The Public Health Landscape in England

A guide for the activity, sport and recreation sector

SPORT+ RECREATION ALLIANCE

UK active More people More active More often

Abbreviations

CCG	Clinical Commissioning Group
DPH	Director of Public Health
GP	General Practitioner
GPPAQ	General Practice Physical Activity Questionnaire
JSNA	Joint Strategic Needs Assessment
JHWS	Joint Health and Wellbeing Strategy
LGA	Local Government Association
NHS	National Health Service
NHSCB	NHS Commissioning Board
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
QOF	Quality and Outcomes Framework

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Foreword

On 1 April 2013 the statutory reforms outlined in the Health and Social Care Bill finally came into full effect. Six months on, it is clear that these changes have fundamentally altered the way in which the healthcare system operates and for the first time guaranteed that public health funding will be ring-fenced.

A strong focus on prevention, early intervention and behavioural change is necessary to stem the growing financial and societal costs associated with the increase in lifestyle-related chronic conditions. It is critical that we adopt a preventative strategy in order to ensure that the NHS remains free at the point of use for future generations.

The evidence for the effectiveness of physical activity in tackling some of the nation's most pressing health concerns is well established. Exercise, sport and day-to-day physical activity can be instrumental in the prevention and management of a wide range of increasingly prevalent conditions including diabetes, cancer, coronary heart disease, obesity, stroke, musculoskeletal conditions and mental health.

We know that over two-thirds of the population are not currently meeting the recommended levels of physical activity.

The Chief Medical Officers in all four home countries have made it clear that physical activity can reduce the prevalence of such conditions by up to 50%, yet we know that over two-thirds of the population are not currently meeting the recommended levels of physical activity. The Lancet refers to an "inactivity pandemic" with physical inactivity being the fourth leading cause of death worldwide.

The sport and activity sectors have a crucial role to play in increasing levels of activity and, in doing so, alleviating the burden associated with lifestyle-related chronic conditions. Our presence in local communities is vital to redressing this rise in chronic disease and the increasing health inequalities associated with inactivity and sedentary behaviour. The facilities, resources and expertise of our sectors, as well as the passion and dedication of our coaches, trainers and exercise professionals to improve the health and wellbeing of millions of people every day is unquestionable.

At times our methods will have to adapt and our approach will need to be tailored to the needs of previously inactive and sedentary populations. This may require counselling interventions and tying into the work of primary care physicians, allied healthcare professionals and various patients groups. We must continue to support people and communities to help them to become more active.

This paper has been jointly published by ukactive and the Sport and Recreation Alliance to ensure that all of our respective members are fully informed about the structures which form the new public health landscape. It should be supplemented by additional support and guidance and needs to be read in conjunction with other useful resources produced by the Department of Health, Public Health England, the Local Government Association, the National Institute for Health and Care Excellence and others, as well as the guidance and direction of local officials, directors of public health and Health and Wellbeing Boards.

Such additional documents might include the Chartered Society of Physiotherapist guidelines, the Royal College of Physicians reports, the ukactive Research Institute's publications, the Sport and Recreation Alliance's ***Game of Life*** report and the Joint Consultative Forum's new set of ***Professional and Operational Standards for Exercise Referral***.

The paper marks the beginning of a broad partnership between our two organisations which we hope will help us achieve our shared objective of increasing participation in physical activity and sport, with the ultimate aim of improving the health and wellbeing of communities across the country.

David Stalker
CEO, ukactive

Tim Lamb
Chief Executive, Sport and Recreation Alliance

1

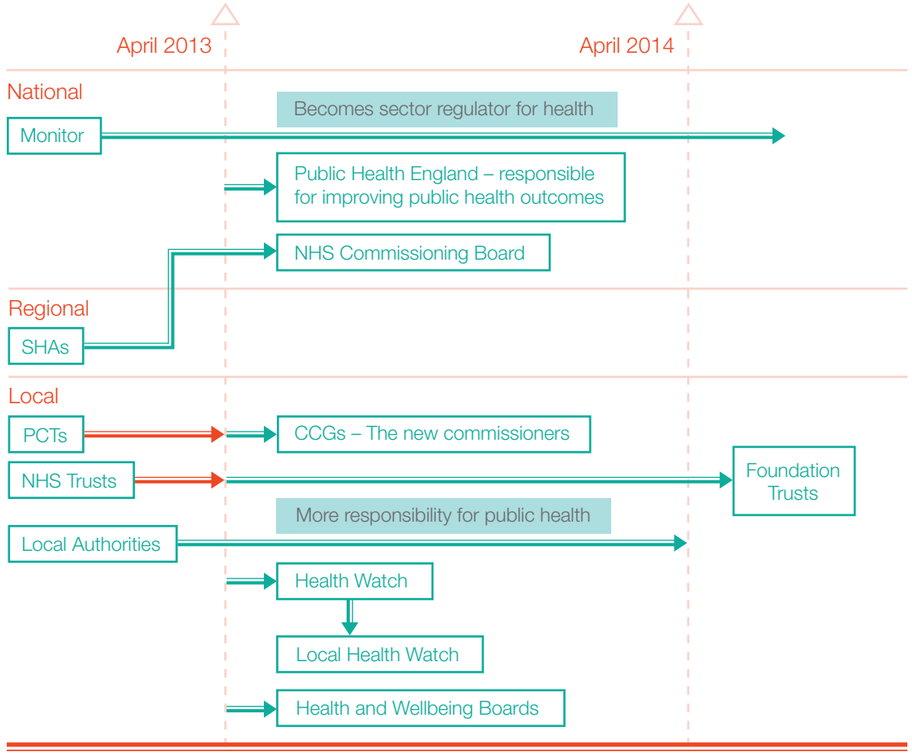
Public health structure

The Health and Social Care Act 2012 represents one of the most radical shake-ups of the NHS ever seen, setting out a major programme of reforms to restructure healthcare services and reallocate public health responsibilities.

