AGENDA ITEM

REPORT TO CABINET

17 MARCH 2011

REPORT OF CORPORATE MANAGEMENT TEAM

CABINET DECISION

Adult Services and Health – Lead Cabinet Member– Councillor Beall
Children and Young People – Lead Cabinet Member – Councillor McCoy

Response to the Public Health White Paper: *Healthy Lives, Healthy people: Our strategy for public health in England*

1. Summary

This paper provides an update on Health policy changes and summarises the main points of the Public Health White Paper and the implications for the Council, as well as incorporating the draft consultation response to be submitted on behalf of the Council and Health and Wellbeing Partnership Board.

2. Recommendations

To note the potential implications of the Public Health White Paper and note the response to the Consultation questions for Stockton Borough Council.

3. Reasons for the Recommendations/Decision(s)

To highlight the direction of travel outlined in the Public Health White Paper and note the proposals outlined.
To ensure that Stockton's feedback is included in the national consultation process.

4. Members' Interests

Members (including co-opted Members with voting rights) should consider whether they have a personal interest in the item as defined in the Council's code of conduct (paragraph 8) and, if so, declare the existence and nature of that interest in accordance with paragraph 9 of the code.

Where a Member regards him/herself as having a personal interest in the item, he/she must then consider whether that interest is one which a member of the public, with knowledge of the relevant facts, would reasonably regard

as so significant that it is likely to prejudice the Member's judgement of the public interest (paragraphs 10 and 11 of the code of conduct).

A Member with a prejudicial interest in any matter must withdraw from the room where the meeting considering the business is being held -

- in a case where the Member is attending a meeting (including a meeting of a select committee) but only for the purpose of making representations, answering questions or giving evidence, provided the public are also allowed to attend the meeting for the same purpose whether under statutory right or otherwise, immediately after making representations, answering questions or giving evidence as the case may be;

- in any other case, whenever it becomes apparent that the business is being considered at the meeting;

and must not exercise executive functions in relation to the matter and not seek improperly to influence the decision about the matter (paragraph 12 of the Code).

Further to the above, it should be noted that any Member attending a meeting of Cabinet, Select Committee etc; whether or not they are a Member of the Cabinet or Select Committee concerned, must declare any personal interest which they have in the business being considered at the meeting (unless the interest arises solely from the Member's membership of, or position of control or management on any other body to which the Member was appointed or nominated by the Council, or on any other body exercising functions of a public nature, when the interest only needs to be declared if and when the Member speaks on the matter), and if their interest is prejudicial, they must also leave the meeting room, subject to and in accordance with the provisions referred to above.

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Response to the Public Health White Paper: *Healthy Lives, Healthy people: Our strategy for public health in England*

SUMMARY

This paper provides an update on Health policy changes and summarises the main points of the Public Health White Paper and the implications for the Council, as well as incorporating the draft consultation response to be submitted on behalf of the Council and Health and Wellbeing Partnership Board.

RECOMMENDATIONS

1. To highlight the direction of travel outlined in the Public Health White Paper and note the potential implications of the proposals outlined.

2. To ensure that Stockton's feedback is included in the national consultation process.

DETAIL

1. The Government published *Equity and Excellence: liberating the NHS*, its health white paper, on 12th July 2010. Following this the Department of Health (DH) launched a series of consultation documents. The consultation period for the White Paper and associated documents closed in October 2010, with over 6000 responses received from a wide variety of stakeholders. A response to the consultations was submitted on behalf of the Council (including health scrutiny) and the Health and Wellbeing Partnership Board. This response was noted in the October 2010 Cabinet paper. The Government's response to the consultation is outlined in *Liberating the NHS: Legislative framework and next steps* published in December 2010. The *Operating Framework for the NHS in England 2011/12* also sets out what needs to happen over the transition year 2011/12.

2. The Public Health White Paper *Healthy lives, healthy people: our strategy for public health in England* was published on 30th November 2010 and expands on the Government's proposals for public health originally set out in *Equity and Excellence: Liberating the NHS*. This Public Health White Paper outlines the Government's commitment to improving people's health and reducing health

inequalities. Putting local government and local communities at the heart of improving health and wellbeing for their populations. Two associated consultation documents providing further detail were published during December 2010 - *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health* and *Healthy Lives, Healthy People: Transparency in Outcomes, a consultation document on proposals for a public health outcomes framework.* Consultation responses to the Public Health White paper and associated documents must be received by 31st March 2011.

