Asking the difficult questions
Making the difficult decisions

Exploring the role of Commissions in developing powerful locally owned evidence based commissioning

1. Background

Department of Health guidance on good practice with regard to commissioning for health and wellbeing at a local level places an emphasis on tools and approaches such as the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

While both of these mechanisms are helpful a number of local authority areas have also been developing other processes that sit alongside these. Formally structured Commissions, for example, place a greater emphasis on:

- A holistic view of place
- Testing priorities through public and stakeholder dialogue
- Cross-sectoral engagement

In November 2012 Yorkshire and Humber Public Health Observatory and Minding the Gap organised a conference to share some of this emerging practice and consider its implications for local commissioning.

The event combined expert academic input with specific examples from six local areas:

Islington	Fairness Commission
Camden	Equalities Task Force
Wakefield	Poverty and Prosperity Commission
Sheffield	Fairness Commission
Staffordshire	Community led approach to Commissioning Healthwatch
North Yorkshire and York	Independent Review of Health Services

These approaches are varied and are not all Commissions as such, but all sought to address significant, multi-faceted and long-term problems through an independently led process. This paper focusses in particular on the Commissions and some of the emerging insights around their common drivers, characteristics and implications for local areas.

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2. Why Commissions?

Over the last two years there has been a growth in the number of commissions. In his presentation at the Conference, Richard Wilkinson who himself has been involved with a number of Commissions referenced at least nine local authorities[1] that have or are conducting Fairness Commissions.

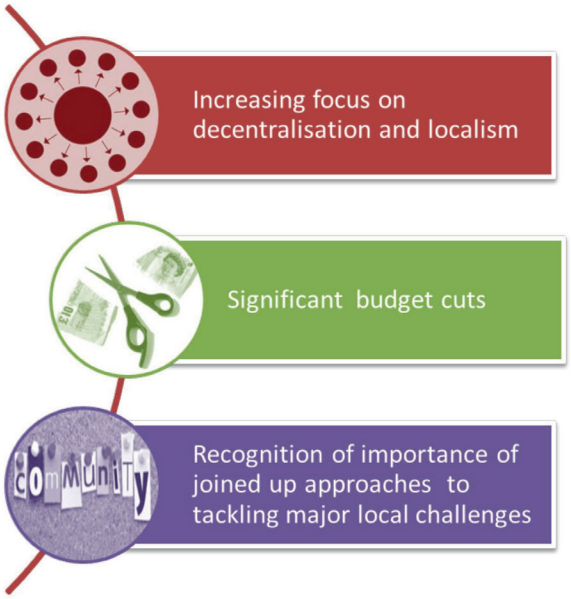
There are a number of drivers for Commissions. Three of the main ones include:

- Firstly, the growing emphasis in Government Policy on decentralisation and localism. With local authorities and increasingly the local NHS through PCTs and soon CCGs being statutorily responsible for understanding and responding to local need. This has been a strand in government thinking for some time and has accelerated and deepened with the present government with the **Localism** Act 2012 which established 'a general power of competence' for local authorities[2].

- Secondly, at the same time many local services - but local authorities in particular are having to manage in a context where the economic and policy environment have resulted in significant **cuts to their budgets.**

- Thirdly there is a growing understanding at a local level that approaches that only rely on public service led solutions to wicked issues such as inequality will not be sustainable or effective. Actions have to be taken by **all sections of the community** - public sector, private sector, voluntary and community sector and most importantly by members of the public themselves. This requires a strategic approach that sits above the commissioning of specific services.

Figure 1: Drivers for Commissions



These pressures - greater local responsibility, fewer resources and continuing wicked issues mean that local leaders - particularly politicians - have to develop strategies that provide them with a mandate to make difficult decisions about priorities and resource allocation. Commissions can help guide this process.

"The Islington Fairness Commission was set up after the (Government) settlement left us facing £100m of cuts, or 28% of our budget. What could a small local authority do to make things fairer?"

Councillor Janet Burgess, Cabinet Lead for Health LBI. YHPHO Conference, November 2012

1. What is a Commission Approach?

There were a number of common characteristics that emerged through discussions as part of the conference:

Figure 2: Common characteristics of Commissions

1.1 Focus on strategic challenge

Most commissions started by describing a simple but very high level challenge. The purpose is to open up enquiry and create a space for local dialogue and debate by providing a non-partisan and time limited structure within which this can happen.

For example:

The Camden Equality Task Force	To explore structural and systemic reasons for inequality in Camden
Sheffield Fairness Commission	To make a non-partisan strategic assessment of the nature, extent, causes and impact of inequalities in the city and to make recommendations to tackle them
Islington Fairness Commission	To focus on tackling inequality to make Islington a fairer place

In most cases Commissions focused on questions that allowed for views about fairness and equity to be tested through public debate. It is significant that in all cases health - in particular health inequalities - was central to the work of the Commission, but health usually emerged naturally as part of a wider concern with fairness or equity. This process is different to that of the JSNA which starts with Health and Wellbeing and then seeks to take the case about health and wellbeing into other sectors.