The new system, which became fully operational on 1 April 2013, focuses more on prevention and on empowering local communities to plan services according to their local priorities. This will be led by local authorities who are now directly responsible for the health of their local populations and receive ring-fenced funding accordingly. Changes will be led by doctors, nurses and other health and care professionals working with local authorities, local directors of public health and local service providers. The diagram below sketches out these reforms in short.

When the reforms took effect around 4,500 people transferred to local authorities including public health consultants, public health commissioners, health promotion specialists, public health knowledge and intelligence staff and others. This paper summarises the wide-ranging NHS reforms and outlines the function and structure of the relevant bodies within the public health landscape.

Reform of the NHS Structures



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Local authorities

Upper tier and unitary local authorities in England have a responsibility to improve the health of their populations and have each received a share of a two-year ring-fenced budget of £5.45bn to spend on public health services.

This constitutes £2.66bn (2013-14) and £2.79bn (2014-15). Through this funding they will drive local commissioning of healthcare, social care and public health and are expected to create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as education provision will also be addressed.

The level of funding that local authorities receive will be dependent on their performance to produce improvements in local health and wellbeing.

2. Local authorities

Local authorities are expected to champion health and wellbeing by promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to drive improved health outcomes. They play a central role across the three domains of public health (health improvement, health protection and health services) and, in addition, have functions to ensure that NHS commissioners are provided with public health advice.

Local authorities have legal power to review and scrutinise any matter relating to the planning, provision and operation of the health service (including public health) in its area. This enables scrutiny of the quality of services provided locally (and proposals put forward for significant changes to those services) such as reorganising stroke care in an area and other linked services such as education, housing, social care, transport and leisure.

They are also supported by an executive agency, Public Health England, and will be guided by the Public Health Outcomes Framework. The level of funding that local authorities receive will be dependent on their performance to produce improvements in local health and wellbeing. This will be measured by the current Public Health Outcomes Framework of which physical activity is one of 66 measurements.

Each local authority has a Director of Public Health who is responsible for exercising public health functions and will be expected to publish an annual report that evaluates overall performance. They will contribute to revising the local annual Joint Strategic Needs Assessment (JSNA or Assessment) and develop the annual Joint Health and Wellbeing Strategy (JHWS or Strategy) with local partners including GP practices and Clinical Commissioning Groups (CCGs) with a jointly-agreed and locally determined set of priorities on which to base their commissioning plans. They will work with CCGs and other healthcare providers through statutory Health and Wellbeing Boards (HWBs or Boards).

Each local authority is required by statute to:

- appoint a Director of Public Health
- establish a local health and wellbeing board
- undertake a review of their commissioning intentions for the upcoming year
- develop a JSNA based on the needs of their local population
- develop a JHWS through a performance management framework.

The Local Government Association will support local authorities to secure improvement and address poor performance. Public Health England will not performance manage local authorities but will partner the LGA in taking forward effective sector-led improvement.

The main priorities for public health improvement include smoking cessation, reducing alcohol consumption, healthy eating and importantly increasing physical activity levels.

3

Joint Strategic Needs Assessments

Joint Strategic Needs Assessments are assessments of the current and future health and social care needs of a local community. They are produced annually by HWBs and are unique to each local area.

The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of local needs and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing in that locality.

The policy intention is for HWBs to consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes

The responsibility falls on the board as a whole and so success will depend upon all members working together throughout the process.

and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.

Nevertheless a range of quantitative and qualitative evidence should be used in JSNAs. There are a number of data sources and tools that HWBs may find useful for obtaining quantitative data. Qualitative information can be gained via a number of avenues, including views collected by the local Healthwatch organisation – which represents the interests of patients – or by local voluntary sector organisations, feedback given to local providers by service users and views fed in as part of community participation within the JSNA and JHWS process.

JSNAs can also be informed by more detailed local needs assessments such as at a district or ward level; looking at specific groups (such as those likely to have poor health outcomes); or on wider issues that affect health such as employment, crime, community safety, transport, planning or housing. Evidence of service outcomes collected where possible from local commissioners, providers or service users could also inform JSNAs.

Local authorities and CCGs have equal and joint duties to prepare JSNAs and JHWSs through the Boards of which they are part. The responsibility falls on the board as a whole and so success will depend upon all members working together throughout the process. Two or more HWBs could choose to work together to produce Assessments and Strategies, covering their combined geographical area. Some Boards may find it helpful to collaborate with neighbouring areas where they share common problems as this can prove to be more cost effective than working in isolation.

Local authorities and HWBs can decide to include additional members on the board beyond the required members including experts from charity and voluntary sectors. Membership of the board is not the only way to be involved in or influence JSNAs and JHWSs – HWBs will need to work with a wide range of local partners and the community beyond their small membership.

