

# Royal College of Psychiatrists Consultation Response

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**DATE: 31 March 2011**

**RESPONSE OF:** THE ROYAL COLLEGE OF PSYCHIATRISTS

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

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Dr Kam Bhui, Dr Jonathan Champion and Richard Meier from the Policy Unit at the College.

This consultation was approved by: Dr Laurence Mynors-Wallis, Registrar.

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Consultation 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 ring-fenced public health and other budgets?

Yes. However, splits between local authorities, NHS and public health bodies must be avoided if commissioning is to be integrated and complementary.

**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?

An essential mechanism to provide a common playing field is to have a simple, transparent commissioning and tendering process. Although the College recognises the potential value of new providers in bringing about innovation, it believes there is an important value in stability of provision and joined-up provision.

**Q3.** How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

The Joint Commissioning Panel on Mental Health - a new collaboration between a range of leading organisations with the aim of improving effective commissioning for mental health, learning disabilities and wellbeing ([www.jcpmh.info](http://www.jcpmh.info)) - intends to produce (in autumn 2011) a public mental health framework providing practical advice to GP consortia and local authorities on public mental health. This standardised framework would

describe public mental health interventions which could be implemented by GP consortia and local authorities.

**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?

No comment.

**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?

The proposals do not present a coherent plan for mental health provision or public mental health, which is not just about the social environment, but also about education, social relationship, and early intervention. Socially excluded groups may be failed by services and commissioners that are not able to 'see' or 'notice' complexity and complex interplays between social, environment, psychological and biological factors.

**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?

Yes, but see reservations in answer to question 7.

**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?

The College does not believe that the neat division of responsibility for these functions and services between local authorities, Public Health England, consortia and the NHS Commissioning Board is sensible, particularly in relation to public mental health. Leaving public mental health entirely to local authorities will mean that the opportunity for consortia, local authorities and national agencies to work in consort to achieve outcomes will be lost. Furthermore, given the fundamental relationship of mental health and well-being to almost all other aspects of individual and public health, the handing of responsibility for public mental health solely to local authorities will have deleterious consequences for achieving good outcomes in relation to public health more generally.

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

Housing, benefits, leisure, vulnerable adults, child protection with education authorities, open spaces and green spaces, sustainability and green issues, social care and family services.

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

Without more detailed plans it is not possible to comment. There is a danger that the ideology of moving mental health to local authorities will be followed even if not sensible.

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

The College believes that far more information on budget sizes, and how agencies would work together, is needed that has currently been set out. We also feel that a set of pilot projects modelling different allocation formulae should be undertaken, otherwise the risk of failure is too high and significant budgets will be wasted in reorganisation with no chance of success.

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

The College believes that developments should proceed in the following order: conduct pilot studies; test information and models of consortia and allocation; then roll out. Safeguards also need testing. Competence and commissioning capacity is a key problem, and will need to be addressed as this will otherwise undermine all other plans.

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

The College believes that it is essential that mental health professionals be represented.

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

There needs to be greater representation of common mental health problems and sub-threshold conditions which are related to risk of population mental illness.

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

Specific interventions and research are needed at this stage on how the plans impact on inequalities, and what budgets will be set aside to tackle inequalities. Penalties should be in place if inequalities are widened, or maintained without an overall increase in health and well being for those in the lowest economic and deprivation strata.

**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?

Yes, especially for socially excluded groups and for work around inequalities, and those with severe and enduring health problems who will not be able to make use of universal interventions.

**Q16.** What are the key issues the group developing the formula will need to consider?

The College believes that much more work needs to be done on modelling plans and potential options before this can be answered.

**March 2011**