So it could be argued that the Commission model is an effective mechanism for embedding Health in All Policies[3] in the work of a local system.

1.2 Inclusive

The second characteristic associated with the Commission Model is a commitment to an independent and inclusive approach with an element of external challenge. The model has many similarities with Government Select Committees. Commissioners are usually drawn from a range of statutory, private sector and voluntary community sector organisations and bring with them expert knowledge and opinions on the area. In most cases commissioners included:

- Local politicians with a cross party membership
- representatives from the faith community
- the local media
- Voluntary and Community Sector
- business
- trade unions
- public health
- academia

Most Commissions made a real effort to ensure that ownership existed across the main political parties represented in the local authority. There was a clear understanding that the credibility of the Commission rested on its ownership and accessibility.

Reasons for involving a broad range of participants included:

- Participation in debate and dialogue is essential to generate ownership and negotiate shared solutions
- Experience on actions that might help do not rest exclusively with one group - but across all stakeholders - so a broad range of views are required
- Solutions are not short term and will need support from all political parties over a long period of time
- Different forms of evidence need to be taken into account - population level data, lived experience, scientific evidence.

1.3 Independent

Recruiting an independent chair of repute - someone from academia, the faith sector or with national reputation in a relevant field was seen as important. Examples that were shared at the conference included:

- **Camden** - Chair was Naomi Eisenstadt - Senior Research Fellow, Department of Education, Oxford University
- **Wakefield** - Professor Andrew Slade - Pro-Vice Chancellor - Leeds Metropolitan University
- **Sheffield** - Professor Alan Walker - University of Sheffield
- **York** - Chair Ruth Redfern, Former Assistant Chief Executive at Yorkshire Forward, Patron - Archbishop John Sentamu

1.4 Public Deliberation

To date the main way in which local organisations seek to determine health and wellbeing priorities and actions has been through apparently rational approaches such as World Class Commissioning, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - the latter now being statutory duties. These place a great deal of emphasis on highly qualified professionals using population data to determine need and interrogate the evidence base (such as NICE guidelines) to decide on actions.

This approach continues to be useful, however it has often struggled to embed health priorities at a system (cross sectoral) level and it has failed to consistently engage and motivate many stakeholders. Commissions take a different approach, they are conducted in a spirit of open exploratory public enquiry.

They do not assume that:

- Analysis of population data is sufficient to tell the story of place - it is important to capture experience and opinions too.
- Solutions can only be found in existing evidence - there was an active interest in hearing from a broad range of experts and debating with them what solutions might be work.

This public debate led by the independent chair might involve expert witnesses being questioned by committee members, workshops involving different stakeholders producing solutions and mini conferences based around a locality or issue of particular interest.

1.5 Clear framework for gathering evidence

All commissions had given a great deal of thought to establish processes that sought to provide a coherent approach to consider the questions that had been set.

For example in Sheffield evidence was gathered in 3 ways.

- Written evidence - from organisations and individuals submitted in response to the Commissions call for evidence (the questions are summarised in the table below)
- Oral evidence from invited experts to Commission meetings
- Satellite meetings held to gather the views and evidence of particular groups or communities who may not have been able to give evidence in other ways.

Table 1: Examples of questions used by Commissions[4].

	Sheffield	York	Wakefield
Evidence	What specific evidence do you hold about inequalities and fairness that may be of use to the Commission?		What are the main Health and Wellbeing challenges currently facing the Wakefield District?
Analysis of current problem	Based on your evidence what is your or your organisation's analysis of the cause/s of inequalities within Sheffield?	Would any changes help to reduce health inequalities?	What are the main barriers to overcoming these challenges?
Good Practice	Are there any examples of good practice in relation to reducing inequalities and increasing fairness(from within the city, elsewhere in the UK, or overseas) that the Commission should be aware of?	Are there already practical examples of work that has successfully reduced health inequalities – in York or elsewhere – that could be expanded in the city?	Please provide any examples of what currently works well in Health and Wellbeing provision/ services in the Wakefield District and of any new ideas or approaches that could be adopted
Ideas for Action	What do you or your organisation believe would be the best way to tackle inequalities and increase fairness in the city?	What can be done (and by who?) to tackle inequalities in life expectancy and healthy life expectancy'? Why is life expectancy so low in men in the most disadvantaged 20% of areas and what can be done about it? How can organisations across sectors work together more effectively across sectors to tackle health inequalities in the new framework?	
Strategic Priority for the area	What should be the top 3 priorities for the city?	Can and should the balance change between resources spent on health care (managed by clinical commissioning groups) and health promotion (managed by the Council)? What is the most effective use of resources to prevent mental illness and to support people who suffer from it? What should be the priorities and success measures of the new local Health and Well-being Strategy?	What should the main priorities be for creating a healthier Wakefield District over the next 5 years? What ONE thing should WMDC and its partners do to improve Health and Wellbeing in the Wakefield District?