Working with local partners will allow Boards to undertake a thorough and broad assessment of local needs by using the evidence and expertise that these partners can provide and allow an opportunity to influence the work of these partners to support addressing the identified needs.

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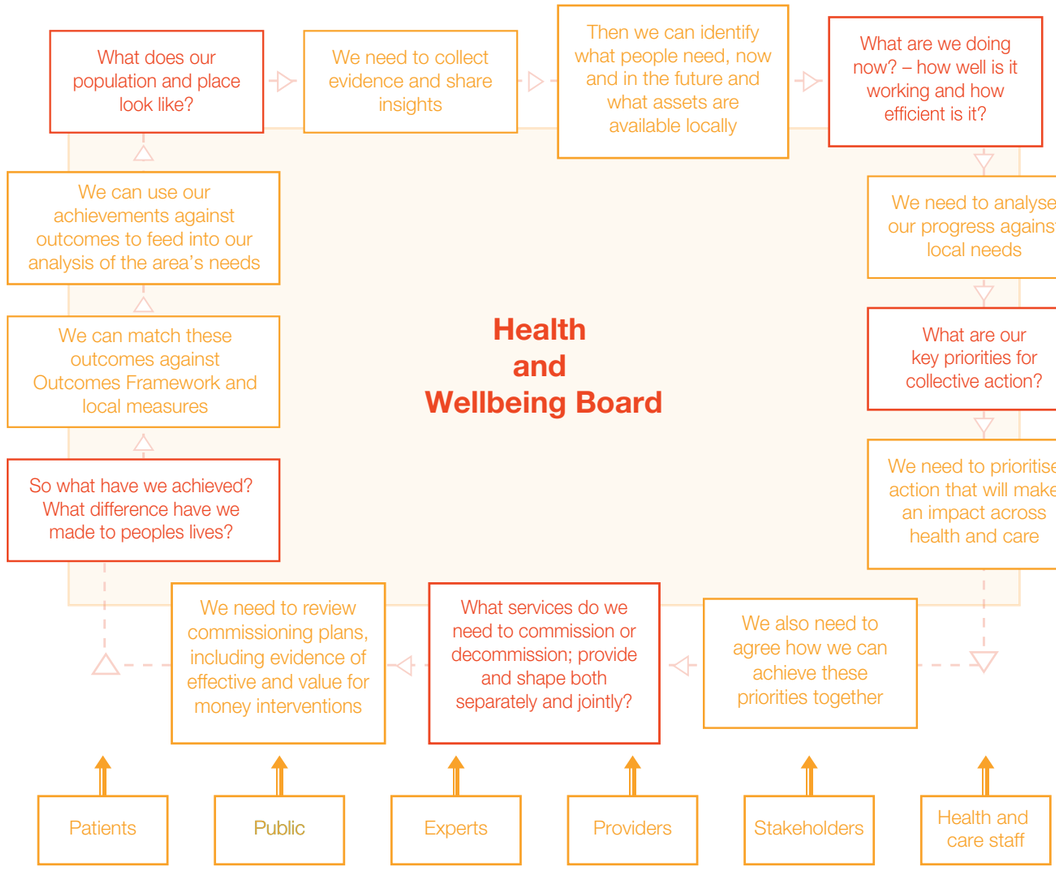
Joint Health and Wellbeing Strategies

The Joint Health and Wellbeing Strategy is the mechanism for local authorities and CCGs to address the needs identified in Joint Strategic Needs Assessments.

It aims to jointly agree what the greatest issues are for the local community based on evidence collated for Assessments, outline what can be done to address them and form what outcomes are intended to be achieved. By agreeing joint local priorities in JHWSs to inform joint action to tackle these needs, HWBs will be able to lead action to improving people's lives, integrate services and reduce inequalities. To support HWBs in undertaking Assessments and developing Strategies, supportive resources have been published on the LGA Knowledge Hub.

JSNA and JHWS: explicit link from evidence to service planning



Involving partners and the community ensures transparency and accountability

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Public Health Outcomes Framework

All local authorities have received a ring-fenced budget that will be spent exclusively on public health services and are able to choose how they spend it according to the needs of their population.

To make sure that progress is made on issues like childhood obesity and physical inactivity, Public Health England has set a series of outcomes to measure whether people's health actually improves.

The performance of each local authority and HWB will be measured against the Public Health Outcomes Framework which comprises 66 indicators including physical activity.

Key facts

- The 353 councils in England will share a ring-fenced budget of around £5.45bn over two years.
- There are 66 indicators on the Public Health Outcomes Framework which includes physical activity.
- Other indicators include:
  - sickness absence rate
  - excess weight in 4-5 and 10-11 year olds
  - excess weight in adults
  - recorded diabetes
  - falls and fall injuries in the over 65s, mortality from causes considered preventable (cardiovascular diseases, stroke, cancer etc.)
  - health-related quality of life for older people.
- Local authorities will be paid a new health premium for the progress they make against the public health indicators. The framework concentrates on two high-level outcomes to be achieved across the public health system.
  These are:
  - increased healthy life expectancy
  - reduced differences in life expectancy and healthy life expectancy between communities.
- The outcomes reflect a focus on both how long people live and on how well they live at all stages of life. The second outcome particularly focuses attention on reducing health inequalities between people, communities and areas.

