Public health white paper: *Healthy Lives, Healthy People*
NHS Confederation response to consultation on the funding and commissioning routes for public health, 31 March 2011

The Government’s public health white paper changes how the NHS and local authorities in England will commission and deliver health protection and health improvement services. It confirms the proposals outlined in the health white paper *Equity and Excellence: liberating the NHS* to move local public health responsibilities from the NHS to local authorities and to establish a new national body, Public Health England.

Overall, our members are firmly committed to working positively with the Government to ensure its ambitions for public health are achieved. They have significant knowledge and experience which they are ready to contribute to making the new system work.

Response to the consultation on funding and commission routes for public health

In preparing this response to the consultation, the NHS Confederation has drawn on feedback from and discussions with our members across all parts of the NHS between November 2010 and March 2011, including directors of public health, PCT directors of finance, commissioners and providers of services.

Below is a summary of our views, followed by more detailed answers to the consultations questions.

This document sits alongside our overall response to the white paper and the response to the consultation on the proposals for a public health outcomes framework.

The NHS Confederation

The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS. We represent over 95 per cent of NHS organisations as well as a growing number of independent healthcare providers. We have a number of networks which represent specific types of organisations within, or working for, the NHS, including foundation trusts, primary care trusts, ambulance trusts, mental health providers, community providers and independent sector providers of NHS services through the NHS Partners Network. The Health Protection Agency is a member of the NHS Confederation.
Executive summary
NHS Confederation response to Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, 31 March 2011

We strongly welcome the white paper’s aim of making public health a top priority in both health services and local government. In particular, we support the increased priority given to ensuring closer joint working between local government and the NHS, as well as addressing the root causes of poor health and well-being.

However, we have indentified significant proposals in the consultation on the funding and commissioning routes for public health that we believe the Government should rethink so that its objectives can be met.

1. Our members are concerned that local authorities may not have enough money to commission and deliver all the public health services for which they will be responsible. While the public health budget will be ring fenced, we emphasise that it is not easy to define ‘public health’ and therefore to identify public health activity and spend accordingly. Adequate funding is particularly important, given the expense of many public health services and the impact on the rest of the health service if public health needs are not met.

2. Extra funding for more deprived areas is to be welcomed. However, we are deeply concerned about unintended consequences that are likely to result from the Government’s plans to use a health premium to reward those areas that reduce health inequalities with extra money. We fear that this may not fairly reward progress and may lead to areas losing money where there is actually most need. We are concerned that areas with high levels of population movement, which are often the most deprived, could unfairly lose funding due to slower progress. The health premium would work very differently in different areas, and a one-size-fits-all approach will not be appropriate. In addition, If the current approach to funding allocations continues, this could mean that areas that succeed in reducing health inequalities are rewarded by the health premium but may be simultaneously penalised by a reduction in their overall public health funding allocation due to the improvement in their deprivation indicators. In further developing the health premium, we believe the Government should:
   • review the health premium mechanism and evaluate it as it is put into practice
   • take local circumstances into consideration through proportional benchmarking of local areas with similar levels and patterns of deprivation, population movement and demography
   • develop other levers and incentives to catalyse action to reduce health inequalities across the NHS, local government, voluntary sector and businesses
   • work to avoid unintended consequences from the interaction of the health premium with other funding mechanisms.
3. More thought needs to be given to how the different elements of the system will work together and where specific responsibilities will sit so that the system functions as a coherent whole. Commissioning services such as immunisation, sexual health, mental health, safeguarding and children’s services, is often a complex, interdisciplinary and interagency process and should not be disaggregated. Under the current proposals, services in each of these areas will be commissioned by multiple bodies. This could result in people ‘falling through the gaps’ between commissioners. To avoid this risk, we believe that each of these services should be commissioned as a package.

4. It will be important for health and well-being boards to monitor all commissioning activity across local government and the NHS to ensure that services are being commissioned in line with the public health, NHS and social care outcomes frameworks. Strengthening performance, prevention and early intervention will benefit all public services. Clarity is required regarding how communities and Public Health England will be able to hold local authorities to account for use of the budget and their public health outcomes.

5. Commissioning of public health programmes must be of the same quality, and carry the same weight as other mainstream commissioning through local authorities or the NHS. GP commissioning consortia, together with their public health colleagues in local authorities, will need to adopt high professional standards when commissioning health services, incorporating public health expertise into decision making. We are concerned that there is currently no mechanism for connecting the expertise of public health professionals with NHS commissioning decisions. Public health professionals have a key role in providing expertise in the new system and GP commissioning consortia will need to make use of public health expertise in commissioning health services more broadly.