3. The Health and Social Care Bill, is currently going through Parliament, and sets out the legislation needed to implement all of these new Health proposals. The Bill contains provisions covering five themes:
    - strengthening commissioning of NHS services
    - increasing democratic accountability and public voice
    - liberating provision of NHS services
    - strengthening public health services
    - reforming health and care arm's-length bodies

4. This Cabinet paper summarises the main points within the Public Health White paper and the implications for the Council, as well as incorporating the response that will be submitted to the consultations on behalf of the Council and the Health and Wellbeing Partnership Board.

Summary of key proposals

5. The Public Health White Paper outlines the considerable public health challenges facing us. It supports Professor Sir Michael Marmot's recommended 'life course' approach to improving health and addressing health inequalities, which focuses on health and wellbeing throughout life to ensure that everyone is supported to make healthier choices. It also emphasises the importance of addressing the wider determinants of health such as employment, educational achievement, environmental, social and cultural factors, as well as housing. It highlights the need to improve wellbeing – mental and physical – as well as treating sickness, and highlights the lead role that local government has in addressing this agenda. Furthermore, the White Paper emphasises the importance of tackling inequalities in health.

6. The White Paper describes a "*radical new approach that will empower communities, enable professional freedoms and unleash new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats".* It talks about a shift from centralised, top down approaches, announcing that "*Centralism has failed [and] we will end this top-down government. It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre"*. The major proposals are outlined below.

Transferring public health

7. From 2013, public health responsibilities currently undertaken by Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be divided between Public Health England (PHE) and local councils. The Directors of Public Health (DsPH) will move to local authorities and will be jointly appointed by councils and PHE.

8. From 2013, upper-tier councils will receive a ring-fenced public health grant to improve the health of the population and reduce health inequalities. The Department of Health will incentivise action to reduce health inequalities by means of a health premium, which will be top-sliced from the public health budget and paid to those authorities that are successful in reducing health inequalities as measured by a series of indicators (identified within the 'outcomes framework').

Public Health England

9. The White Paper announces the creation of a dedicated and professional public health service, known as Public Health England's (PHE), within the Department of Health. PHE will be accountable to the Secretary of State for Health, who will have new powers to protect the population's health. PHE will have a close relationship with the NHS, social care, business and voluntary sector partners, and with the NHS Commissioning Board. It will incorporate the current functions of the Health Protection Agency, National Treatment Agency, Regional Directors of Public Health (Regional DsPH), Public Health Observatories and cancer registries. At local level, Directors of Public Health (DsPH) will develop relationships with GP commissioning consortia, through Health and Wellbeing Boards (HWBs).

10. PHE will hold responsibility for the ring-fenced public health funding which comes from the overall NHS budget. Early estimates suggest that current spend on the areas that are likely to be responsibility of PHE could be approximately £4 billion. Public Health England's role will include:

    - Providing public heath advice, evidence and expertise to the Secretary of State and the wider system;
    - Delivering effective health protection services;
    - Commissioning or providing national-level improvement services, including appropriate information and behaviour change campaigns;
    - Jointly appointing DsPH and supporting them through professional accountability arrangements;
    - Allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework;
    - Commissioning some public health services from the NHS;
    - Contributing internationally-leading science to the UK and globally.

Focus on outcomes

11. A national outcomes framework for public health will set the broad public health and health inequalities outcomes for all areas and organisations to address. The Outcomes Framework paper puts forward a series of suggested indicators across five domains: health protection and resilience; tackling the wider determinants of ill health; health improvement; prevention of ill health; and healthy life expectancy and preventable mortality.

Director of Public Health and transfer of public health staff

12. All upper-tier and unitary authorities will be required to have a Director of Public Health, though they can be shared with other councils. DsPH will be employed by local government and jointly appointed with PHE, and will be "the strategic leader for public health in local communities, deploying the local ring-fenced budget to achieve the best possible public health outcomes across the whole local population". DsPH will be public health professionals with a support team with specific public health and commissioning expertise. Critical tasks for DsPH are:

    - Promoting health and wellbeing within local government and advising on health inequalities and developing local strategies to reduce them
    - Providing and using evidence relating to health and wellbeing and leading public health through membership
    - Advising and supporting GP consortia
    - Developing an approach to improve health and wellbeing locally
    - Working with PHE health protection units to provide health protection as directed by Secretary of State
    - Collaborating with local partners – i.e. GP consortia, other local DsPH, local business etc

The role of the NHS in public health

13. The NHS will continue to play an important role in public health. PHE will commission the NHS Commissioning Board (NHSCB) to undertake screening, including cancer screening, some aspects of emergency preparedness, childhood immunisations and public health aspects of primary care contracts, through the Secretary of State's mandate to the NHSCB.