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Physical activity outcomes

The indicator definition of physical activity as defined in the Public Health Outcomes Framework is the:

- Proportion of adults (16+) achieving at least 150 minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more.
- Proportion of adults (16+) classified as “inactive” that do less than 30 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more.

*They are based on the Chief Medical Officers’ recommendations and report **“Start Active, Stay Active”** (2011).*

7

Health and Wellbeing Boards

Health and Wellbeing Boards have been established by local authorities to bring locally elected councillors together with key healthcare commissioners including representatives from Clinical Commissioning Groups, directors of public health and local providers.

Each top tier and unitary authority has its own board with board members collaborating to understand their local community’s needs, agreeing priorities and encouraging commissioners to work in a more joined-up way. This may include the pooling of funds and integrated provision.

HWBs assess the current and future health and social care needs of the local community through Joint Strategic Needs Assessments. Each Assessment is based on a principle of analysing the available evidence on the local community’s health and social care needs. This includes engaging and working with a wide range of local stakeholders such as patient groups, voluntary organisations and the public.

Using the JSNA, Boards will then jointly agree strategic priorities for local health and social care services through the publication of their annual Joint Health and Wellbeing Strategies. Taken together, JSNAs and JHWSs are intended to form the basis of commissioning plans across local health and care services (including public health and children’s services) for CCGs, NHS England and local authorities.

Key facts

- Local authorities are legally required to establish a HWB.
- There are a total of 152 HWBs which at the very least comprise:
  - one locally elected representative
  - the director of adult social services and children’s services for the local authority
  - the Director of Public Health for the local authority
  - representative of the local Healthwatch organisation
  - representative from the local clinical commissioning group.
- HWBs are free to expand membership to include a wider range of expertise such as representatives from charity and voluntary sectors and have a statutory duty to involve local people.
- Sub-committee structures and political proportionality will be a matter for local determination, and papers and minutes must be made publicly available.
- The core functions of the HWB remains within the collective ownership of the board.

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Public Health England

Public Health England has been established as the operationally independent executive agency of the Department of Health.

Public Health England (PHE) allocate ring-fenced budgets to local authorities for them to commission public health services, build a local evidence base and coordinate the integration of local services.

It provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies.

There are 15 local centres with 5,500 people working within Public Health England in total.

Key roles

- Supporting local government in its leadership of public health.
- Supporting local authority directors of public health across the range of their responsibilities enabling them to access specialised advice and support when required.
- Working with NHS England to support it in its role as a direct commissioner of key services, including specialist services and national public health programmes.
- Making comparative data available to help drive improvements and reports annually on progress against the public health outcomes set out in the Public Health Outcomes Framework.
- Providing leadership in responding to emergencies where specialist public health expertise is necessary.

Key aims

- Help people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with high blood pressure, obesity, poor mental health and insufficient exercise.
- Reduce the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact including dementia, anxiety, depression and drug dependency.
- Improve health in the workplace by encouraging employers to support their staff and those moving into and out of the workforce to lead healthier lives.

PHE is ultimately responsible for protecting and improving the health and wellbeing of the population and reducing inequalities in health and wellbeing outcomes.

It works with a range of delivery partners including local government and private health providers. Part of the ring-fenced public health budget will be used by Public Health England for population-wide issues.

Regions and Centres

Public Health England will operate through four regions and 15 centres. These are shown on the map.

North of England

1. North East
2. Cumbria and Lancashire
3. Yorkshire and Humber
4. Greater Manchester
5. Cheshire and Merseyside

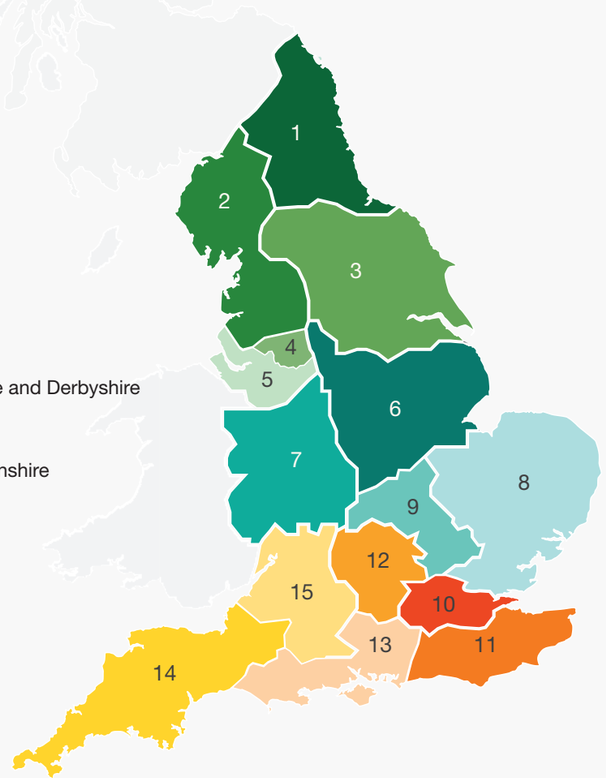
Midlands and East of England

6. Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire
7. West Midlands
8. Norfolk, Suffolk, Cambridgeshire and Essex
9. Bedfordshire, Hertfordshire and Northamptonshire

10 London Integrated region and Centre

South of England

11. Sussex, Surrey and Kent
12. Thames Valley
13. Hampshire, Isle of Wight and Dorset
14. Devon, Cornwall and Somerset
15. Avon, Gloucestershire and Wiltshire



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Directors of Public Health

Each local authority has, together with fellow NHS representatives, appointed a Director of Public Health (DPH) to act as the ambassador of health issues for the local population.

