that is easier for residents to understand.

Funding for housing energy efficiency improvements now largely comes via energy companies and is not targeted at the most vulnerable. A key development of the scheme has been securing funding from the National Energy Action (NEA) Warm Homes Partnership Fund matched by the Better Care Fund (BCF) that is enabling physical measures, such as new boilers or insulation, to be installed for over 150 of the most vulnerable households. They are identified by risk stratification using housing, social care, GP and hospital discharge data and then contacted directly with an offer of advice and support. Evaluation to demonstrate impact on health and social care use is important to see if the scheme warrants the allocation of local funding to sustain and expand it.

## What impact has it had?

The move to the council has enabled public health to build closer links with adult social care and housing colleagues which have been essential to getting the scheme running effectively and making links between services. The team have also maintained good links to the NHS and are in a better position to influence change across the whole system.

Being able to work as a team across public health, adult social care, housing and procurement was a real strength. The public health team brought experience of working on fuel poverty, understanding of the evidence

for what works, a picture of local needs and their NHS links to the team. Adult social care brought their learning from running affordable warmth programmes and direct links with vulnerable residents and housing were able to link up other programmes through the Lightbulb Project to increase the impact. The advice of the procurement during the tender process on documentation, timescales and evaluation of the tenders was invaluable.

The approach being taken in Leicestershire to housing support is now more coherent and affordable warmth is embedded in this and is seen as a key component of BCF work.

## Case Study

Miss Q who lives alone in a two bedroom bungalow had been without suitable heating or hot water for two years as her boiler had developed a fault and she could not afford the upfront cost of repairs. A Resident Support Officer from her local authority referred her via the Leicestershire First Contact service (a referral pathway for participating organisations to put people in touch with relevant services).

Papworth Trust contacted Miss Q and arranged a home energy advice visit to see what help could potentially be available. As Miss Q has mobility and mental health conditions, the benefits she received qualified her for funding that Papworth Trust hold on behalf of the Foundations Independent Living Trust. Papworth Trust was able to apply to the SSE Warm at Home Fund and Gas Safety Charity funding to cover the majority of the cost of the works to repair the boiler using a local contractor.

It was also identified that Miss Q was eligible for the Warm Homes Discount (£140 credited to her electric account) and an application was submitted over the phone by contacting her supplier. At this time she was also added to the Priority Services Register as she keeps medication in the fridge which could be affected by a power cut.

Additionally her supplier was able to

change her to a more competitive tariff, fixed for a longer period of time saving her approximately £96 over the course of the year. Meter readings were also submitted to ensure she was not paying more than necessary.

## What has been learned?

Working across two tiers of local government is complex but the challenges this creates can be overcome through building good relationships, having clear goals and the right attitude to working together. Good governance structures and processes help with this. Having a strong partnership with clear goals helped Leicestershire to secure external funding to expand the project as they could demonstrate to funders that they knew how to use the funding effectively.

Planning for the whole pathway from identification to the provision of support is important. Once funding was secured for physical improvements the programme was able to have a bigger impact.

Evaluation is important to making the case for sustainability and expansion of test programmes. Case studies are useful alongside the numbers for making evaluation more real.

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### Further information





# Drink Less Enjoy More – an alcohol licensing intervention in **Liverpool**

As part of its strategic approach to tackling alcohol-related harm in the city, Liverpool City Safe Partnership developed an intervention aiming to address the culture of drunkenness in the city centre at night and reduce levels of intoxication. It centred on increasing awareness and enforcement of the Licensing Act 2003 which created an offence of serving or buying alcohol for someone who is drunk. Evidence from Stockholm suggested it was possible to have a significant impact by implementing a multi-component intervention including public communications, police enforcement and bar staff training.

## What approach was taken?

The City Safe Partnership worked with Liverpool City Council Public Health team and Liverpool CCG to fund and trial a campaign Say No to Drunks in 2014. This mainly focused on training bar staff, and to a lesser extent police enforcement. Evaluation showed limited impact and made recommendations for an accompanying public communications campaign and for more proactive police enforcement.