6. Further clarification is needed on how a ring-fenced budget for public health might operate within a system that aims to promote place-based budgeting. If public health budgets are to be ring fenced, it will be important that there are mechanisms to audit and safeguard their use and any initiatives funded from this budget are based on a clear rationale of how they will contribute to improving mental and physical health and well-being across the local population.

7. To successfully transition responsibility for public health to local authorities, appropriate conditions will be required. This is particularly pertinent during the early years of the new system, it will be important to set out what and when local authorities will be expected to deliver. We welcome the plan to publish shadow ring-fenced allocations but propose that local authorities should be given an indication of future budgets in 2011/12 rather than 2012/13 in order to aid them in transition planning and developing strategies for staff recruitment.
Introduction

0.1 It is not easy to define ‘public health’ or identify public health activity and spend. The work of many healthcare professionals and others combines prevention, treatment and long-term care in a way that is practically difficult to separate and apportion. Separating the public health budget from the NHS budget could lead to fragmentation of the system. Our members have highlighted key areas within the system that require further thought and posed solutions where appropriate.

Q1. Is the health and well-being board the right place to bring together ring-fenced public health and other budgets?

1.1 The health and well-being boards could make a valuable contribution to providing oversight for the three domains of public health, including health services, health service design and strategy and take on the role of local level system leadership. This might help to address some of the concerns about the loss of a ‘system manager’ within the NHS and across public health and social care to oversee the local health economy. However it is not clear that they have sufficient powers to undertake these functions.

1.2 In principle the health and well-being board is the right place to bring together ring-fenced public health and other budgets. However, much of the board’s ability to act as the ‘system manager’ will depend on the capacity, resources, relationships and behaviours that are developed at a local level. It is not clear where much of the required system leadership will sit in the new system. Taking the example of infant mortality, it is proposed that local authorities will be responsible for commissioning smoking cessation services, GP commissioning consortia will commission maternity care and the NHS commissioning board will commission neonatal and specialist care.

1.3 There is a danger that health and well-being boards will become overburdened with PCT functions that do not fit elsewhere in the system which could distract them from their core functions. Health and well-being board development would be assisted through the provision of clear, consistent advice guidance and support. This should include the principles to underpin the workings of the board, and draw on good practice and learning from existing partnership working and emergent health and well-being arrangements. To carry out commissioning functions effectively, health and well-being boards will require a degree of local freedom to make evidence based decisions for their population. Providing decisions are evidence based and work locally, subsidiarity should be the underlying principle for the boards and public health reform.

1.4 GP commissioning consortia are primarily accountable to the NHS Commissioning Board. In some areas partnerships between GP commissioning consortia and local authorities through the health and well-being boards may be unbalanced if either party is responsible for significantly
more resources than the other. GP commissioning consortia governance arrangements will impact upon how GP commissioning consortia engage with health and well-being boards.

1.5 **NHS Confederation ask**

It is important that any new arrangements build on the extensive learning from the wide range of existing partnership working in which our members have been involved. These include local strategic partnerships, existing health and well-being boards, integrated care organisations, whole system demonstrator sites and other examples. Public health and mental health services particularly have developed effective approaches to integrated working, with joint appointments and commissioning across local government and the NHS to improve the wider determinants of health such as employment for people with mental health problems.

1.6 The health and well-being board provides a structure through which joined up decision-making can be made about the public health ring-fenced budget and other budgets. We believe health and well-being boards should draw lessons from the Total Place pilots, which pooled budgets to benefit the whole health economy of public health, health and social care. The development of place-based budgeting could support integration and be particularly helpful in tackling shared priorities such as action on drugs and alcohol. They also hold the potential to support improvements for public mental health.

1.7 **NHS Confederation ask**

More information is needed on how place-based budgeting could operate more generally within the new structures, and enable the pooling of NHS, public health and local government funding streams.

1.8 Incentives are needed within the system to encourage integrated and joined up working. Currently we believe there are more incentives to create competition between them than to strengthen cooperation. It will be difficult to strengthen joined up working if members of the health and well-being boards are competing with each other for funds. It will be essential that GP commissioning consortia and local authorities are working together to commission public health services. If commissioning for these services goes wrong it will be the responsibility of the NHS for treating the crisis.