In practice, this means that they will lead discussions about how the ring-fenced money is spent to improve health. This will include influencing investment decisions right across the local authority with the goal of enhancing health and wellbeing. Crucially, they will be able to make sure that public health outcomes are always considered when local authorities, GP consortia and the NHS make decisions.

DPH will be a statutory member of the HWB and will contribute to the preparation of JSNA and the development of JHWS within the framework of the national Public Health Outcomes Framework.

They will ensure a focus on local priorities and action across the life course to ensure a preventive approach is embedded in the local system.

Key roles

- To be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues such as local people's health and concerns around access to health.
- Know how to improve the population's health by understanding the factors which determine health and ill health, how to change behaviour and promote health and wellbeing to reduce inequalities.
- Statutory chief officer of the authority, providing the public with expert, objective advice on health matters.

Additionally, they will:

- Be an active member of the HWB, advising on and contributing to the development of JSNAs and JHWSs.
- Commission appropriate public health services accordingly.
- Take responsibility for the management of the local council's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money.
- Contribute to and influence the work of NHS commissioners, including CCGs, ensuring a whole system approach across the public sector.

...public health outcomes are always considered when local authorities, GP consortia and the NHS make decisions.

10

Clinical Commissioning Groups

Clinical Commissioning Groups are made up of a range of healthcare professionals including GPs, nurses, hospital doctors and others medical professionals including physiotherapists and patient representatives.

This range of professionals use their knowledge of local health needs to plan and buy services for their local community from any service provider that meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers.

Healthcare professionals within GP practices aim to resolve problems locally including through services provided by the practice. If a condition requires more specialised treatment, or further investigation, patients may be referred to another healthcare provider. These could be based in a hospital or in the community. Patients are entitled (where possible) to choose between different types of care and providers of their care, and should be supported to make the choice that is best for them.

10. Clinical Commissioning Groups

CCGs will commission the majority of health services including emergency care, elective hospital care and community and mental health services, and will work closely with HWBs to ensure that services are integrated and deliver the best quality health and care outcomes for their population.

They hold providers of NHS services to account through contracts but are ultimately accountable for the way that the majority of local NHS services are planned and paid. CCGs are also accountable to NHS England for how well they meet their population's needs.

Key facts

- A full national system of 211 authorised CCGs have taken on budgetary responsibility.
- They will be commissioning care for an average of 226,000 people each.
- All 8,300 GP practices in England are part of a CCG.
- CCGs are responsible for an annual budget of around £65 billion (around 60% of the total NHS budget).
- There are over 36,000 GPs in England, working in over 8,300 practices.
- Together these services deal with over 1 million patients every 36 hours.

CCGs have drafted and published their plans and priorities for 2013/2014 which will be available online. These broad plans will then be aligned with the priorities outlined by local HWBs and incorporated into the broader JHWS.

These might include:

- improving the health status of local populations
- making sure local children and young people have a better start in life
- tackling the challenges of an ageing and growing population
- making services more accessible and responsive to the needs of communities
- managing resources more effectively and responsibly
- addressing the holistic needs of the changing age profile of the population
- commissioning clinically effective, better quality services closer to home
- making the best use of public funds to ensure healthcare meets the needs of local patients.

11

CCG Outcomes Indicator Set

The CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework) is part of the NHS Commissioning Board's (NHSCB) systematic approach to promoting an improvement in quality.

Improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes.

Its aim is to support CCGs and HWBs in improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes – and to support transparency and accountability by making this information available to patients and the public.

It will cover each of the five domains of the NHS Outcomes Framework taking clinical effectiveness, patient experience and patient safety into account.

Examples include premature deaths from cardiovascular disease, health and quality of life for people with long term conditions and patient reported outcomes for operations. It will also contain measures developed by NICE from Quality Standards (e.g. prescribing rates of anti-psychotic medication for people with dementia) and measures developed from other data collections.

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NHS Commissioning Board (NHSCB)

The NHS Commissioning Board is an independent board that has been established to allocate resources to CCGs and provide commissioning guidance for predominantly primary care services.

The board is organised into nine national directorates, four slim sub-national regions and a national network of local offices, led by local area teams, in which the bulk of its staff will fulfil NHS-facing functions.