Behavioural insight work was commissioned to identify the target audiences for the public communications work. This identified four groups of people who were at the greatest risk of alcohol-related harm: the Chardonnay socialite, ritual relaxer, drinkers in denial and balanced bingers. Balanced bingers were the group who mainly drank heavily at weekends as part of their night out and were selected as the target audience for the design of the intervention.

The group was made up mainly of 18 to 30 year olds coming into the city on stag and hen dos from the Liverpool City Region and students. Their main aim was enjoyment with friends, which far outweighed any health concerns – hence the change of name of campaign to Drink Less Enjoy More. The core

message was that drunks won't get served in the city and they and their friends could have their night out cut short. Campaign messages were tested with the target audience and the campaign was designed around the lead up to the night out and the journey into the city centre. It included radio adverts, adverts in off licences, on public transport, at arrival stations and on walking routes to the pubs and clubs. There was a social media campaign and support from the local press.

The police sent letters to all bars in the city centre alerting them to the campaign and advising that they would be actively enforcing the Licensing Act legislation. Bar staff were trained about the legislation and how to refuse to serve a drunk customer by Trading Standards staff. The campaign ran during November 2015.

An independent evaluation of the campaign was commissioned from Liverpool John Moores University.

## What impact has it had?

The intervention has been independently evaluated by Liverpool John Moores University (LJMU). They used a validated Actor Study Research Tool, where actors mimic severe drunkenness whilst attempting to be served, to test whether bar staff would serve alcohol. The work replicated the methodology used in a previous LJMU national study in 2013. In 2013, 84 per cent of attempted purchases were successful, compared with only 26 per cent after the intervention in November 2015. The same method was also used in a survey in another large city in October 2015, where there was little movement from the 2013 national figure of 84 per cent.

A survey of night life users before the intervention showed that over 70 per cent of participants: expected their level of drunkenness to be high when they left the

city's nightlife that night; reported their ideal level of drunkenness as high; thought that the typical level of drunkenness that people reach on a night out in the city centre was high; and believed that getting drunk was socially accepted in Liverpool's nightlife.

A survey after the intervention showed an increase from 45 per cent to 66 per cent awareness that it is illegal to serve someone who is drunk, from 35 per cent to 55 per cent that it is illegal to buy alcohol for someone who is drunk and a reduction from 63 per cent to 51 per cent in those thinking that bar staff don't care if customers are drunk.

Bar staff were also surveyed after the intervention. 81 per cent would not serve alcohol to someone who was drunk and 93 per cent felt confident to refuse to serve someone. 55 per cent of the staff surveyed were aware of the campaign and of these over 70 per cent said they were less likely to serve someone and that the intervention had helped them to refuse.

Early analysis of NHS data shows a promising positive impact on A&E attendances and alcohol-related hospital admissions.

## What has been learned?

Evaluation is critical. The learning from the initial Say No to Drunks campaign led to significant changes to the follow up campaign such as active police enforcement and using behavioural insights to identify the target audience and design the campaign around them. Demonstrating the positive impact of the redesigned campaign has been essential to sustain the engagement of partners, the impact of the programme and to secure funding for future work.

Assessment of the return on investment through savings to police and NHS costs is particularly important to make the case for future funding.

The programme has increased the visibility of public health with a wide range of partners and has demonstrated how public health knowledge and skills in understanding population need and evaluation can help to solve some of the complex issues facing the system.

Whilst this has been a successful campaign, it is only one component of a wider strategy that has been developed in the city covering five priority areas – prevention and early intervention, treatment and recovery, community safety, protection and licensing and enforcement.

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### Further information

The campaign website at  
[www.drinklessenjoymore.co.uk](http://www.drinklessenjoymore.co.uk)

Evaluation of the Drink Less Enjoy More intervention at  
[www.researchonline.ljmu.ac.uk/3175/](http://www.researchonline.ljmu.ac.uk/3175/)



# The **London** Sexual Health Transformation Programme

The London Sexual Health Transformation programme was established to deliver a new collaborative commissioning model for sexual health genitourinary medicine (GUM) services.

