



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

A Consultation Response

NAT (National AIDS Trust)

Introduction

NAT (National AIDS Trust) is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

This consultation response is NAT's response to the Government's consultation on the funding and commissioning routes for public health, and highlights the impact of this proposal on people living with HIV.

NAT is happy to provide further information on any of the answers below.

Consultation questions

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

The creation of Health and Wellbeing Boards with responsibility for Joint Strategic Needs Assessments and the development of a Health and Wellbeing Strategy can contribute to local coordination and integration of health and social care.

However some concerns remain about the representation of the rights and voice of people whose care is commissioned centrally by the NHS Commissioning Board, rather than locally, such as people with HIV. The disconnect between the national commissioning of HIV outpatient treatment and care, and the local commissioning of, for example, primary care or social care creates potential for the needs of people with HIV to be overlooked in the Health and Wellbeing Board. Specific responsibility for ensuring that the needs of people whose care is commissioned centrally are represented in local commissioning decisions should be given to the Directors of Public Health so as to address this problem.

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?

There is a diverse and vibrant voluntary and community sector in England dedicated to meeting the needs of people with HIV and affected communities. The current financial climate and budgetary cutbacks are imperilling much of this capacity. Funding and contractual decisions need as far as possible to be multi-year agreements; there should be an ongoing engagement around evaluation of outcomes with timely indication of concerns or areas for improvement; decisions on contracts or renewal of contract must be done in a timely way so as to enable voluntary sector organisations to plan funding, budgets and services and ensure sustainability.

Consideration must also be given as to how local Health and Wellbeing Boards can draw on the experience and knowledge of the voluntary and independent sector when developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. Structured involvement should not be limited to current providers or indeed to potential ones but to all relevant bodies within the voluntary and independent sector.

One possible mechanism might be for Joint Strategic Needs Assessments always to include a mapping of the voluntary and independent sector active in the area, how that sector is currently meeting health needs and where there are gaps. Local Health and Wellbeing Boards should have a general objective (perhaps a 'due regard' requirement) of supporting diverse voluntary sector activity in their area, especially around community and peer support, self-management and involvement.

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

Key elements in public health advice to the NHS in relation to HIV are provided by the two current national HIV prevention programmes (CHAPS for MSM and NAHIP for African communities). National HIV prevention programmes need to be retained by Public Health England (and indeed further extended also to address the needs of others at risk of HIV). HIV prevention is complex, raising a number of clinical, social, behavioural and ethical issues. It is unlikely that at the local level policies, resources and research can be effectively and cost-effectively developed to meet these needs. The economy of scale of national programmes is essential.

Directors of Public Health must be responsible, on behalf of local Health and Wellbeing Boards, for communicating and advocating for the strategic priorities of their local area to the NHS both centrally (the NHS Commissioning Board) and locally (GP consortia). It is essential that this information is shared in a structured manner to ensure that commissioning of local primary and secondary care takes account of local public health needs.

Health and Wellbeing Boards must likewise take full account of the needs of people with HIV when those responsible for commissioning their treatment and care (the NHS Commissioning Board) are not present. There should be a statutory duty on Directors of Public Health (or perhaps a PHE 'condition') to represent the needs of people whose treatment is commissioned centrally at local Health and Wellbeing Boards to ensure there is effective integration of health and social care and high quality care for all, irrespective of the commissioning arrangements for their condition.

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

No specific comments

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?

It is encouraging that the impact assessment recognises the potential for fragmentation of services, and the potential risk of this to vulnerable groups, for

example African communities, but there is no discussion of how this risk is minimised or mitigated in the consultation documents. It is important that more work is done to ensure that vulnerable people do not 'fall through the cracks' which could be caused by fragmentation of commissioning. Pertinent outcome indicators are one of the key mechanisms to ensure this does not occur (such as that on late HIV diagnosis), as are a small but focussed set of requirements/conditions made of local authorities by Public Health England on the content and process for the local authority commissioning of public health.

In relation to behaviours (such as certain sexual behaviours) or particular communities, there is a risk, through the involvement of the local political process in public health, of decisions being made which are not based solely on evidence and human rights, but motivated by ideology or prejudice.

It would be useful for Guidance to be drawn up as to how local authorities should commission in the light both of the Human Rights Act and the public sector equality duty.

We have particular concerns as to whether local commissioning will take full and proper account of the health and public health needs of marginalised groups including people not in settled accommodation, mobile populations, and migrants with undetermined residency status. There are numbers of people not registered with a GP whose health needs must be assessed and met in local commissioning. There is a danger that the stress on GP commissioning acting on the basis of the needs of their patients will compromise this 'whole population' approach.

