March 2011 **Paper 3**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: consultation on the funding and commissioning routes for public health

Summary

This further consultation document under the public health white paper consults on which organisation should be the lead commissioner for specific services and on aspects of funding, such as how the health premium should work.

Public health services will be funded by a new ring-fenced public health budget, separate from the budget managed through the NHS Commissioning Board. Public Health England (PHE) will fund public health activity through:

- allocating funding to local authorities;
- commissioning services via the NHS Commissioning Board; or
- commissioning or providing services itself.

The paper describes the flows of the public health budget from the Department of Health (DH) across the system. Decisions as to how services would be best commissioned will determine how much funding flows through different parts of the system. The majority of the public health budget will be spent on local services, either commissioned via the NHS Commissioning Board (who may choose to pass the responsibility down to GP consortia) acting on behalf of Public Health England, or led by local authorities through the ring-fenced grant.

The paper asks whether the proposed health and wellbeing boards, which will provide a mechanism for bringing together discussions about investment in cross-cutting services such as social care primary prevention, are the right place to bring together ring-fenced public health and other budgets.

The government claims that the reforms, alongside the ring-fenced budget, will open up opportunities for local government 'to take innovative approaches to public health involving new partners. The Department of Health expects that local authorities will want to contract for services with a wide range of providers and incentivise and reward those organisations for improving health and wellbeing outcomes and tackling inequalties'. The Department 'would encourage and expect that local authorities, where possible and appropriate, should be commissioning on an any willing provider/ competitive tender basis'.

On a national level, Public Health England will directly fund and commission some services, such as any national campaigns; directly provide some services, for example the functions currently carried out by the Health Protection Agency; and directly provide

some activity which will be exercised locally, for example via the local networks of Public Health England Health Protection Units.

There will also be some commissioning at a sub-national or a supra-local level. The paper says that these would be services that are specialised in nature, such as services for victims of sexual violence and for vulnerable groups. They could be commissioned as part of Public Health England, or local authorities could choose to adopt supra-local arrangements for commissioning certain activities for which they are responsible.

Public Health England in some cases will ask the NHS to take responsibility for commissioning public health interventions or services funded from the public health budget. These will include population interventions such as screening programmes, that are most effectively delivered as part of a wider pathway of care. It is assumed that most NHS commissioning for public health will occur via GP consortia.

Consultation questions and responses

1. **Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?**

We consider that it is, as this would provide the board with oversight of all funding activity relating to prevention, health protection and health and wellbeing of the whole population. It would also provide transparency and a partnership approach to priority setting, with consultation prior to final decision making. Ultimate responsibility for the budget should rest with the Director of Public Health.

Another advantage is that local people will have access to information held by the board, which informs commissioning decisions. There will also be transparency for local people on public health spending and outcomes achieved.

2. **What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?**

It will be necessary for councils to consider of their constitution and financial policy that informs procurement practice.

The best solution may be to use the Chest to allow potential providers to bid or make expressions of interest. However, it is also important that commissioners are able to stimulate local enterprise solutions that build community capacity and wellbeing.

Councils are well placed to further develop existing relationships with the Voluntary, Community and Faith Sector. Building public health capacity is a core part of workforce

development. This will ensure that providers are supported in providing health and wellbeing services that are commissioned.

There are barriers which may hinder the involvement of third sector organisations and small independent organisations, such as lack of resources, skills, and time. Full cost recovery means the third sector are disadvantaged against larger organisations. Sharing expertise and skills with these organisations will minimise barriers and allow them to compete in the tender process.

3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

The priorities for public health will need to be taken into account by the NHS Commissioning Board, GP Consortia and the Health and Wellbeing Board. The Director of Public Health and public health professionals will therefore need to be responsible for ensuring that priorities are taken into account when commissioning decisions are made, and that strategic decisions encompass regional, sub regional and local issues.

It will be essential that local needs and experiences also shape universally commissioned services. In addition to gaining and interpreting local data, it will be necessary to gather information on the experiences of citizens and patients.

4. Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

There is a case for Public Health England and local authorities to commission services currently provided under the GP contract. This could align services - such as screening and child health surveillance - with existing services which councils provide such as child protection, safeguarding and child health. This would create an opportunity to gather information around the individual in a holistic approach to health and wellbeing.

