Role: Commissioner within a CCG for the last three years, with remit for Children’s Health Services and Urgent Care. Writing in a personal capacity. Previously a public health physician for five years, four of which were in primary care trusts and specialised commissioning.

1. The Health and Social Care Act (2012), with the subsequent creation of Clinical Commissioning Groups and the firm grip on NHS management costs, has in my experience improved relative importance of clinicians in shaping services. Contrary to many pundits’ predictions, many areas have seen increased collaboration, as settled senior doctors have taken a long-term view for commissioning or providing in their local areas.

2. In my previous submission, contained in the Twelfth Report to the 2010-2012 session, I noted the contribution of public health in terms of the skills of public health doctors which they bring to health services commissioning and planning. This area (or ‘healthcare public health domain’) was less obvious than the specific activities of health protection (e.g. response to Rabies) and health promotion.

3. The potential loss of the healthcare public health domain in 2013 was thought to be addressed by the provision of a standardised ‘offer back’ (‘core offer’) to the NHS from Local Authorities and Public Health England. It seemed odd for NHS commissioning organisations to lose in-house expertise required for commissioning, but in fairness to the proponents several public health organisations explicitly stated their desire for the teams containing all three domains together.

4. Now being a commissioner, and with the benefit of three years in the new commissioning landscape, I perceive that the current standardised offer, delivered inconsistently, is inferior to the bespoke support provided by public health physicians and their teams in Primary Care Trusts pre-2013.

5. The core offer is delivered inconsistently because there are not Service Level Agreements between local authorities and CCGs in relation to the ‘core offer’, and even if there were, the wording of the core offer is so vague that it would be unenforceable. I am fortunate as a commissioner to receive healthcare public health from my local authority which I consider to be of a good standard – but if it had been below standard, I would be in the inequitable position of having transferred the resources to obtain healthcare public health expertise to the council but no means of redress were that the expertise to be substandard.

6. In my experience the previous bespoke in-house expertise was far more powerful at catalysing improvements to health services. For example, in my public health role within the NHS before I switched over to commissioning, I worked on modelling and estimating the health and financial impacts of establishing a hyper-acute stroke unit at Cambridge, which was established; designating specialist vascular surgery centres based on their mortality rates and literature on the relationship between volume and outcomes; investigated a high standardised mortality ratio at Bedford Hospital and initiated a plan with my hospital-based colleagues, which was successful, to bring it down. I doubt very much that the majority of councils do this for their NHS colleagues as of the end of 2015.

7. CCGs are probably better off being returned this specific function so that they can acquire advice more specific to their local needs – this may either be through in-house expertise or through partnerships of healthcare public health consultants covering a wider area but with particular subject matter areas in greater detail. The current setup despite its best intentions does not provide many commissioners with what they need.

16 December 2015