Key functions

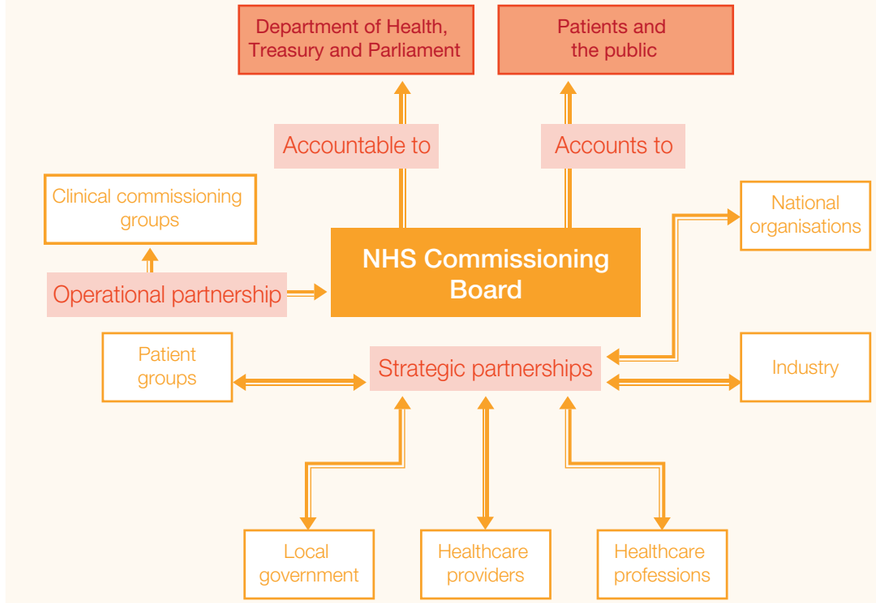
- Delivering improved health outcomes
- Supporting quality improvements
- Developing commissioning guidance
- Championing patient interests
- Overseeing the commissioning budget
- Supervising the development and overall outcomes of CCGs.

The NHSCB will be held into account by Ministers and will have to regularly make a progress report to parliament.

The board will also be accountable to the Department of Health and HM Treasury for keeping within its annual commissioning budget and achieving value for money.

The broader strategic objectives of the NHSCB will be to:

- transfer power to local organisations
- establish the commissioning landscape
- develop specific commissioning and financial management capabilities
- develop ‘excellent’ relationships.



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NHS Outcomes Framework

The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in quality.

It has been published to provide a national overview of how well the NHS is performing, wherever possible in an international context.

The aim is to provide an accountability mechanism between the secretary of state for health and the proposed NHSCB and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities.

The NHS Outcomes Framework is structured around five domains (see right), which set out the high-level national outcomes that the NHS should be aiming to improve. The five domains were derived from the three-part definition of quality. Domains one to three include outcomes that relate to the effectiveness of care, domain four includes outcomes that relate to the quality of the patient experience and domain five includes outcomes that relate to patient safety.

Domain One	Preventing people from dying prematurely
Domain Two	Enhancing quality of life for people with long-term conditions
Domain Three	Helping people to recover from episodes of ill health or following injury
Domain Four	Ensuring that people have a positive experience of care; and
Domain Five	Treating and caring for people in a safe environment; and protecting them from avoidable harm

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NHS England

NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients.

It funds local CCGs to commission services for their communities and ensures that they do this effectively, and further works with leading health specialists to ensure national standards are consistently in place across the country. Throughout its work it promotes the values and commitments enshrined in the NHS Constitution.

NHS England is operationally independent from the Department of Health but is given a specific mandate that highlights the areas of health and care where the Government expects to see improvements in the NHS and contains a number of objectives which NHS England must seek to achieve.

The mandate is intended to provide the NHS with the stability to plan ahead. It is therefore set for a number of years at a time, with the secretary of state refreshing it on an annual basis, yet not during the year without the agreement of NHS England (except in exceptional circumstances or after a general election).

It is the main way in which the secretary of state holds NHS England to account for the commissioning system, as Ministers do not have a day-to-day role in the running of the NHS.

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Other key bodies

The Department of Health will continue to set objectives, budgets and hold the system to account on behalf of the Secretary of State.

The department will enable health and social care bodies to deliver services according to national priorities and work with other parts of government to achieve this. The secretary of state for health has ultimate responsibility for ensuring the whole system works together to meet the needs of patients.

Health Education England has taken over strategic health authorities' responsibilities for local education and training and operates to ensure that the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of local education and training Boards that plan education and training of the workforce to meet local and national needs.

The view and experiences of patients, carers and others service users are taken into account when local needs assessment and strategies are prepared.

Healthwatch England is a national independent body that enables the collective views of the people who use NHS and adult social care services to influence national policy, advice and guidance. It will advise the NHSCB, Monitor, the Secretary of State and local authorities. It will also have the power to recommend that action is taken by the Care Quality Commission when there are concerns about health and social care services.

Every upper tier and unitary local authority area in England has arrangements with a local Healthwatch organisation to support patient and public involvement activities in its area. The activities include promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local health and care services. Local Healthwatch organisations are able to enter and view certain health and social care premises and produce reports and make recommendations that influence the way services are designed and delivered.

Local Healthwatch gives citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. It is an evolution from the existing Local Involvement (LINks) and will form the local level mechanism of the national body Healthwatch England. If a local Healthwatch organisation sends a report or recommendation to a specified provider or commissioner of a local health or social care service, the provider or commissioner is legally obliged to respond to the local Healthwatch organisation in writing. Local Healthwatch organisations provide information and advice to the public about local services and pass on views to Healthwatch England.

Local Healthwatch bodies have a seat on HWBs, ensuring that the view and experiences of patients, carers and others service users are taken into account when local needs assessment and strategies are prepared, such as JSNA and authorisation of CCGs. It will be funded by local authorities and held to account by them for their efficiency and effectiveness. Local authorities have responsibility for commissioning NHS complaints advocacy and the intention is that the local Healthwatch will either provide the service or be able to signpost people to the provider of the service.

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National regulators

Changes to the public health landscape have changed the way that NHS service providers will be regulated through the introduction of a licence for NHS providers. Monitor will have responsibility for issuing this licence and setting the conditions that all providers would have to meet.