The aim of the programme is clear: through working together councils will benefit patients and the public by delivering measurably improved and cost effective public health outcomes.

There was awareness that some change was necessary. London Councils currently spend in excess of £100 million per annum on GUM services. The ongoing increases in the size of the population, London's demographic profile and the trend of increasing rates of sexually transmitted diseases (STIs) has meant that expenditure on these services has increased year on year. Services are provided on an open access basis with service users from across London often travelling into central London to use services. The patterns of service use cross the boundaries between boroughs making collaboration on the redesign of the service essential.

Rather than simply looking to cut or top slice budgets the project was set up to transform the service model to meet demand, improve public health outcomes, ensure services are sustainable and deliver better value.

## What approach was taken?

There are three strands to the programme:

Moving away from a traditional pricing model to an integrated tariff. This will allow for greater flexibility and ensure services are paid for appropriately.

Smaller partnerships of boroughs in sub regions are working together to procure the most effective face-to-face provision for their area.

Creating a “channel shift”: for some people there is no need to attend a clinic. They can be tested at home and receive the advice and support they need. This frees up clinic time for those with a greater need.

The collaborative approach across London has already resulted in significant cost containment in the face of increasing activity. Collaborating boroughs have agreed a new model of service for London and the programme is on track to have procured an e-service for asymptomatic patients to commence in April 2017. This pan-London portal will signpost patients to the most appropriate place to receive services. For some people, where it is clinically right, this might be a home testing kit which can be sent directly to them. The commissioners are hoping it may also be possible for the portal to be used as a booking tool for those who need to attend a clinic.

This work, accompanied by a collaborative approach to managing system capacity, will ensure that boroughs can continue to meet their statutory duties to deliver open access sexual health services in a way that is cost effective and sustainable in light of continued pressures on local government funding.

The programme has also invested time in engaging with the market through two separate Prior Information Notices (PINs) to test out providers and potential provider views on how services could be transformed and delivered.

Significant engagement work was undertaken with the clinical workforce in London. This included three half day events attended by all providers and eight focus groups set up to explore key issues in further detail. These focus groups covered primary care, clinical governance, self-care, the role of technology, partner notification and service integration.

Regular briefings have been circulated to Public Health England, NHS England, the British Association for Sexual Health and HIV, the Faculty of Sexual and Reproductive Health and the Association of Health Advisors.

A waiting room survey was undertaken with patients in 10 GUM services across both inner and outer London. There were approximately 1,500 respondents to the survey which was analysed and results shared on a commissioner and provider basis with all collaborating councils. This was followed up by four targeted focus groups of black and minority ethnic (BME) people and men who have sex with men (MSM). A Survey Monkey questionnaire closed in March which sought views from patients and residents in London on the future shape of sexual health services. Over 2,000 responses were received. Initial analysis shows that there is a commonality of theme in the responses to the comments made in the waiting room survey and focus groups. Further focus groups are planned with users of self-sampling services to support deeper understanding of the profile of patients who find this form of service acceptable and to support the development of the service specifications.

All of the feedback, from providers, commissioners, patients and the public has been used throughout to challenge, test and nuance the model being considered. In addition, a procurement with negotiation process will be used to allow for further innovation to be suggested by providers.

Monthly briefings are circulated to all stakeholders, with core group members meeting with a wide range of people and organisations at national level to ensure all views are taken on board and to develop wide support for the work of the programme. Additional regular briefings have been offered to the chief executives London Councils group and its health sub group, the Society of London Treasurers, Council Finance and Procurement Leads.

A briefing for members has been arranged via London Councils.

Dr Andrew Howe the DPH for Harrow and Barnet is the director of the programme. He said, "Working with 32 boroughs with their own decision making structure and local circumstances has been challenging. But there has been huge commitment to what the programme is trying to achieve and a clear recognition that things do need to change for the benefit of patients. So I am very pleased with the progress that has been made. There is still a long way to go but as the procurement phase commences I am very confident that the programme will deliver improved outcomes and a new patient centred and cost effective service for London."