14. Other health professionals, including GPs, dentists, pharmacists, health visitors, dieticians, speech therapists all have an important role to play in improving health and addressing health inequalities. GPs in particular, will be incentivised – both as primary care professionals and commissioners – to focus on prevention and early intervention. Locally, GP consortia and DsPH will work with councils, the voluntary and community sectors and the business sectors through HWBs to ensure that services and commissioners are maximising their effectiveness on health improvement and reducing inequalities. To incentivise GP practices, the Quality and Outcomes Framework (QOF) will focus far more on primary and secondary prevention, with funding for this work coming from the PHE budget. GPs will continue to provide a range of public health services such as childhood

immunisations, contraceptive services, cervical screening etc but in the future PHE may wish to change how services are commissioned and delivered.

Addressing health and wellbeing throughout life

15. The White Paper takes a 'life course' approach to health improvement outlined in Prof. Sir Michael Marmot's report encompassing:

    - Starting well – focusing on maternal and child health and breaking the intergenerational cycle of ill-health and inequalities. There will be a particular focus on children who are at risk of poor outcomes.
    - Developing well – focus on child and adolescent wellbeing, including mental wellbeing and self esteem. Schools have an important part to play in delivering better health outcomes for children and young people in promoting physical activity, providing high quality personal, social and health education, improving self-esteem and mental wellbeing through a range of existing and new programmes.
    - Living well – encompasses all factors which contribute to health and wellbeing, including housing, planning, the natural environment, access to active transport, etc. The White Paper lists a range of new and existing schemes to support people to make healthier choices in relation to eating, physical activity, environmental sustainability and use of alcohol. It highlights many ways that councils can influence health through their housing, planning, environmental, licensing, community development and regulatory functions.
    - Working well – promoting good physical and mental health at work. This section focuses on the importance of work in promoting health and wellbeing and the intention of the Government to support people with long term health conditions to get back into work.
    - Ageing well – supporting older people to remain active, healthy and independent within their own homes. It summarises a wide range of universal benefits and more targeted support to enable older people to maintain their health, wellbeing and capacity. A crucial component is the *Vision for Social Care* published on 16 November 2010.

16. There is a focus on mental health and wellbeing throughout life, with a particular emphasis on mental wellbeing of children and adolescents.

Health protection and emergency planning

17. New arrangements for emergency preparedness and health protection in which PHE will bring together the health protection and emergency planning functions of the Health Protection Agency with the public health functions of PCTs and SHAs. At local level, DsPH will have a leading role in emergency planning.

Role of business, the voluntary sector and other partners

18. The paper highlights the role of business and the voluntary sector through the Public Health Responsibility Deal with five networks on food, alcohol, physical

activity, health at work and behaviour change. The Responsibility Deal will be launched with further details in 2011. It is expected to include undertakings from retailers on more socially responsible selling of alcohol. Individuals will be encouraged to make healthy choices by the provision of subsidised sporting activities.

Consultation Process

19. The Department of Health (DH) launched its public consultation setting out proposals to support this White Paper covering:

20. The Health and Wellbeing Partnership held a session to discuss the White Paper and a member's seminar session was held in February to outline the proposals and discuss the key issues. Discussions at various internal meetings and attendance at regional events have also helped to shape and influence the comments that have been collated.

21. A summary of the Stockton response to the Public Health White paper consultations is attached (**Appendix 1 - 3**). This will be submitted in line with the DH deadline of 31st March 2011.

Local Issues

22. The Health White Paper signals a significant period of change for the Local Authority and NHS. This is in parallel to challenging financial constraints in both areas. The management of the transition period will be critical in "skilling up" all organisations to manage their new functions, transferring health improvement functions & personnel to the Local Authority and reshaping pathways to enable efficiencies to be released and ensure that quality of care is maintained.

23. A project plan to manage the transition is being developed and the Health and Wellbeing Management Team will help to oversee the development of the project plan.

FINANCIAL IMPLICATIONS

24. Public health funding will transfer to the Local Authority as part of ring fenced budgets. A full assessment of the implications needs to be undertaken when there is clarity regarding the budget and how it will be transferred to the Local Authority.

LEGAL IMPLICATIONS

25. Health and Wellbeing Boards will have statutory responsibilities and will ensure coordination, integration and partnership working on social care, public health and health improvement.

RISK ASSESSMENT

26. Not applicable

SUSTAINABLE COMMUNITY STRATEGY IMPLICATIONS

27. The Sustainable Community Strategy (Shaping Our Future) for Stockton-on-Tees 2008-2021 sets out the vision and key improvement priorities for the local area. Stockton on Tees Council Plan 2008-2011 sets out directives aimed at helping create a sustainable community in which residents and local organisations play an active role in developing and maintaining their own environment and society. 'Being healthy, improved access to integrated services, improved health and emotional wellbeing, improved quality of life, increased choice and control, and leadership' are key objectives in the Borough.