Clusters using multi-sectoral public health data could be used to compare matched populations.

5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

When commissioning, there is often insufficient representation from each community. Representatives from communities that are less visible, and people from minority groups need to be included.

The policy should state that commissioners should actively seek representation from hard-to-reach communities. It should also ensure that a quality criterion is applied, and that continuous evaluation and systematic audit is included.

6. **Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?**

Yes, but will health visitors will experience a change in their ways of working, as some of their responsibilities will shift to local authorities. We await further clarification in this area.

Clarification is required for public mental health, regarding who commissions Child and Adult Mental Health Services and drug and alcohol services if responsibilities are transferred to the local authority.

7. **Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:**
   a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
   b) reduce avoidable inequalities in health between population groups and communities?
   If not, what would work better?

Yes - we think the proposed primary routes for commissioning will be the best way. This will allow local authorities and Public Health England to work together on issues that have relevance for both bodies.

Under this arrangement, PHE will require resources and appropriately skilled staff to enable them to identify forthcoming issues and to advise councils. PHE will also need to be flexible enough in its approach to allow councils to apply the advice according to local population needs.

It is also important that all commissioning bodies have clarity about who is commissioning a service. With so many different commissioning routes possible, there is the potential for some services to 'fall through the cracks'. For example, with public health for children under 5, there are roles for the NHS Commissioning Board, Public Health England, local authorities, and combinations of these groups. The government will need to ensure full guidance is provided.

8. **Which services should be mandatory for local authorities to provide or commission?**

The services included in Table A, public health funded activities.

9. **Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?**

The following conditions should be placed on the grant:

- Outcomes should be linked to the Joint Health and Wellbeing Strategy and outcomes framework for social care and public health
- The Director of Public Health should be responsible for the ring fenced budget to ensure the money is spent on the priorities determined by public health data and evidence-based interventions.
- Local accountability should be held by the Health and Wellbeing Board to meet desired outcomes.

10. Which approaches to developing an allocation formula should we ask ACRA to consider?

Any approach to developing an allocation formula should bear in mind the need for the formula to be transparent, and to reflect local authority responsibilities, population data and population needs.

11. Which approach should we take to pace-of-change?

The approach that should be taken will depend upon the amount of funding to be transferred from the PCT to the local authority. We will need to consider the impact of this locally, and upon current contractual arrangements.

12. Who should be represented in the group developing the formula?

- Public health commissioners
- GPCC commissioners
- Local authority commissioners
- Voluntary / Community / Faith Sector
- Health Watch
- Council members
- GPs
- Public health observatories

13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

The health premium should be awarded where the goals in the outcomes framework have been achieved, and local outcomes identified by local need have been accomplished. This will need to be set locally, for various levels of achievement, therefore encouraging authorities to improve.

Consideration will also need to be given for short, medium and long term outcomes.

The health premium should relate mainly to reducing health inequalities, improving health and wellbeing in areas of disadvantage and deprivation.

14. How should we design the health premium to ensure that it incentivises reductions in inequalities?

Payment should be made on the reduction in the base rate of health inequalities for each area. This should be in a staged approach with the premium increasing according to the decrease in health inequalities, based on the achievement of milestones.

15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

Yes – this would be a good method of providing incentives, but there may be other ways of doing this that are not solely financial. This should be further considered and consulted upon.

Health Improvement Budgets should be set according to local need with the added incentives to increase funding from other means. Innovation, quality and prevention needs to be part of the development work which may not attract extra money from the onset.

16. What are the key issues the group developing the formula will need to consider?

The formula should reward local authorities who demonstrate:

- Behavioural change in their communities
- Sustained improvement measures
- Continuous monitoring and evaluation
- Links with JSNA analysis through observatories providing accurate data
- Improvements in the wider social determinants of health e.g. in housing, income, employment, education
- Sustainable impact of large scale change initiatives on communities and services
- Early intervention and prevention
- Building on strengths, assets and resilience of individuals and communities to bring about change

- Production of baseline data and well-being analysis that informs strategic direction and service development, with a wellbeing focus
- The use of asset and deficit indicators.