1.9 **NHS Confederation ask**

It will be important for health and well-being boards to monitor all commissioning activity across local government and the NHS to ensure that services are being commissioned in line with the public health, NHS and social care outcomes frameworks. Strengthening performance, prevention and early intervention will benefit all public services. Clarity is required regarding how communities and Public Health England will be able to hold local authorities to account for use of the budget and their public health outcomes. Clear mechanisms are required for involving communities particularly as the white
paper proposes they, as well as local government, will be responsible for reducing health inequalities.

**Q.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?**

2.1 The NHS Confederation supports the involvement of voluntary and private sector organisations in delivering public health services and we support the principle of subsidiarity. However, our members are concerned there may be limited local influence over contracts negotiated at a national level. They are concerned that larger national organisations will have significant advantages when bidding against smaller local organisations.

2.2 **NHS Confederation ask**
A clear mechanism is required to enable smaller providers to play their full part in delivering services. The health and well-being boards and Public Health England will need to ensure localities make the best use of voluntary and independent sector capacity to support implementation of local health and well-being strategies.

2.3 Many very good third sector providers have been providing services that span multiple commissioners in the proposed new system. The changes to commissioning structures could pose a threat to their ability to continue providing such services.

2.4 **NHS Confederation ask**
The health and well-being boards will need to facilitate and ensure commissioning between health and local government enables third sector organisations to continue to deliver services.

2.5 Many members of communities are already actively involved in their local area but are not necessarily well connected to local authority and statutory bodies.

2.6 **NHS Confederation ask**
Health and well-being boards will need to develop a new and more equal relationship with communities working in partnership and using asset based approaches to assessing population needs. Support to existing as well as newly developing community groups, and strengthening mechanisms to involve community members, will be required to enable the Government’s Big Society vision to happen and increase people’s responsibility for improving their own health.
Q3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

3.1 GP commissioning consortia and the NHS Commissioning Board will require engagement and support from public health professionals to support inform commissioning decisions and will need adequate funding for this. It is important to ensure public health expertise is used when commissioning providers to deliver integrated health services as well as health improvement and health protection services across primary, secondary and tertiary care.

3.2 **NHS Confederation ask**
Guidance to GP commissioning consortia is required to ensure health improvement becomes more integrated and a core priority across healthcare service commissioning. To deliver the public health outcomes framework, directors of public health and GP commissioning consortia will need to coordinate commissioning functions to invest in upstream interventions.

3.3 A shift in focus is required for GPs as providers to act as commissioners taking into account wider use of evidence of population needs. GPs' local knowledge could bring advantages, strengthen understanding of local circumstances in commissioning and align perspectives with council-led public health work. There is a risk that without active incentives participation in research and knowledge translation will not be adopted by GP commissioning consortia. This could weaken the evidence base and in time the quality of care delivered to patients. Health and well-being boards could be encouraged by formal frameworks to take an overview of health and social care research undertaken in their area and set strategy for its development.

3.4 **NHS Confederation ask**
It will be important that commissioning of public health programmes is of the same quality, and carries the same weight, as other mainstream commissioning through the local authority or the NHS. GP commissioning consortia, together with their public health colleagues in local authorities, will need to adopt high professional standards when commissioning health services, and incorporate public health expertise into decision making. Public health professionals currently provide ready access to: the considered evidence base of interventions and elements of delivery, examples of good practice, modelling techniques and expertise and health economic expertise, such as advice on measures of return on investment as well as adaptable frameworks to inform quality business planning. Continuous professional development is required for public health specialists and they will need to remain connected to academic public health research, connecting researching activity with commissioning and service provision. This will ensure there is a competent local multidisciplinary public health workforce in place to address public health and health service commissioning and service delivery needs across local authorities and the NHS.
3.5 **NHS Confederation ask**
Mechanisms are required for how Public Health England and the NHS Commissioning Board will work together to commission and deliver public health services, including the use of public health expertise to inform commissioning of health protection and health services.

**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 might this be achieved?**

4.1 We welcome the proposal for allocating a percentage of the Quality and Outcomes Framework (QOF) to public health. However, it is possible that a significantly greater proportion than 15 per cent of the QOF is already spent on activities that contribute to public health. Much of GPs’ activities such as establishing effective disease registers and systematic management of patients are all public health initiatives. Giving an allocation of the QOF to public health may be a positive initiative to ensure GPs deliver certain public health interventions, but it may also limit their obligation to public health. To make every primary care contact count, a health promotion contact with clear advice, support and sign-posting to appropriate services to prevent illness or recurrence of illness is essential. While the NHS Commissioning Board will be responsible for negotiating changes to the QOF and monitoring GP performance, Public Health England will fund the public health elements of QOF and may want to change the way this budget is spent, for example, by changing the QOF indicators.