## What has been learned?

It is important to build networks and engagement from as early on in the programme as you can. This programme is working across 32 boroughs. As each borough has its own decision making structure and political agenda, it can take some time to work through all of these to achieve consensus. Ongoing communication and engagement throughout the process is vital to maintain commitment and momentum.

The key lesson regarding providers is to recognise their expertise and commitment to patients and use this to help shape the agenda. London Councils have found providers to be thoughtful and innovative in their response to this programme.

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**Further information** is available on the website for the London Sexual Health Transformation Programme at <http://www.westlondonalliance.org/wla/wlanew.nsf/pages/WLA-385>



# Commissioning a latent TB screening service for **Wolverhampton**

Cases of Tuberculosis (TB) have been increasing in recent years, with around 7,000 new cases now being diagnosed each year in England. Wolverhampton has a high rate with 29.1 new cases per 100,000 population compared with 13.5 per 100,000 nationally.

A national collaborative TB strategy was produced in 2015 which identified screening of new entrants from high incidence areas for latent TB as one of its priority actions. The rationale behind this is that evidence suggests three out of four people with active TB were born abroad, and the majority of these cases are due to reactivation of latent TB infection. People with latent TB infection do not have symptoms, but can be identified through screening and successfully treated. This prevents them developing active illness and from passing the infection on to others.

Through their work to assess the health needs of refugees and migrants, done in partnership with the Refugee and Migrant Centre (RMC), the City of Wolverhampton Council public health team had also identified latent TB as an important local issue. They were keen to build on the work with the RMC and worked with their local CCG and TB nursing service to run a pilot project to test the feasibility of screening at the RMC. They have subsequently worked with their colleagues in Walsall, supported by West Midlands TB Control Board, NHS England and PHE, to develop a plan to further this work which is in part financed by national funding earmarked for the implementation of the national strategy.

## What approach was taken?

The RMC was chosen to pilot a screening programme for latent TB. They support around 2,500 new migrants a year from across the Black Country, providing them with a holistic service to help them find housing, employment and access health care. They are centrally located and had established trust

with the clients. Many come from countries that have a high prevalence of latent TB and a high proportion are not registered with a GP when they first attend.

The pilot programme required a partnership approach with the RMC identifying clients and providing premises, interpreters and follow up support, the local TB team providing assessment and treatment, a phlebotomist taking blood samples, Oxford Immunotec providing tests and the public health team coordinating and evaluating the programme.

As one of its priority areas detailed in the national TB strategy, national funding became available via NHS England to support the development of screening programmes for latent TB. A collaborative bid was submitted by Wolverhampton and Walsall Public Health, based on the learning from the local pilot. The national model indicated delivery through primary care, and although the local model centered on the RMC had already demonstrated this would work effectively, the process to secure national funding to roll-out this model, including a contract variation with local providers to deliver the service, was complex, time-consuming and difficult to navigate. These issues have now largely been resolved and progress to roll out this service model is back on track.

## What impact has it had?

The pilot project was run in February and March 2015, and offered testing to 100 high risk people. In the group that were tested there was a 33 per cent positive rate for TB. In addition one person with HIV was identified. 97 per cent of the people who tested positive completed their treatment. This is exceptionally high for a group of people who feel well and have to continue with treatment for several months. The RMC staff played a vital role in keeping people engaged with their treatment by providing follow up support.

Health problems such as TB can be difficult to get prioritised, partly because they represent a small part of health service workload. The work done on migrant health needs assessment and on the development of this programme has increased the understanding and interest in the needs of migrants amongst local partners. This has led to the development of an enhanced primary care service to ensure that migrants are registered with GPs and have a new patient health check appropriate to their needs. It has also strengthened the links between the public health team and the housing and homelessness team who provided a key link into the RMC.

## What has been learned?

Tackling an issue like TB takes a whole system collaborative approach. This model has depended on strong and sustained local collaboration between commissioners and providers, with support from the PHE local centre to facilitate the links with NHS England and the national PHE team. The PHE centre's team experience of working with local authorities on health protection issues was particularly important. In designing national programmes, it is important for sufficient flexibility to be built in to allow the most effective model to be implemented at local level.