Monitor is the economic regulator for all providers of health and adult social care services. It protects and promotes the interests of people using health services by making sure that NHS services are effective and offer value for money. All providers of NHS services are expected to hold a Monitor licence.

In addition to Monitor, the Care Quality Commission measures whether services meet national standards of quality and safety. It should be noted that most health and social care professionals must be registered with one of the independent regulators, such as the General Medical Council, who ensure that professional standards are met.

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National research bodies

National Institute for Health and Care Excellence

NICE provides guidance to help health and social care professionals deliver the best possible care for patients based on latest available evidence. It involves patients, carers and the public in the development of its guidance and other products.

National Institute for Health Research

The National Institute for Health Research's clinical research networks form a health research system in which the NHS supports individuals, working in world-class facilities, conducting leading edge research focused on the needs of patients and the public.

Health and Social Care Information Centre

This body supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers.

The National Institute for Health Research's clinical research networks form a health research system in which the NHS supports individuals, working in world-class facilities, conducting leading edge research focused on the needs of patients and the public.

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The commissioning structure

The planning and purchasing of NHS services is undertaken by organisations (or individuals) known as commissioners. They are responsible for assessing the reasonable needs of their populations as purchasers aim to secure services that are affordable and of the highest quality.

They can buy services from any provider that meets NHS standards of care and prices. Local authorities and CCGs hold the responsibility and resources to commission public health services. Local authorities are responsible for services such as smoking cessation, locally-led nutrition initiatives, public mental health services and increasing levels of physical activity in the local population and will work with CCGs to provide as much integration across clinical pathways as possible.

CCGs provide the organisational infrastructure to enable GPs (working with other health professionals) to commission services for their local communities. CCGs' governing bodies have GP, nurse and secondary care representatives, as well as at least two 'lay' members who are not NHS professionals.

The services that CCGs commission include rehabilitative care, urgent and emergency care (including out-of-hours and accident and emergency services), most community health services, maternity services and mental health and learning disability services.

Commissioning happens on an individual level every day in a GP practice. For example, when a GP refers a patient to a particular hospital for further investigation or treatment, the GP is effectively buying care for that patient from the hospital through that referral.

This 'secondary' provider is paid to treat the patient through the NHS payment system. What care the GP can buy for their patient is determined by the commissioning organisation.

Because of the complexity and scale of the healthcare system, it is more efficient to plan and commission healthcare at a population level, such as a town and its surroundings or a metropolitan borough.

This is one the reasons why all GP practices are required to be a member of a CCG. In order to plan their commissioning decisions, local authorities and CCGs (coming together through Health and Wellbeing Boards) use Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies to agree local priorities for local health and care commissioning.

Once a CCG or other commissioning organisation has made a decision to buy a service from a provider of care, a contract must be drawn up which clearly sets out the detailed specification of what the provider must deliver.

Commissioners must review the performance of providers through the contract and monitor the outcomes achieved by the service. This ensures that they can manage and check the quality of services and make an informed decision when they choose providers in the future.

Although GPs and other local health professionals commission most NHS services, some services are not appropriate to be commissioned locally, for example some specialised mental health services. NHS England commissions services which are more appropriate to commission at a national level.

18. The commissioning structure

In addition to commissioning services itself, NHS England also has responsibility for ensuring the overall system of commissioning NHS-funded services works well. This involves working on plans to improve commissioning for specific conditions (e.g. dementia) or patient groups (e.g. children's services).

NHS England provides information and resources for CCGs, and holds them to account for how they carry out their commissioning activities and improve the healthcare outcomes that matter locally. NHS England also looks at how well CCGs operate within their budgets, engage with their local populations and deliver the pledges, rights and values expressed in the NHS Constitution.

Commissioning support units can support CCGs to fulfil their commissioning duties, for example by helping with service redesign, giving advice when CCGs negotiate contract terms with providers or by assisting with information analysis. As part of their role, commissioners should work together with providers to determine the services needed for local areas.

NHS England is responsible for working with CCGs to encourage them to collaborate (where appropriate) to plan the structure of services. For services commissioned nationally, NHS England takes the lead role in coordinating key bodies in the local areas.

NHS England provides information and resources for CCGs, and holds them to account for how they carry out their commissioning activities and improve the healthcare outcomes that matter locally.

This can involve discussions over large changes to how services are organised, often called reconfigurations. NHS England has been set the objective of ensuring that any proposals for major service change meet four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical evidence base.
- Support for proposals from clinical commissioners.

If the relevant local authority does not consider the proposed changes to be in the best interests of the local population, they can refer the matter to the secretary of state for health.

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The Quality and Outcomes Framework

The Quality and Outcomes Framework is a voluntary annual reward and incentive programme for all GP surgeries in England. It is not about performance management but resourcing and then rewarding good practice.

The QOF contains groups of indicators (including physical activity for the treatment of hypertension as of April 2013) against which practices score points according to their level of achievement. It gives an indication of the overall achievement of a practice through this points system. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take into account the surgery's workload and the prevalence of chronic conditions in the practice's local area with results published annually.