4.2 **NHS Confederation ask**
We support Public Health England having greater flexibility regarding commissioning services as a whole as well as those services provided through the GP contract. However, dialogue between the NHS Commissioning Board and Public Health England will be essential to ensure that such changes to the QOF are negotiated in line with the rest of the contract and are managed so as not to disenfranchise GPs.

**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?**

5.1 Although the equality impact assessment mentions the health premium it does not discuss the possible impact it could have on areas with increasing levels of health inequalities. See below response to questions 13, 14 and 15 for more details.
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?

6.1 It is unclear whether the level of funding to be made available to local authorities will be commensurate with local authorities' new responsibilities and functions mentioned in table A.

6.2 **NHS Confederation ask**
The public health funds will be subject to efficiency savings as with the rest of the NHS budget and clarification of the total amount of the public health ring-fenced budget and how much will be allocated to different parts of the system is needed, including how much of the budget will be required to fund nationally commissioned services.

6.3 We understand the figures for the public health ring-fenced budget will be taken from levels of PCT spend on public health. However, it is difficult to separate and apportion public health spend across the NHS; services and populations are different in different parts of the country.

6.4 **NHS Confederation ask**
We are concerned that local authorities may not receive the right amount of funding to commission and deliver health improvement services locally and pay for the expertise required to take on new public health responsibilities. **If local authorities don't receive the right amount of funding this will have a knock on effect on GP commissioning consortia to commission and deliver health services locally.** It will be difficult to align public health budgets with funding allocated to GP commissioning consortia, as allocations for the consortia will be based on the registered practice population and we assume that the funding for public health to local authorities will be based on the resident population of a local authority. Aligning funding for public health budgets with funding allocated to GP commissioning consortia will be essential to connect health service activity and access to health services to the health improvement and health protection work of local authorities.

6.5 As the public health budget will be the only ring fenced budget within localities our members are concerned that there may be a tendency to define existing local government services as public health. In the past, PCTs have paid for initiatives to grit roads and strengthen tobacco control and in reality local authorities and particularly directors of public health and GP commissioning consortia will have to agree how to best commission a range of services in collaboration. New ways of working will be required to strengthen joined up commissioning and avoid cost shunting between health, public health and social care. While ring-fenced funding of public health may help to protect expenditure on disease prevention and health promotion activities, it could undermine progress on embedding initiatives and responsibility for improving public health across all NHS organisations. We are concerned that the proposed approach could have unintended consequences such as
encouraging cost-shunting through the re-classification of activities, removing incentives for NHS service providers to play their vital role in public health improvement or leaving responsibilities for delivering services at the interface between local government and the NHS ill defined.

**NHS Confederation ask**

6.6 **GP commissioning consortia will need to include integrated health improvement services within providers’ contracts.**

6.7 **NHS Confederation ask**
Further clarification is needed on how a ring-fenced budget for public health might operate within a system that aims to promote place-based budgeting. If public health budgets are to be ring fenced, it will be important that there are mechanisms to audit and safeguard their use and any initiatives funded from this budget are based on a clear rationale of how they will contribute to improving mental and physical health and well-being across the local population. Table A provides a comprehensive overview of most public health funded activity but it isn’t exhaustive. A key element missing is the commissioning of designated safeguarding professionals within the health service, see response to question 7 for further details.

6.8 The public health white paper and related consultation documents do not mention the important role optometrists play in identifying key signs of diabetes and glaucoma and it is not clear who will commission such services. Table A proposes that public dental health will be commissioned by local authorities. However, it is not clear whether this includes screening for mouth cancer, the reforms propose that Public Health England will commission all screening service, the details of which are yet to be defined.

6.9 **NHS Confederation ask**
We recommend that screening that the NHS Commissioning Board will commission is defined to make clearer what is involved and ensure all areas of screening are adequately covered. Because the dental contracts will be held by the NHS Commissioning Board, screening commissioned by Public Health England and dental public health commissioned by the local authority, clarity is urgently required to avoid fragmentation of the system.

**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?

7.1 The consultation document proposes which parts of the system will commission particular public health services. In a number of cases the proposals suggest many different parts of the system: the NHS
Commissioning Board, local authority, Public Health England and the NHS/GP commissioning consortia. Taking the example of immunisation, three parts of the system will be commissioning elements of the programme but the skill set required is the same and therefore duplication of effort may occur. Having vaccination targets has proven to be effective at achieving good population level outcomes but having multiple commissioners for one service could become problematic.