In this case, Wolverhampton had already identified that many of their migrant population were not registered with GPs and so a model based solely on primary care would not pick up those at highest risk. It is helpful for national bodies to develop model specifications based on the best evidence as this saves duplication of effort and ensures that local areas benefit from specialist expertise. However these need to be adapted to local circumstances to ensure optimal delivery.

It is important that data collected from the initial screening process can be passed on to primary care and TB treatment services in a timely and secure manner. The sharing of data has been a significant issue in the development of this programme. Securing data-sharing agreements nationally would

save duplication and delay at local level.

When developing a screening programme, the whole treatment pathway needs to be worked through. For instance, the active role played by staff at the RMC contributed to the high treatment completion rates achieved in a group of people who were new to the area and not accessing other services. This was supplemented by the local TB team conducting additional bespoke clinics and offering translation services. The number of new cases identified resulted in an increased workload for the TB nursing team which they could not readily absorb within their existing resources. Limitations placed on national funding meant that the local team had to negotiate and influence the system in order to use the funding where it felt it would have the most impact.

It is important to have certainty of funding over a realistic time period to commission programmes effectively – the short term nature of national funding makes it more difficult to roll out local programmes.

Collaborative working increases the complexity of relationships but it also brings opportunity through sharing skills and capacity. It makes a steering group and planning with all partners represented critical to keeping the programme on track.

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### Further information

Collaborative TB strategy for England 2015  
to 2020

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/396265/TB\\_infographic\\_16\\_jan\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396265/TB_infographic_16_jan_2015.pdf)

# Links to useful resources

## General guidance on commissioning

### **Commissioning Academy**

Commissioning Academy development programme

<https://www.gov.uk/government/publications/the-commissioning-academy-brochure>

The Commissioning Academy Framework document: this document summarises the definitions and approach taken by the Cabinet Office Commissioning Academy to commissioning.

<https://www.gov.uk/government/publications/the-commissioning-academy-framework-document>

## Local Government Association

LGA Commissioning for Better Public Services: provides useful background to commissioning approaches – what it is and isn't and how to get the best out of it.

[http://www.local.gov.uk/c/document\\_library/get\\_file?uuid=3e20c466-923c-4eb6-997b-1f493b7b7d4c&groupId=10180](http://www.local.gov.uk/c/document_library/get_file?uuid=3e20c466-923c-4eb6-997b-1f493b7b7d4c&groupId=10180)

### **LGA Commissioning guidance page**

<http://www.local.gov.uk/procurement-commissioning>

### **LGA procurement guidance page**

<http://www.local.gov.uk/web/lg-procurement>

## LGA resources on integrated commissioning and health

### **Guidance on commissioning for better health**

<http://www.local.gov.uk/documents/10180/5756320/Commissioning+for+Better+Outcomes+A+route+map>

### **Who is responsible for commissioning what in health services?**

One of the criticisms of the health system post-2013 is that the commissioning system is fragmented and confused. This document sets out the respective commissioning responsibilities of councils, CCGs and NHSE. Many of the commissioning responsibilities are linked, meaning good collaborative working across local systems is essential.

<https://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf>

### **Intelligence about public health outcomes**

This site provides the Public Health Outcomes Framework data and more in depth data profiles for specific health priorities. It enables comparison of local data with national, regional and comparator local authorities. Some data is available below local authority level. It is easy to navigate and data is kept up to date.

<http://fingertips.phe.org.uk/>

## Health economics

An informative series of blogs from Brian Ferguson, Chief Economist at PHE, setting out the strong economic case for investment in prevention

<https://publichealthmatters.blog.gov.uk/author/brian-ferguson/>

A WHO document making the case for investing in public health that provides a useful summary of interventions that provide a return on investment and those which are cost-effective.

[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/278073/Case-Investing-Public-Health.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf?ua=1)

## Social value

This blog from PHE gives a useful overview of the potential for councils to achieve better outcomes through effective use of the Social Value Act and provides a link to a PHE resource to support councils.

