Draft Corporate response to: Healthy Lives, Healthy People: Our strategy for public health in England

Consultation Questions on Funding and Commissioning

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

Response:

Yes but this will need clear accountability and a shared understanding of responsibility for delivery. CYC welcome the clarity around separate and reinforced scrutiny of health and wellbeing across the whole system.

CYC would welcome more information about democratic input to these processes and about how conflict will be managed and arbitrated. The relationship with the NHS Commissioning Board will be very important to ensure that needs are met consistently between areas.

Some members are concerned that some of the policies set out in the white paper could be undermined by policies and decisions made in other sectors. The Health and Wellbeing Board will need to consider these external influences to maximise health gain.

Question 2: How can local authorities best be encouraged and supported to commission on an any willing provider/ competitive tender basis? How can securing a wide range of providers best be achieved?

Response:

Local Authorities already have systems in place to challenge service delivery on best value. Councils' Financial Regulations encourage and require competition, where there is a market available. Councils will need to be able to ensure sufficient capacity within existing commissioning and procurement teams, and as part of this to maximise the opportunities for joint commissioning.

A framework for evaluating and benchmarking current providers of services would be useful, to help commissioners work with current and potential providers.

Market development is already an emerging area of good practice in other commissioning areas within the local authority, and it should be possible to draw on this work. Regional and sub regional working will also help to encourage new providers understand the opportunities that exist, based on local Joint Health and Wellbeing Strategies.

Question 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 done?

Response:

Local authorities will wish to influence the commissioning of services through the main GP contract and will need to be able to develop local enhanced services as appropriate. This will require a relationship through Public Health England to the NHS Commissioning Board.

Responsibilities

Question 6: Do you agree Public Health England and local authorities should be responsible for funding functions and services in the areas listed in Table A?

Question 7: Do you consider the proposed primary routes for commissioning of public health funded activity (column 3) to be the best way to:

- **ensure the best possible outcomes for the population as a whole; and**
- **reduce avoidable inequalities in health between population groups and communities?**

Response to Q6 and Q7:

CYC supports the approach to transfer as much responsibility as possible to local authorities and would question why some areas remain with Public Health England, such as children's public health for the under 5s.

Funding to local authorities

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

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

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

Question 12: Who should be represented in the group developing the formula?

Response to Q9-Q12:

It is critical that local authorities receive appropriate funding to meet the public health duties transferred in April 2013. This should cover all of the areas set out as local authority responsibilities (lead and support), not just those determined as mandatory. CYC would expect that existing spend on these areas would be transferred in the first instance.

The allocation formula should not be based on historic patterns of spend as these are not necessarily an accurate indication of need and may in fact be counter productive. Instead a combination of population health needs (including age and deprivation) and potential to benefit would seem appropriate.

The pace-of-change between the current spend and a target allocation should be as rapid as possible with the intention of each local authority receiving its target allocation within 3 years.

Health Premium

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

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

Question 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?

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

Response to Q13- Q16:

CYC welcomes the use of public health outcomes to measure current and future success. If the outcomes are used to influence funding it is important that they are timely, accurate and robust over time. They need to be specific to the area in question ie there is a direct relationship between action and outcome and should not skew activity to those areas where the measurement of the outcome is easiest (eg measuring overall smoking prevalence rather than smoking cessation activity).

It will also be important to use outcomes in a proportionate way, considering the impact (size of affected population and resulting change), the balance (across different parts of the community) and the relative challenge (eg an incremental change may get harder the better the baseline).