The QOF contains four main components (known as domains) with each consisting of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2010/11 QOF measured achievement against 134 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

The four domains are:

- **Clinical:** Consists of 86 indicators across 20 clinical areas (e.g. coronary heart disease, heart failure, hypertension) worth up to a maximum of 697 points.
- **Organisational:** Consists of 36 indicators (worth up to 167.5 points) across five organisational areas – records and information, information for patients, education and training, practice management and medicines management.
- **Patient experience:** Consists of three indicators (worth up to 91.5 points) that relate to length of consultations and to patient experience of access to GPs.
- **Additional services:** Consists of nine indicators across four service areas – cervical screening, child health surveillance, maternity service and contraceptive services.

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QOF indicators for physical activity (2013-14)

The QOF currently rewards GPs in England for screening hypertensive patients for physical activity and delivering a brief intervention.

Although this incentive is currently only limited to hypertension, this is a large patient group (7.3 million) and sets an important precedent for incentivising GPs to prescribe physical activity for the prevention and management of a broader range of chronic diseases. GPs in Scotland and Wales will not face the indicators.

The QOF will award practices up to three QOF points to offer the General Practice Physical Activity Questionnaire (GPPAQ) each year to the 7.3m patients with hypertension in England. A further three points are available if they provide brief advice to those deemed 'less than active'.

GP practices receive nothing if they achieve up to 40% of patients receiving the intervention. Above 40% they get an increasing proportion of the points, and if they reach 80% (or above) they get all the points.

The average 'price' of one point is £152.96 but this varies between practices depending on list size and prevalence. The points allocations set out in the table below have been in place since 1 April 2013.

Indicator	Points	Threshold (13/14)
HYP003. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less	50	40-80%
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 12 months	5	40-80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months	6	40-80%

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Personal health budgets

A personal health budget is an agreed amount of money provided to an individual by their local NHS team to support their healthcare and wellbeing needs.

It has been designed to help people become more involved in discussions and decisions about their care and enable those with long-term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

Everyone with a personal health budget can get support to think though how they would like to use their budget to meet their health and wellbeing needs. Local NHS teams provide advice and make recommendations. This is often described as brokerage. Personal budgets could be spent on any care or services set out in an agreed care plan – such as therapies, personal care and equipment – and are part of a broader care plan designed to enable individuals to meet their specific health and wellbeing objectives.

There are a few obvious things that a personal health budget cannot be spent on such as alcohol, tobacco, gambling or debt repayment, or anything that is illegal. It cannot also be used to buy emergency care or buy services that the GP already provides – for instance seeing the doctor to discuss health issues or get a prescription. However, it can also be used for acquiring other recommended services such as physiotherapy. Those receiving a personal health budget and a personal budget for social care can join the two budgets together.

Following a three year pilot programme in the NHS, the Minister of State for Care Services announced the national roll out of personal health budgets on 30 November 2012. They will initially be aimed at people who are already receiving NHS Continuing Care but clinicians can also offer them to others that they feel may benefit from the additional flexibility and control. Patients will have a right to ask for a personal health budgets from April 2014.

Personal budgets could be spent on any care or services set out in an agreed care plan – such as therapies, personal care and equipment.

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Case Study – the ‘Let’s Get Moving’ model

The *Let’s Get Moving* programme is a physical activity pathway involving GP surgeries, national governing bodies, leisure centres and activity providers.

It uses motivational counselling to engage and support the most inactive members of local communities to improve their activity levels. It was initially founded by the Department of Health and has since been developed by ukactive to incorporate a partnership model.

The project is currently being delivered in Bedfordshire and Luton with Bedford Borough Council, Luton Borough Council and Central Bedford Borough Council with additional support from the County Sports Partnership, Team BEDS&LUTON.

Let’s Get Moving…

Helps the most inactive members of the local community improve their activity levels through a motivational interviewing programme. The project follows the successful testing of the ***Let’s Get Moving*** model by ukactive and a consortium of partners with five Primary Care Trusts in Essex.

This saw 504 previously inactive participants amass a total of 164 million steps, accounting to 48,000 active hours, 11.2 million kcal and 69,000 miles walked. For previously inactive people in danger of developing chronic diseases related to their lifestyle choices, this was a significant outcome.

The model was originally developed by the Department of Health, validated by Loughborough University and recommended by the National Institute for Health and Care Excellence.

Is the provision of professional expertise (ideally) within a GP surgery with a view to supporting inactive people to understand what stops them from living a more active lifestyle and why it might be beneficial to change their habits. Participants are supported to explore ways that they might become more active, utilising evidence-based behaviour change techniques.

Group settings are used to provide peer-to-peer support and motivation. At the appropriate time, individuals are signposted to local sporting activities and services that provide previously inactive people with a friendly, welcoming and supportive environment in which they can try new activities. It then aims to retain participants who have completed the pathway within the service, so as to provide on-going peer-to-peer support at group sessions.

Has been backed by Sport England, who have provided the necessary resources to not only deliver both sporting and health outcomes for inactive people in Bedfordshire, but to also further systemise the concept in order to support its continued expansion into other areas of the country in a cost effective and proven manner.

For more information, please contact:

Simon Butler
Policy Officer
Sport and Recreation Alliance

Burwood House
14-16 Caxton Street
London SW1H 0QT

sbutler@sportandrecreation.org.uk
www.sportandrecreation.org.uk

Constantinos Skinitis
Public Affairs and Policy Officer
ukactive

3rd Floor Castlewood House
77–91 New Oxford St
London WC1A 1PX

ConstantinosSkinitis@ukactive.org.uk
www.ukactive.com