<https://publichealthmatters.blog.gov.uk/2016/03/30/the-social-value-act-helping-commissioners-improve-health-and-reduce-inequalities-in-local-areas/>

## Guidance on specific health topics

The key organisations providing guidance on specific health topics are the Local Government Association, the National Institute for Health and Care Excellence (NICE) and Public Health England.

### Local Government Association

The LGA produces reports on a wide range of topics relevant to commissioning for better health. Many of these contain case studies from local authorities. They are all available on the publications page of the LGA website:

<http://www.local.gov.uk/publications>

Examples from recent months are below:

Public health transformation three years on: extending influence to promote health and wellbeing

[http://www.local.gov.uk/web/guest/publications/-/journal\\_content/56/10180/7660767/PUBLICATION](http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7660767/PUBLICATION)

Good progress but more to do: teenage pregnancy and young parents

[http://www.local.gov.uk/web/guest/publications/-/journal\\_content/56/10180/7661314/PUBLICATION](http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7661314/PUBLICATION)

## Behavioural insights and health

[http://www.local.gov.uk/web/guest/publications/-/journal\\_content/56/10180/7659108/PUBLICATION](http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7659108/PUBLICATION)

Healthy Beginnings: Giving our children the best start in life

[http://www.local.gov.uk/web/guest/publications/-/journal\\_content/56/10180/7561302/PUBLICATION](http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7561302/PUBLICATION)

Prevention: a shared commitment

[http://www.local.gov.uk/web/guest/publications/-/journal\\_content/56/10180/7527623/PUBLICATION](http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7527623/PUBLICATION)

## National Institute for Health and Care Excellence (NICE)

NICE produces evidence-based guidance on public health issues together with pathways and quality standards where these are appropriate. The range of topics covered is increasingly comprehensive, with recent topics including community engagement, workplace health, skin cancer prevention and older people's independence and wellbeing, for example.

The index to public health guidance can be found at:

<https://www.nice.org.uk/guidance/published?type=ph>



# Public Health England

## Dental public health

<https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

## Health inequalities

This PHE webpage provides a series of evidence summaries and briefing papers on tackling key issues impacting on health inequalities that local authorities have responsibility for such as employment, housing, green spaces and young people's resilience.

<https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers>

## Healthy Child 0-19

<https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning>

## NHS Healthchecks

PHE and NHSE have developed a comprehensive webpage to support commissioning and provision of NHS healthchecks. It also includes information about the diabetes prevention programme.

<http://www.healthcheck.nhs.uk/>

## Obesity

PHE has a webpage that brings together a comprehensive range of resources to support commissioning to tackle obesity. This includes access to data and all the relevant NICE guidance.

<https://www.noo.org.uk/>

## Physical activity

PHE resources to support the implementation of Everybody Active, Everyday including evidence reviews for what works in local physical activity interventions.

<https://www.gov.uk/government/publications/everybody-active-every-day-a-framework-to-embed-physical-activity-into-daily-life>

## Sexual health

<https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services>

## Tobacco control

A self assessment tool that local authorities can use to assess their local system for tobacco control to inform their commissioning approach.

<https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment>

## TB

Joint PHE and NHSE guidance on commissioning for TB services.

<https://www.england.nhs.uk/wp-content/uploads/2015/07/coll-tb-com-strat-guidance.pdf>

## Other sources of guidance

The Kings Fund have produced several relevant reports that can be found at:

[www.kingsfund.org.uk](http://www.kingsfund.org.uk)

A particularly good resource on effective interventions to tackle the wider determinants of health is:

<http://www.kingsfund.org.uk/publications/improving-publics-health>

The Faculty of Public Health also produce useful guidance on specific topics that can be found at:

[www.fph.org.uk](http://www.fph.org.uk)

Their resource on public mental health is one of the most comprehensive available

[http://www.fph.org.uk/better\\_mental\\_health\\_for\\_all](http://www.fph.org.uk/better_mental_health_for_all)

The Public Services Transformation Network has local government case studies of commissioning:

<http://publicservicetransformation.org/resources/commissioning/better-commissioning-public-services>

The Health Foundation has published several reports on commissioning:

<http://www.health.org.uk/publication/need-nurture-outcomes-based-commissioning-nhs>





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