7.2 We are concerned that separating the commissioning of immunisation programmes through schools such as HPV and the teenage booster to be carried out by local authorities, from other vaccination programmes such as flu to be commissioned by the NHS Commissioning Board, would not make best use of expertise and resources required. Separating the commissioning of immunisation programmes could make it difficult for local authorities and GP commissioning consortia to reach sufficient population immunity required to protect the population and may result in people falling through the gaps between the different commissioners.

7.3 **NHS Confederation ask**
Clarity is required about how each part of the system will work together to ensure effective and coordinated commissioning.

7.4 **Sexual health**
Levels of sexual transmitted infection have been increasing year on year despite the best efforts of health service professionals, with young people between the ages of 15 and 24 most at risk. Managing this is a major challenge for GUM services, HIV services and public health units. The approach going forward requires more sophisticated and integrated solutions that pull together the current expertise in sexual health services, contraception and women’s health services, academic units and public health services, alongside those with an interest in the health and well-being of young people including school health services, local authorities and voluntary sector organisations. In splitting the commissioning responsibilities such that local authorities become responsible for sexual health and school health services, the NHS Commissioning Board for contraception services and Public Health England for HIV, it will be important not to lose sight of the relationships between these services and the coordinated work which will be necessary. The ability to deliver rapid access to diagnostics and treatment alongside enhanced prevention programmes will require committed partnerships across the full range of commissioners and providers. There needs to be a willingness to embrace new technologies and improve understanding of the social and behavioural determinants of the spread of infection.

7.5 It is not clear how local authorities commissioning sexual health services and the NHS Commissioning Board commissioning HIV treatment and promotion of opportunistic testing and treatment will be delivered and integrated. Disconnecting commissioning of HIV services from other sexual health services could jeopardise the quality of comprehensive service provision.
7.6 **NHS Confederation ask**
It is not clear how local authorities and the NHS Commissioning Board through the GP contract will ensure joined up provision of such services and integrated pathways, further clarity and details of how this will work is required. **To enable more integrated working and avoid further fragmentation of services, we recommend that services are jointly commissioning services between GP commissioning consortia and public health departments within local authorities at local or supra-local levels.** Clients will not necessarily remain within their borough to access sexual health services and can purposefully travel outside of their area to obtain services. As commissioning for sexual health is a specialist skill, in some areas it would be more cost effective for these services to be commissioned on a supra-local basis. Ensuring adequate sexual health services are available to all including school age young people is essential. To avoid unnecessary outbreaks of sexually transmitted infections independent and ‘free’ schools will need to cooperate as with other schools.

7.7 It is not yet clear what GP commissioning consortia responsibilities will be for commissioning but it is difficult to separate health improvement from primary care and in reality we expect GP commissioning consortia to take on commissioning for some health improvement related services. However, where at all possible this should be uniform across all GP commissioning consortia and not be subject to GP commissioning consortia with particular interests.

7.8 **Children’s public health**
Commissioning children's health services is often a complex, interdisciplinary and interagency process. In the new system it is not clear which commissioners will do what, for example, who will commission designated safeguarding children leads and how will they work with other commissioners. GP commissioning consortia will be responsible for commissioning maternity care and healthcare for children aged 0 to 19 years (not defined as public health in table A) and local authorities will commission the rest of children’s public health. Fragmenting commissioning responsibilities in this way will make it difficult for not only local authorities, but for GP commissioning consortia and the NHS commissioning board. It is not clear how local authorities will be incentivised to invest sufficiently in prevention and early intervention initiatives that will result GP commissioning consortia not having to fund unnecessary treatment.

7.9 **NHS Confederation ask**
Establishing a specialist subgroup of the health and well-being board to encompass responsibilities for providing integrated children’s services and safeguarding could achieve more joined-up commissioning.

7.10 In the white paper there is limited focus on the public health of young people. The transition from childhood to adulthood is a particularly sensitive time for

NHS Confederation response to *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, 31 March 2011*
health behaviours as it is when young people are exposed to and start to experiment with smoking, alcohol, drugs and sex.

7.11 **NHS Confederation ask**
Clarity is required about how Public Health England, local authorities and the NHS will commission and deliver appropriate and tailored services for young people.

