Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health

Response by the Association of Directors of Adult Social Services (ADASS)

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children Social Care within their Local Authority.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of their local communities and for the promotion of that well-being and protection through the use of direct services and the co-ordination of, and liaison with the NHS, voluntary agencies, private companies and other public authorities, as well as close working with the relatively newly transferred posts of Directors of Public Health, now set within Local Authorities.

ADASS members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal partnership arrangements.

ADASS welcomes the opportunity to contribute to the Department of Health consultation on the “Healthy Lives, Healthy People: funding and commissioning routes for public health”.

Consultation Questions

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

The Health and Wellbeing Board (H&WB) in discharging its function would bring together information to ensure that there is co-ordinated activity across health and social care. This is different from 'executive' responsibility for managing budgets which will be the responsibility of the Local Authority, who will be accountable for them.

Ensuring innovation and equity in decision making in a tight financial climate will be critical. External health economics advice may be needed as local arrangements could otherwise become replicas of existing Local Strategic Partnerships.

A key risk is that in the shadow year, the Local Authority will inherit existing contracts which have only just been negotiated and thus may not be reviewed for three years. This will limit Local Authorities ability to be creative and innovation funding will be needed to pilot alternative provision during the shadow year so that any contractual changes can be made in 2013.

Question 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?

Local Authorities have a good track record in commissioning from the independent sector and this expertise can be built on in terms of Health Improvement Plans. This includes tendering where appropriate. This must be balanced with ensuring value for money and sustainable interventions, which Local Authorities should be free to analyse.

Health and Wellbeing Boards should have clear accountability to co-ordinate the health and social care system, including provider engagement. This could be achieved in a number of flexible ways:

- Contract conditions could be amended to ensure that all services recognise the contribution they make in ensuring health and wellbeing, and that they address those outcomes considered important locally. Ensuring health improvement contracts are awarded to providers who will recruit and train local staff will ensure that capacity is grown locally. Formal multi system strategy and delivery groups including providers will ensure engagement.

- Behaviour change training could be supplied in the transition period to enable volunteers to become health trainers in their community. Shared funding arrangements between GP Consortia and the Local Authority could be developed to facilitate the voluntary and independent sector impacting on universal health outcomes (e.g. population programmes and targeted programmes (e.g. Long Term Conditions).

Question 3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?
At a local level, there needs to be clarity about the expectations of the Directors of Public Health in terms of time and resource given to support GP Consortia. This is an important area, but Local Authorities will need to understand the financial and people implications, give their accountability for these resources. GP Consortia should be supported by representatives of Public Health England with regard to; priority setting, optimizing care pathways and service specifications. Health economic advice should be available from the existing public health observatories that will move into Public Health England. All new commissioning must be supported by a strong evidence base based on; clinical knowledge summaries, NICE public health guidance, clinical and interventional guidance etc.
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 achieved?
Yes. All contracts and commissioned services should be regularly reviewed to ensure that they remain fit for purpose. We would expect a range of benchmarking costs, activity and outcomes to enable comparisons to be drawn and commissioning focused on improving standards. At the same time, there needs to be clarity of how this activity is integrated into other services. Public Health England, the NHS Board and the Health and Wellbeing Boards will need to work closely together regarding the monitoring and influence required to ensure health improvement is sustained. Public Health Outcomes overlap with Health Care Outcomes and Adult Social Care Outcomes. The interface requires joint monitoring and shared accountability. Public Health England could publish priorities for action by GPs within contracts which could be monitored by the NHS Commissioning Board, with the Health and Wellbeing Boards holding commissioners locally to account for outcomes.
Question 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?
The potential negative effects of the proposals will need to be mitigated by dealing with the risks below: • Their vulnerability to the emerging geographies of GP Consortia not aligning with local authorities. • The existing contractual shortfalls being carried forward. • A lack of capacity among GP leads to participate in wider decision making bodies than just the Health and Wellbeing Boards. • The low funding per head provided in the interim year for the provision of management services. • Lack of a national IT strategy underpinning the changes. • The unknown formula for calculating the allocations. • The risk of fragmentation of effort by the 3 way division of public health responsibilities. • The risk of reduced prioritisation of public health expenditure in the transition period.

