PHAST – Public Health Action Support Team response to: *Healthy Lives, Healthy People*

Consultation on the funding and commissioning routes for public health.

Q1	Is the health and wellbeing board the right place to bring together ringfenced public health and other budgets?
A1	Yes. It will be important that HWBs recognise the three domains of public health and have duties around all three. As described in the White Paper HWBs seem to lack real power to influence commissioning. The word 'encourage' is used frequently to describe their role and this particular set of proposals says they will 'provide a mechanism for bringing together discussions about investment in cross-cutting services...', but this may not be enough to ensure that everyone who needs to engage does engage. As the Marmot Review has pointed out, there is opportunity to make substantial improvements in people's health through 'wider determinants' and therefore those parts of the LA with relevant responsibilities (e.g. education, transport, environment, housing) will need to connect with the HWB and the Director of Public Health. The DPH and HWB will need to have an overview of LA decision-making in order to pursue the Marmot agenda. • LAs and GPCCs will have an 'equal and explicit obligation to prepare the joint strategic needs assessment'. This is a good thing, but there will need to be a mechanism to enshrine this in GPCC 'must-dos' and another to monitor this. This may be a role for the NHS commissioning board. • It also says they have a duty to 'take regard to' the JSNA, which does not sound strong enough to ensure decisions are based on the needs of communities. • Arrangements will need to take account of the potential mismatch between GPCC populations and the LA population. If a situation arises in which there is no natural "defined geographic area" for a GPCC, any arbitrary decision about population denominators might have negative knock-on effects for funding, particularly in terms of populations that are below the radar. • Representation on HWBs should include the local third sector. • There are concerns that the commissioning of complete care pathways will become more fragmented under these proposals. This is well illustrated within certain long term conditions where public health preventions and NHS care provided by GPs and specialists will be commissioned by separate bodies. These arrangements will make service planning and commissioning around the patient more complex. In addition there will be no one responsible commissioner.

Q2	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?
A2	• The notion of utilising VCS and social enterprise capacity to support health improvement plans is positive but these bodies will need to build capacity in order to engage in this kind of commissioning (as opposed to grant seeking). This is a particular problem in the current economic climate which is meaning cuts to the third sector. • The establishment of local and regional Voluntary and Charitable networks would support this process. • This sector will only be able to participate if they are supported and helped initially to respond to tender specifications. Similarly the encouragement of Social Enterprises is important. The current reduction in funding to the third sector will be detrimental to this ambition for plurality of provision. • HWBs should be encouraged to include third sector representation. • Capacity building in the third sector would not be an appropriate use of the public health ring fence • Increasing competition can be achieved by having clearly defined service specifications, quality standards and tendering processes. Partnerships with leading health charities to raise awareness and quality standards would also be beneficial.
Q3	How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?
A3	• It is important that policy-makers recognise the 3 aspects of Public Health – health improvement, health prevention and quality and effectiveness of service provision. The latter is the most relevant here. It is crucial that the Public Health function can support both LAs and GPCCs. PHE needs to support this model with back-up information and intelligence and supporting good networking so that the limited PH capacity is not too fragmented. • Plans need to address confusion about whether GPCCs are to be responsible for patient lists or populations. If the former is the eventuality those responsible for NHS commissioning (the national board and GPCCs) need to explicitly take account of those not on lists and have plans to (1) get people engaged in primary care and on lists and (2) provide health care for those who do not or cannot engage. This is a fundamental issue that needs to be addressed first. This is particularly important if we are not to see greater health inequalities. • There is a range of models for how DsPH and specialist public health teams can work and where individuals can be deployed but arrangements should avoid having small fragmented and isolated teams or individuals. The available capacity should be maintained or increased and deployed to best effect. DsPH should work across systems and have a clear role with GPCCs. • PHE will ask the NHS to take responsibility for commissioning some population interventions such as screening programmes. This makes sense given scale needed and if GPCCs are expected to do the commissioning it should be made clear to them that they will need high quality public health input. • Significant changes to NHS services should be accompanied and supported by health and equalities impact assessments that identifies the need to address service gaps and the optimum solution for change.