7.12 **Health visiting**
The NHS Confederation welcomes the Government’s focus on prevention and early intervention in its new health visitor plan. However, the plan focuses on increasing the numbers of health visitors in the system within a short timeframe and it is unclear whether targets will be achievable. Clarity is also required about why there is a focus on numbers of staff roles rather than outcomes as is the case with other parts of the system. Focusing on outcomes requires a multidisciplinary approach involving a range of skills and cost-effective use of resources to reduce health inequalities. Our members support the need for more resource to improve children’s public health but question whether a single profession is able to address the varied needs of communities. As local authorities become the commissioners for health visitors in the future it is not clear how this service will remain joined up with NHS services. In the interim period it will also be difficult for the NHS Commissioning Board to commission such a service that is specific according to local variations. A more joined up long term approach to early intervention and prevention for young children will set up a more robust system able to ensure the best possible outcomes for the population as a whole as well as the most vulnerable.

7.13 **Safeguarding**
Table A does not mention safeguarding and there is very limited reference to safeguarding in the reforms. More clarification is required regarding lines of accountability and how it could work in the new system. The NHS Confederation is concerned about where the responsibility for safeguarding will sit in the new system and which organisation or officer will have the responsibility for continuing to develop local safeguarding systems that are integrated within and across different services. As GP commissioning consortia boundaries may not be coterminous with local authority boundaries, it is not clear how local safeguarding boards will work across NHS and local authority services.

7.14 **NHS Confederation ask**
The reforms should ensure that processes that are working well within existing services can be replicated or retained in the new system. The NHS and local government reforms and the re-energised health visiting service provide opportunities to strengthen safeguarding and early intervention.

7.15 **NHS Confederation ask**

NHS Confederation response to *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*, 31 March 2011
The NHS Confederation believes that the current safeguarding partnerships should not be lost as the new commissioning approach is developed between health and social care. The need for these skills in the future should be recognised, along with a succession plan which enables training for these roles to be an integral part of workforce development. Networks for named and designated professionals to learn from each other, discuss issues of common interest and concern and develop new local guidance etc should be maintained and supported by providers and commissioners locally. As the public health service transfers to local government, safeguarding and particularly the commissioning of the designated professional role should be included as part of this service with the funding explicitly identified within the transferred budget. This would also work well in the future as the commissioning of health visitors will also become the responsibility of local government public health departments. The links between violence and safeguarding are clear so this proposal sits well with wider local authority public health responsibilities for tackling violence.

7.16 The proposed Public Health Outcomes Framework contains one element on safeguarding specifically targeted at children under five years of age and the proposed Social Care Outcomes Framework contains one element around adult safeguarding. The NHS Outcomes Framework has no elements relating to safeguarding directly. We are therefore concerned about the lack of overlap or alignment of the frameworks or cross referencing to other guidance.

7.17 **NHS Confederation ask**
The NHS Confederation urges the Government to ensure that the issue of safeguarding for both children and vulnerable adults is part of the outcomes frameworks for public health, social care and the NHS in an explicit and coherent way. This would also encourage focus by both providers and commissioners on the preventative and protective elements of safeguarding practice.

7.18 **Public mental health**
Our members are concerned about the fragmentation of public mental health and mental health services, particularly around dementia and the separation of drug and alcohol and mental health service commissioning. Currently a number of mental health providers carry out mental health promotion and anti-stigma work in their local areas, such as The 5 Boroughs Partnership NHS Foundation Trust and many mental health providers are well equipped to continue with such work. It is not clear how local authorities responsible for mental health promotion, illness and suicide prevention will connect with mental health care providers delivering treatment and recovery services. It is not clear how integrated pathways for dual diagnosis and prison health services will be developed.

7.19 **NHS Confederation ask**
Joined up commissioning between the GP commissioning consortia, local authorities and the NHS commissioning board is required. To reduce health inequalities it will be important for the new system to improve the public’s
mental well-being, meet the physical health needs of people with mental health problems and the psychological needs of people with long-term conditions. Such important areas should be jointly commissioned by one organisation and delivered through different bodies with clear accountable lines rather than fragmented across the system.

7.20 Focusing on addressing health inequalities will contribute to addressing offender public health challenges. The health outcomes for people in touch with the criminal justice system are poor, and higher numbers of people in the system have mental health problems and learning disabilities. Measures to extend access and improve the quality of interventions targeted at this group are not only important for addressing wider health inequalities, but also for reducing rates of offending and re-offending. Mental health providers and commissioners have a major role to play in making that a reality.

7.21 **NHS Confederation ask**

We support the recommendations of Lord Bradley’s review and would like to see those fully implemented. We particularly welcome the commitment to a national roll out of diversion services in the coalition Government’s green paper, *Breaking the cycle: Effective punishment, rehabilitation and sentencing of offenders*.