Question 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. However, the funding arrangements in transferring to Local Authorities need to be transparent at a local level.	
Question 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?
The clarity on commissioning routes is welcomed, especially if there is sufficient resource to undertake this. There are opportunities to secure greater effectiveness in commissioning when linked to the NHS associated activity. It will be important for the NHS contracts to ensure that they have regard to the public health activity. Commissioning will be complex in this system and there are concerns about fragmentation and lack of clarity. This is particularly evident in Children's Services with the distinction between Under and Over 5s.	
Question 8.	Which services should be mandatory for local authorities to provide or commission?
Physical activity, early years preventative services to reduce conduct disorders, mental health outreach into schools, assistive outreach for vulnerable families that need support, behavioural change programmes, school nursing services (to deliver PSHE, health screening on entry, sexual health drop ins), falls prevention services, drug and alcohol and smoking harm reduction and cessation services.	
Question 9.	Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?
The principle of a ring-fenced Public Health Grant appears to be contrary to the government's policy in relation to grants. It is clear that the more conditions there are on this grant, the less flexibility Local Authorities will have. This ring-fence should only be seen as a temporary measure. That said the following will be important:: • That the fund should be used to tackle priorities in the JSNA. • All commissioning plans should include the identified targets for reducing inequalities with consequences for any missed targets. • All members of the Health and Wellbeing Board will need to have completed an induction programme to ensure they are familiar with the three arms of public health and fully understand the determinants of health and the Marmot report. • Within the ring-fence, Local Authorities should have the freedom and flexibility to develop public health functions according to local need and circumstances. They should not be constrained by prescriptive requirements for staff grades/roles and existing services where improvements can be demonstrably made.	

Question 10. Which approaches to developing an allocation formula should we ask ACRA to consider?
All existing local services as per Table A should be mapped and costs apportioned to the demography of the GP Consortia / Local Authority area.
Question 11. Which approach should we take to pace-of-change?
There is a risk that contracts being transferred could penalize Local Authorities in terms of risk and TUPE considerations.
Question 12. Who should be represented in the group developing the formula?
Alongside other professionals, such as PCT and Local Authority finance leads, health economists and the Marmot research team, we believe that Association of Directors of Adults Services and Association of Directors of Children's Services could provide an effective contribution in developing the formula.
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?
The determinants of health include education, housing, employment, mental and physical health as well as genetic and lifestyle risk factors. The main phase in which health inequalities emerge are in the early years as identified in the Marmot report – early year's prevention programmes should continue through family based approaches. The Royal College of Psychiatrists approach to promoting public mental health also provides evidence on how to apply successful interventions at key stages along the life-course of individuals.
Question 14. How should we design the health premium to ensure that it incentivises reductions in inequalities?
For commissioning programmes that address the outcome indicators listed in themes A-F of the Marmot report. These outcomes must be above national and regional averages and have a gap that is statistically significant at baseline. Full consideration must be made to ensure areas of high multiple deprivation are not penalized due to the complexities and deep-rooted nature of the health inequalities they face. The funding formulas and the health premium needs to take full account of these long term challenge faced by a number of Local Authorities, particularly those with highly transient populations within inner urban areas.

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?
Yes, provided the outcomes framework is modified to reflect monitoring indicators for each theme in the Marmot report, then incentive payments should be according to progress in each life stage. This would ensure that partners in delivering each theme would be continually engaged.
Question 16. What are the key issues the group developing the formula will need to consider?
• Not to lose sight of wellbeing indicators as the Public Health Outcomes framework in its current form focuses heavily on Marmot theme F rather than theme A • The timing of shadow budgets in relation to existing contracts and penalties for early closure • Existing programme budgets by specialty • Population age profile compared to England, trends in migration, births and deaths and the impact on services • Baseline of current inequality – poverty, housing, employment etc. • Weighting factors for existing vulnerable and hard to reach groups • The complexities of deep rooted multi-deprivation upon long term health inequalities