Q4	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 this might be achieved?
A4	• This refers to public health interventions in the GP contract such as childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. • An alternative to the NHS commissioning board commissioning these via the GP contract would be for PHE to commission them, given that they will have the expertise to do so and geographical consistency is so important. An alternative whereby individual LAs were responsible for commissioning could result in inconsistency and fragmentation of what is basic public health provision. • We believe TB presents a special case. Because of small (but growing) numbers in London, it is not commonly seen by individual GPs. TB control in London requires a coordinated pan-London approach, so that the disease can be better prevented and treated. This work cannot be carried out by a multiplicity of GP consortia.
Q5	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?
A5	• Appendix B of the Impact Assessments document draws out potential impacts on a range of population groups, including those from socioeconomically disadvantaged populations. It describes the risk that the ring-fenced budget may not be sufficient to meet demand, and suggests that this risk will be mitigated by LAs being able to use 'all of their budgets to best meet demand from their local population'. • We agree that this is a major risk, but are concerned that the significant cuts to local government funding do not support the credibility of the suggested mitigation. In fact, it may be that public health budgets, which often do target the least well off, will be vulnerable themselves because of the financial climate in LAs. • The document does not sufficiently address the risks of greater fragmentation of the specialist public health workforce, which it does acknowledge already has limited capacity. Plans need to address the serious risk to health inequalities posed by confusion about whether GPCCs will be responsible for patient lists or whole populations. If the former is the case those responsible for NHS commissioning (the national board and GPCCs) need to explicitly take account of those not on lists and have plans to (1) get people engaged in primary care and on lists and (2) provide health care for those who do not or cannot engage.
Q6	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?
A6	• The Table raises a number of questions around the ability to clearly define and identify current expenditure on all of these activities. • The concern of the greater fragmentation and responsibility for planning and commissioning of services highlighted in the answer to question 1 above should be addressed initially before an answer can be given to this.

	• In London it has been agreed with the London Mayor and GLA, to develop a London Health Improvement Board with London-wide remit, and responsibility initially for 3% of the PH budget. Whilst this is a good idea to address London wide issues there are serious concerns about it including suitable 'partners'. Whilst the LA Health and Wellbeing Boards will include representatives responsible for the wider social determinants of health, it appears that the intention is not to include them at this London wide level. This will be a retrograde step in comparison with the current approach in London which has an independent London Health Commission including partners such as those from Transport for London. The London Improvement board should have same parameters as the HWBs locally. • This added complexity also means that there is potential for even more confusion of who is doing what and fragmentation. Clear lines of responsibility need to be agreed.
Q7	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?
A7	• No, the health check programme and prevention/early intervention may not be seen as priorities by a LA whose resource base is shrinking and who will not necessarily see the effects of rising hospital admissions because these programmes are not delivered. Separating the commissioning of different parts of the patient pathway in this way could result in two parts of the system being incentivised differently and a rise in unaffordable and avoidable admissions. If these are to stay with LAs, there needs to be compulsion for LAs to deliver them at meaningful levels despite resource constraints. LAs need to understand the effects on the whole system of care. • No, some of the activities proposed for commissioning by LAs, for which there is good public health evidence, may be vulnerable because of ideological/political beliefs or because of social stigma. For example, sexual health services, pregnancy termination, HPV vaccination, mental health promotion. Whilst local commissioning of these is desirable, again there needs to be some compulsion for LAs to deliver them at meaningful levels despite opposition on ideological grounds. Examples of this type of behaviours have already been apparent in some schools in relation to health and sexual health education. • Another important issue to consider is the splitting of the responsibility for health promotion for infants and children between Local Authorities and the NHS. This does not follow the 'life course' approach which is fundamental in both the Marmot Review and the Public Health White paper. Multi professional interventions could be needed at any stage from the age of 0-4 , these will be led by the NHS then over 5s by LAs. If a family has Children spanning those ages plus LAs are to have the lead on obesity, nutrition, physical activity etc it appears there could be significant duplicate activity plus families dealing with multi-professionals • We believe that additional protection should be given to public health interventions that respond to the needs of minority, vulnerable and stigmatised groups (see A8 below). • It is essential that TB services are commissioned on a regional basis - especially for London. These should not sit with GPCC commissioning.