**Q8. Which services should be mandatory for local authorities to provide or commission?**

8.1 In some areas the voting public may not be in favour of the local authority providing essential public health services such drug addiction or sexual health services for young people. Some key public health services should be universally available either within a local authority boundary or at regional level, such as health visiting or safeguarding. The process for mandating services should ensure key services are available for all but should not restrict localities prioritising interventions targeted at meeting specific local population needs. Our members believe that the Secretary of State for Health through Public Health England should mandate local authorities to provide services that may not be seen as desirable by the voting public including drug addiction and sexual health services. This will ensure comprehensive public health services are available to protect and improve community health.

**Q9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?**

9.1 The accountability mechanisms for public health funding, outcomes and intermediate measures to monitor progress are currently unclear.

9.2 **NHS Confederation ask**

In order for successful transition of responsibility for public health to local authorities to take place smoothly appropriate conditions will be required. This is particularly pertinent during the early years of the new system, it will be
important to set out what and when local authorities will be expected to deliver. However, these conditions should be clear but not so restrictive so as to deter innovation or the setting of local priorities.

9.3 We see the transition period as the area of greatest risk, during which expertise could be lost and local public health services could fail to deliver.

9.4 **NHS Confederation ask**

Public Health England will need to ensure there are continuing connections and networks that link up public health professionals with others throughout the transition. The white paper does not provide details on the role of academia in public health. Maintaining partnerships with academic institutions particularly during transition will be important to ensure access to new evidence.

9.5 It may take time for local public health systems to operate effectively. Public Health England and the NHS Commissioning Board will need to work together to build public health commissioning capacity in GP commissioning consortia and local authorities.

9.6 **NHS Confederation ask**

It may be necessary for health and well-being boards to start operating earlier than planned to ensure smooth adequate handover of duties and responsibilities. Better and clearer articulation of public health functions is necessary to ensure that the new structures have sufficient and skilled commissioning capacity.

9.7 **NHS Confederation ask**

It is unclear who will be accountable for health protection and emergency response in 2012/13 and steps need to be taken now to ensure adequate capacity and planning before the 2012 London Olympics. PCTs understand their coordinating role in emergency planning and resilience; losing staff with this expertise and knowledge during the transition will be a significant loss to the system and needs careful consideration during the transition period.

9.8 **NHS Confederation ask**

We welcome the plan to publish shadow ring-fenced allocations but propose that local authorities should be given an indication of future budgets in 2011/12 rather than 2012/13 in order to aid them in transition planning and developing strategies for staff recruitment.

9.9 **NHS Confederation ask**

With budgets under pressure, it is important that when central and local government are looking for savings, they take into account the impact of various services on public health, and avoid adversely increasing health inequalities. The Marmot Review, *Fair Society, healthy lives*, clearly outlined recommendations on how to reduce health inequalities and the recent indicators published by the Marmot Review team will help to monitor health
inequalities and the social determinants of health for all ‘upper tier’ local authorities in England. Our members believe that local authority funding cuts risk restricting progress on more joined up working between health, public health and social care.

**Q10. Which approaches to developing an allocation formula should we ask ACRA to consider?**

**Q11. Which approach should we take to pace of change?**

In response to questions 10 and 11:

10.1 As demonstrated by the consultation documents it is not easy to define ‘public health’ and identify public health activity and spend accordingly, particularly as the work of many healthcare professionals combines prevention, treatment and long-term care in a way that is practically difficult to separate and apportion. The current financial systems do not break down health service expenditure according to public health services.

10.2 **NHS Confederation ask**

Our members have highlighted it is difficult to disaggregate spend as public health is dealt with differently in different areas. They emphasized that the public health budget should not be looked at in isolation of the overall health system. If the formula does not allocate the right amount of public health budget to local authorities this will have a detriment impact on the NHS. The new method of estimating public health spend should acknowledge that due to the way that current systems are set up PCTs may identify public health spend differently. Proper evaluation of the proposed approaches mentioned (utilisation, cost effectiveness and population health measures) is required to ensure that the funding allocation formula is appropriate and according to communities’ needs.

10.3 Currently PCT expenditure on public health in different areas varies due to differing demography and historical spend. If a national formula is calculated, it is unlikely to match current spend in every area.