1.6 External Challenge

Most of the Commissions actively sought to involve external experts to bring challenge and test assumptions for example:

- Camden brought in the Young Foundation;
- Sheffield invited Professor Danny Dorling a leading Social Geographer;
- Wakefield involved a team from Leeds Metropolitan University;
- A number of Commissions involved Professor Richard Wilkinson (Equality Trust) with Islington asking him to chair their Commission.

2. Measuring the impact of Commissions

The ambition of the Commission model is for the process of system level deliberation to lead to cross-sectoral actions. From a public health perspective these actions need to mobilise all sectors - consistent with a Health in All Policies approach. While the Commission approach is still comparatively recent the conference heard of a number of promising examples where despite the current economic environment positive actions were being taken.

Other Commissions such as York, Shefield and Newcastle have now produced their recommendations. Islington was one of the first authorities to report and some of the follow-up actions are listed in the table below.

Table 2: Taking forward recommendations from the Islington Fairness Commission

Issue	Actions taken by Islington
London Living Wage	First Local Authority to become a living wage employer
Pay Ratio (see note below)	Cut CEO Salary by £50k and pay ratio to 1:10
Debt	Debt Prevention, Enforcement programme
Advice	New CAB opened 1000 users a month
Housing	Ambition to build 1800 affordable new homes by 2014
Literacy	Literacy drive in schools, libraries and prisons
Jobs	Apprenticeship programme established 120 businesses
Anti Social Behaviour	Hotline established
Health Inequality	Health and Wellbeing Board to draw up clear plan to address health inequalities in borough

Note - Pay Ratio - Voluntary Sector 10:1, Public Sector 15:1, Private sector 300:1 (FTSE 100 Companies)[5]

3. Implications for Health and Wellbeing Boards

3.1 Leadership

The Commission model provides a tremendous opportunity to generate a cross system debate on key issues such as health inequalities. It is important to recognise that the starting point is not health and wellbeing or health inequalities but more fundamental questions usually focused on equity, fairness or sustainability.

Health and Wellbeing Boards potentially have much to gain through supporting and advocating for such an approach but will need to resist trying to own or prescribe it if cross system ownership is to be secured.

Responsibility for how fair or equitable a local authority feels rests with key leaders such as the Leader of the Council, Cabinet or Mayor. They need to be supported, mandated and held to account by the Health and Wellbeing Board to provide this systemic place based leadership.

3.2 Deliberation

The approach presents a fundamental challenge to established approaches to strategic decision making. Commissions place a much greater emphasis on deliberative democracy and bring an opened minded spirit of enquiry - taking a more inclusive approach to evidence. Commissions require an ability to break down silos between analytical, strategic and engagement expertise.

3.3 Expertise

Commissions have tremendous potential to make better use of expertise and to lay the foundations for more substantive relationships in the future - be that expertise arising from personal experience, from policy experts or from academia. They are assertive about the importance of place, have some humility about their own existing professional expertise and confident of their entitlement to seek out national experts to challenge and advise them.

3.4 Cost and Risk

Commissions do cost; however, like needs assessment processes such as JSNA there has been little work looking at cost benefit analysis of Commissions - the Islington Commission (excluding officer time) cost £13,990. Aside from the need to justify additional expenditure particularly in very tough financial circumstances, a key risk is probably reputational raising expectation of change and then failing to deliver.

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Acknowledgments

The writers of this report would particularly like to thank the following who shared their experience of commissions at the conference in York in November 2012: • Professor Richard Wilkinson - Emeritus Professor of Social Epidemiology at the University of Nottingham, co-author of the 'The Spirit Level' and Commissioner for York Fairness Commission • Naomi Eisenstadt – Senior Research Fellow, University of Oxford and Chair of the Camden Equality Taskforce • Professor Hugo Mascie-Taylor – Medical Director, NHS Confederation and Chair of the Independent Review of Health Services in North Yorkshire and York • Professor Jane South - Director of the Centre for Health Promotion Research and Review Panel, Leeds Metropolitan University and Member of Wakefield Poverty and Prosperity Commission • Councillor Janet Burgess - Executive Lead for Health and Wellbeing, Islington Council • Kate Waterhouse - Head of Customer Insight, Staffordshire County Council • James Henderson - Head of Strategy, Sheffield City Council

February 2013

1 Richard Wilkinson mentioned - Islington, Liverpool, Newcastle, York, Sheffield, Blackpool, Leicester, Southampton, Newport
The Localism Act: An LGIU Guide 2012

2 The Adelaide Statement on Health in All Policies is to engage leaders and policy makers at all levels of government. It emphasizes that government objectives are

3 The Adelaide Statement on Health in All Policies is to engage leaders and policy makers at all levels of government. It emphasizes that government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development. WHO Adelaide 2010

4 From Local Democracy and Health (http://localdemocracyandhealth.com/2012/05/21/local-commissions-tackle-social-determinants-of-health/)

5 One Society - Leading the Way on Fair Pay. One Society London 2012