Q8	Which services should be mandatory for local authorities to provide or Commission?
A8	• Local politicians may have ideological reasons for supporting or not supporting some types of public health provision or provision to particular population groups. Examples include pregnancy terminations, sexual health services, drug treatment services, HPV vaccination, children's height and weight measurement. We believe a set of principles should be agreed that LAs would need to demonstrate they abide by in terms of a meaningful offer on the above issues and to vulnerable groups. Principles should include a duty to reducing health inequalities and to promoting social inclusion, and a duty to provide interventions that are evidence-based.
Q9	Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?
A9	• Conditions should stipulate that the grant can only be spent on activities that are (a.) listed in Table A of the document and (b.) whose primary purpose is health improvement, health protection or health service improvement. • The ringfenced grant to Local Authorities should initially be accompanied by a current schedule of budgets and commitments and changes as a result of scaling back of non-front line services to provide a transparent transfer from the NHS. See Q8.
Q10	Which approaches to developing an allocation formula should we ask ACRA to consider?
A10	• Intelligence about population health need, and therefore efficient commissioning, will be jeopardised without the population denominator that was possible through distinct populations that were coterminous with Local Authority boundaries. • With new population boundaries, much health service activity data will cease to exist, the potential cost of realigning data to new boundaries/denominators could be millions and the historical comparators lost. We will not be able to gauge unmet need for health services because we will have numerator data only. • It is recommended that ACRA take into account current expenditure, current health outcomes, the need and health inequalities within different areas from an agreed set of health indicators. The work that has previously been done or commissioned by ACRA on, for example, inequalities should be taken into account. Some of this was commissioned from UCL, Department of Public Health and Epidemiology. (Steve Morris as PI)
Q11	Which approach should we take to pace-of-change?
A11	• The winding down of PCTs and SHAs carries considerable risks and must be managed carefully to prevent planning blight, confusion and the loss of skilled staff. • PCTs also have many statutory functions and responsibilities that will need to be reallocated after they are abolished and there is a lack of detail on how these issues will be addressed. • Public health professionals are working at low capacity already, and will need to be able to use their resource to increase the professional capacity

	needed to effect transition.
Q12	Who should be represented in the group developing the formula?
A12	• Members of the Marmot Review Team • The original academic contributors familiar with the territory (eg UCL see Q 10) • Health economists • Public health professional bodies (FPH, RSPH) • DH statistics/Public Health/ONS/ ACRA members and experts/academics who have been commissioned by ACRA on these topics previously • DsPH and RDPH involved in LAA • PHOs • Lay public • CIPFA
Q13	Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?
A13	• It is difficult to see how a 'short term' health premium will help towards long term objectives of better health and wellbeing. Indeed it is difficult at present to see how use of indicators can readily incentivise improved health and wellbeing, which is a long term objective and takes years to manifest itself in positive results. The only way you can easily incentivise in the short term is by encouraging *processes or interim proxy outcomes* where there is strong evidence that they improve outcomes in the longer term and are cost effective. • The approach adopted by London Health Commission(LHC)/ London Health Observatory(LHO)/GLA whereby they reviewed progress against 10 indicators (already collected data) including such entities as employment, housing, transport is a model to be considered.[1] • A recently report 'Fair London, Healthy londoners?' has identified a new set of 6 indicators relating to the life course and Marmot recommendations. These also engage 'partners' who may be responsible for social determinants as they cover life expectancy etc but also readiness for school and young people Not in Education, Employment or training (NEET) etc. [2] • Similar 'short term' improvements in early years have been measured over a three year period in Birmingham. • If implemented, the Health Premium should take into account local factors such as migration, population churn, language, age profile, ethnicity, impact of wider economy (e.g. employers leaving and large companies closing) and quality of primary care. • These factors may mean that LAs in poorer areas will struggle to achieve outcomes and then be penalized financially thereby escalating the problems.

[1] Health in London: Review of the London Health Strategy high level indicators. GLA, London 2002 (and sequence).
[2] Fair London, Healthy Londoners? . LHC/LHO/GLA/Marmot Team et al. March 2011.

Q14	How should we design the health premium to ensure that it incentivises reductions in inequalities?
A14	• There is a risk that the premium could simply be allocated to areas of wealth and low deprivation as their health outcomes improve. In areas of higher deprivation that also face a significant reduction in Local Authority budgets there is the potential for public health outcomes to diminish • The provision of some form of peer support similar to the schools 'special measures' process or the National Support Teams approach where LAs do not achieve outcomes. See also answer to Q 13.
Q15	Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
A15	See answers 13 and 14
Q16	What are the key issues the group developing the formula will need to consider?
A16	• They should consider local factors such as migration, population churn, impact of wider economy (such as employers leaving and large companies closing) and quality of primary care.

Broader White Paper Consultation

Consultation questions

a. Role of GPs and GP practices in public health: Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

- We are pleased to see that both **QIPP and QOF** will remain as mechanisms to focus and incentivise prevention and outcomes, respectively. They will both need careful maintenance and development to ensure their suitability.