10.4 **NHS Confederation ask**

A direct move to a national formula would likely leave some local authorities with significant overspends and others with significant underspends. To avoid such the problems this will cause, some form of a pace of change policy is required. This requires an accurate assessment of current spend. In the NHS, pace of change policy has involved differential levels of growth rather than direct redistribution of funding from over funded areas to under funded areas. This approach could be problematic if growth is nil or very limited resulting in movement to target taking place slowly.

10.5 If public health budgets are to be ring fenced, it will be important that there are mechanisms to audit and safeguard their use and any initiatives funded from this budget are based on a clear rationale of how they will contribute to

NHS Confederation response to *Healthy Lives, Healthy People*: consultation on the funding and commissioning routes for public health, 31 March 2011
improving mental and physical health and well-being across the local population.

**Q12. Who should be represented in the group developing the formula?**

11.1 **NHS Confederation ask**

Input from public health professionals (directors of public health, public health consultants, specialists and health economists), existing PCT finance directors, local government and NHS Commissioning Board representatives and academics with expertise in this area will be required to develop the formula. There is a risk that the process to developing the funding formula could be seen to be politicised. Therefore it will be important to ensure that those involved in developing the funding formula are professionals with the expertise and skills required and are acting independently. To ensure the process for devising the funding formula is transparent and is seen as transparent by the public and others we believe that the Advisory Committee on Resource Allocation (ACRA) should engage with relevant organisations and bodies throughout the process. This will ensure that those organisations most affected have an opportunity to share their concerns and are able to understand the process for devising the final funding formula.

**Q13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?**

**Q14. How should we design the health premium to ensure that it incentivises reductions in inequalities?**

**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?**

In response to questions 13, 14 and 15:

12.1 Extra funding for more deprived areas is to be welcomed but the health premium allocation to incentivise localities to reduce health inequalities is potentially one of the most problematic parts of the public health reforms. The white paper explains that localities will receive more funding if they demonstrate progress in reducing health inequalities. However, we believe the health premium shouldn’t be looked at in isolation of the overall funding allocations to local authorities. Currently some funding is allocated to PCTs according to levels of deprivation. If this continues in the proposed new system if deprivation goes down due to action taken to address inequalities, this will result in less funding through the standard allocation formula but more money received through the health premium.

12.2 **NHS Confederation ask**

The mechanism shouldn’t disadvantage deprived areas where improvements will be much harder to achieve and there is a risk that the impact of success in
reducing deprivation could result in a loss of funding overall despite the health premium.

12.3 Demographic flows may have a far greater impact on health inequalities than any public health efforts. Previously disadvantaged groups choose to move out of a deprived area once their economic circumstances have improved and we know from the Marmot Review that the social gradient in health means that the people with the least resources have worse health and less access to services. This mechanism thus risks rewarding areas that find population health improvement easier to achieve such as places with low levels of deprivation and may penalise areas with high levels of population movement that will find it difficult to make progress.

12.4 **NHS Confederation ask**
The NHS Confederation would like the Government to review the health premium mechanism and evaluate it as it is put into practice.

12.5 Patterns of deprivation in different parts of England vary. Levels of deprivation can be found in pockets of more affluent areas and across whole boroughs and the health premium would work very differently in such areas.

12.6 **NHS Confederation ask**
A one-size-fits-all approach won't work; areas need to be treated differently to achieve public health outcomes. Areas with similar levels and patterns of deprivation, population movement and demography could be proportionally benchmarked against each other to incentivise and measure progress, but this may still not sufficiently take into consideration local circumstances to measure progress fairly. If the health premium is a relatively small amount of funding, this will not sufficiently incentivise action to reduce health inequalities. Other levers and incentives are required to catalyse action on reducing health inequalities across the NHS, local government, voluntary sector and businesses.

12.7 Many of the public health outcomes that have most impact on health inequalities will not be achieved in a short timeframe, which would complicate how the health premium might work. Progress in some cases may be measured over decades rather than months or years. It is difficult to robustly measure changes in health inequalities over a short period of time and there is currently no established measure of health inequality at local (i.e. within-district) level that is both robust enough and responsive enough to be a basis on which to calculate a health premium.

12.8 **NHS Confederation ask**
Many of the health outcomes that have most impact on health inequalities will not be achieved in a short timeframe. Intermediate outcome measures would therefore support the NHS Commissioning Board, GP commissioning consortia and health and well-being boards work towards more achievable goals.
Q16. What are the key issues the group developing the formula will need to consider?

See responses to above questions.

Further information
Please contact Nicola Stevenson, NHS Confederation senior research and policy officer, on 020 7074 3227 or email: nicola.stevenson@nhsconfed.org.