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?

NAT has questions and concerns as to who will be responsible for commissioning HIV testing. HIV testing is not part of a national screening programme but there is increasing awareness of the public health gains of acting to reduce late diagnosis and increase early diagnosis. This has recently been confirmed by the new NICE Public Health Guidance on HIV testing for MSM and for African communities.

HIV testing in sexual health clinics and presumably in community settings will be commissioned by Local Authorities (we trust incentivised by a late diagnosis outcome indicator). But we must also consider who will commission HIV testing in primary care and in non-HIV parts of secondary care and ensure integration with the whole of the 'HIV testing economy' and clinical pathways, especially when its importance will vary according to local prevalence.

The NHS Commissioning Board should not only have responsibility for commissioning the national screening programmes but also other testing programmes within the NHS mandated by Public Health England such as HIV testing (either directly in primary care or indirectly through the commissioning framework required of GP consortia).

- 7. Do you consider the proposed primary routes for commissioning for public health funded activity 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?

Whilst a ring-fenced budget for public health separated from the NHS and provided to local authorities can protect long-term investment in health from the immediate demands of acute care, there is also a danger it will act as an artificial 'cap' on public health investment where previously there was flexibility within a single local PCT budget to meet treatment and health improvement needs. The danger is especially serious if there is an underestimate of the real costs of public health need and an inadequate ring-fenced budget.

In assessing local need, in developing the Joint Health and Wellbeing Strategy and in making local commissioning decisions, there should be flexibility to draw on sources of local authority and NHS support in addition to the ring-fenced health improvement budget. Examples of good practice in this regard should be disseminated.

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

The Government have used open-access sexual health services as an example of the type of services that should be mandatory. This is welcome but it is unclear what is meant by and included in the term. NAT recommends that Public Health England require local authorities to commission 'comprehensive sexual health services' and also specify the essential elements of such services.

Comprehensive services must include (but not be limited to)

- rapid, open-access sexual health services (which must include GUM, contraception and abortion),
- specialist and reference services for STI microbiology,
- submission by local services of the range of data required for national and local surveillance to ensure public health strategic planning informed by current evidence of need,
- and, according to need, community based HIV and STI prevention interventions and testing services.

There must be guidance as to the content of comprehensive sexual health services to ensure consistency and clarity across the country.

That comprehensive sexual health services are mandatory would not require each Local Authority to commission all aspects of these services by itself. That could well not be cost-effective. We are pleased that the Government is encouraging the consideration of sub-national or supra-local commissioning of certain services. Particular services such as community based HIV prevention work may be better provided at a supra-local level to enable resources to be pooled, with perhaps one local authority taking a lead commissioning role. Specific direction should be given to local Health and Wellbeing Boards to consider this approach to commissioning HIV prevention services.

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

As has been stated in answers to other questions in this consultation, amongst the essential conditions required of local authorities we recommend -

- The commissioning of comprehensive sexual health services (which need to be fully described)
- The role of the Director of Public Health in representing the needs of patients whose care is not commissioned locally
- Due regard to supporting a diverse and involved voluntary and community sector
- Routine collection and appropriate timely reporting of surveillance data
- Formal guidance on how to take account of the Human Rights Act and the public sector equality duty in local commissioning processes, and
- Responsibility to attend to effective integration of health and social care at the local level, with clear processes as to how concerns should be raised and addressed.

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

NAT supports the approach of using “population health measures” to develop an allocation formula. The population health measure should be linked, but not limited to the Outcomes Framework. It is important that the approach to the formula looks wider than just those public health issues which have outcome indicators attached to them, otherwise the formula will be too restricted in its identification of need.

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

NAT agrees with the recommendation that these changes should not be done suddenly.

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

No specific comments

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

We have yet to understand the rationale for the Government’s intention to select only a sub-set of the agreed outcome indicators for Health Premium incentive. NAT recommends that the Health Premium potentially be linked to all of the agreed outcome indicators.

If there is to be a more limited selection of indicators for the Health Premium, it is important that those outcome indicators where there are no direct financial implications for the Local Authority from either taking or not taking action are built into the health premium, so as to provide an alternative means of incentivisation. For example, in the absence of a treatment and care budget for HIV held by the Local Authority, the inclusion of the HIV late diagnosis outcome indicator in the health premium would ensure local authorities consider this health outcome for possible action at the local level.

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

No specific comments

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?

NAT believes that linking access to growth in health improvement budgets to progress on elements of the Outcomes Framework has the potential to be an effective incentive mechanism.

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

No specific comments.

NAT
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