- We are pleased that the white paper recognises that "the NHS has a crucial role to play in public health… ensuring that health services meet the needs of the whole population…") (para 4.46.) Our understanding is that the majority of commissioning for health services will be undertaken by GPCC, however GPCC will be responsible for the people registered on the relevant GPs lists and NOT for the whole population. This is different to what is proposed in para 4.50 of the public health white paper which states that "GP consortia will have responsibility for the whole population in their area, including registered patients, unregistered citizens and visitors requiring urgent care". These contradictory statements need rapid clarification. If GPCC are only responsible for their 'list' patients then this will mean that there is particular risk of not matching the needs of the whole population and it is likely that the more disadvantaged, disaffected and seldom heard groups – who are likely to have more health needs- will be doubly disadvantaged and will not have their 'needs' provided for in the commissioning process.

- There appears to be a be a **mismatch in the populations covered** as outlined in various policy documents and in response to questions.

- One of the crucial issues for people's health is to ensure that the full pathway is being commissioned and delivered. **The pathway** covers: wider determinants – prevention- screening and diagnosis- treatment – rehabilitation – care

- The proposed changes both to the NHS, social care and PH need to ensure that this full spectrum is covered and seamless, both in terms of commissioning and provision. At the present time the proposals appear somewhat piecemeal and there is a serious risk of fragmentation, and people falling down the 'gaps'.

- We recognise that the Health and Wellbeing Board is seen as the mechanism to draw things together at a local level. However the complexity of the commissioning arrangements at national, sub-national and local level and between different responsible bodies (e.g. as in table A of the funding routes white paper), we consider there is a very real risk of fragmentation and omissions/duplications. In the present economic climate when all parts of the public sector have to make significant savings, there will also be a risk of cost shifting and game playing between organisations.

- There needs to be absolute clarity as to who is responsible for what and streamlined mechanisms by which they can be held to account.

b. Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

- It will be essential that commissioning is allied with health outcomes. They need to go hand in hand together for evaluation purposes.
  The NHS has had very good data on public health intelligence (public health outcomes) at LA level for many public health indicators including deprivation, mortality, morbidity and Marmot indicators etc (not only QoF) for 7 years. It is suggested that for the first years of GPCCs (particularly with severe NHS financial constraints) GPCCs should be compared using the same yardstick ie across Las. This will ensure GPCCs are transparent and accountable as the Equity and Excellence white paper has promised.

- It would very expensive (many £millions not yet budgeted by DH) to start again from information 'year zero' - using a very irregular and different geography to build up the same wealth of health intelligence for a new geography of GPCCs It would also have no historical data to compare- so would be unaccountable.

- But this is not necessary. Public health intelligence is currently recorded at LA level. Since 2007 most PCTs in England have commissioned for populations coterminous with LA boundaries.

- The provider function of GPs and the Commissioning function of GPs in GPCCs needs ethically to be clarified and distinct- and need not have exactly the same boundaries. It is quite possible for GPCCs to commission primary care and secondary care for their LA population (s). That is the LA in which most of their population reside- with accountabiliy to neighbouring and overlapping GPCCs- if some patients of the LA live near boundaries in another GPCC.

- This will help in understanding best practice commissioning public health outcomes, give more transparency to methods, and make GPCCs accountable to each other. Public health intelligence forms the obvious bridge between

public health in the LA and the health outcomes much sought after by GPCCs. This model of public health intelligence will also save a very large budget, needed otherwise for new health intelligence infrastructure and staffing.

c. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioral science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

- Develop an information strategy to address what there already what needs updating and what new evidence is needed .. commission research for the new evidence
- Ensure adequate resource for public health research and dissemination.
- The consultation on outcomes asks about alignment across the NHS, Adult Social Care and Public Health. There is a concern that this is missing children.

d. Public health evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

- Community health profiles should be continued and HWBs should have resource for training and development in evidence-based decision making.
- Nationally NHS and PHE need to make it clear that this evidence should be used. HIA is a useful tool for ensuring evidence is used to underpin policy and delivery decisions.

e. Regulation of public health professionals: We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

All PH specialists from all backgrounds should follow the same registration and regulatory mechanisms. It is not and should not be voluntary.

PHAST would be pleased to discuss further with you the points in this response. We believe we have a unique perspective as the only public health focussed social enterprise and can bring valuable experience to bear on these proposed changes. Please see also PHAST responses to the consultations on '*Healthy Lives, Healthy People*' the strategy for public health in England and to the Outcomes Framework.

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March 2011.