EQUALITIES IMPACT ASSESSMENT

28. Not applicable

CONSULTATION INCLUDING WARD/COUNCILLORS

29. A councillor briefing session was held in February where there was an opportunity to discuss and feed into the consultation questions. The Health and Wellbeing Partnership Board undertook a facilitated session to consider the White Paper. This has fed into the consultation response.

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Education related: Not applicable

Background Papers: Appendix 1-3 attached

Ward(s) and Ward Councillors: Policy Update Briefing session undertaken

Property: Not applicable

Appendix 1 - Response to Public Health White Paper: '*Healthy Lives, Healthy people: Our strategy for public health in England'*

The Stockton Health and Wellbeing Partnership Board acknowledge the direction of travel outlined within the Public Health White Paper: '*Healthy Lives, Healthy people: Our strategy for public health in England'.* The principle that Local Authorities will have a lead role in protecting and improving the health of local people and communities is welcomed. However, there is still a lack of detail regarding the respective roles of Public Health England and Local Authorities, the financial arrangements and employment issues such as staff transfer. These are all key issues and further clarity is required.

Specific issues raised through the Stockton Health and Wellbeing Partnership Board include:

- The development of Health and Wellbeing Boards is welcomed. Particular importance was placed upon the need to ensure that local flexibility is retained to agree how these Boards should be developed and function
- The size of the total public health budget, and the financial split between Public Health England and local authorities, will be absolutely critical
- The arrangements to ensure that the needs of children are addressed are not clear. Maintaining a focus on the needs of children is considered essential
- The period of transition to the new model brings with it significant risks. It is crucial that this is properly managed and that there is early information about workforce implications such as TUPE and local authorities and PCTs must be involved in the formulation of these transition plans.(asset transfer plans, property matters, novation of ongoing contractual liabilities etc),

Responses to the specific consultation questions are attached below.

Consultation questions

a. **Role of GPs and GP practices in public health: are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?**
   It is essential that clear lines of communication are in place to ensure that GP Consortia are aware of the latest public health evidence and have clarity on how public health and prevention approach can support their objectives.

   It is important that all parties are aware of the responsibilities and areas of commissioning which each party is responsible for. The GP Consortia and PHE should share work plans to enable them to identify any areas of work that they would want to be involved in or kept informed about.

   Clarity on governance arrangements is vital so that both PHE and the GP Consortia fully understand their relationship and accountabilities to each other.

b. Public health evidence: what are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

In order for public health evidence to be practically applied in the commissioning and development of public health programmes and approaches, the evidence must be up-to-date, succinct and take consideration of application in different geographical situations. It is also important that this evidence links to the Joint Strategic Needs Assessment with local information included. The use of guidance and tools such as Standard Evaluation Frameworks is supported locally as it allows best practice and evidence to be shared in a very practical way.

Defining the roles and responsibilities of local authorities and PHE in the collation, analysis and dissemination of intelligence is important to minimise duplication. They must have a very clear understanding of each others role so that those requesting information are not sent 'back and forth' between organisations.

c. Public health evidence: how can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

It is important that PHE are able to present evidence and intelligence in a manner that shows the contribution of public health approaches within wider initiatives such as QIPP. This will help facilitate the adoption of public health and preventative approaches with partners such as GP Consortia.

At present, evidence on the cost effectiveness of interventions and local intelligence relating to the cost effectiveness of pilot programmes, including the information collected and measures used for evaluation, are difficult to obtain. PHE could help to share this information and best practice in evaluation techniques.

The behavioural science approach has focussed on the steps that can be taken to 'nudge' individuals into adopting healthier practices. It should be noted that this is not sufficient by itself to address the wider (social) determinants of health such as issues around employment, the environment, housing and education. The behavioural science approach may have a part to play in reducing health inequalities but there needs to be a much stronger evidence base as to the effectiveness of 'nudge' type interventions, and the role of other approaches such as legislation and regulation should not be forgotten.

d. Public health evidence: what can wider partners nationally and locally contribute to improving the use of evidence in public health?

One issue that should be addressed is the lack of a framework for assessing the relative effectiveness of public health as against clinical interventions. For example, it is easier to measure the effectiveness of a new treatment for cancer in terms of prolonging life than the effectiveness of, say, a programme for winter heating of homes occupied by older people. While the difficulties of

measuring the latter are evident (for example there are more variables to control for), if health budgets are to be used effectively then partners need to find ways of drawing up credible evidence on this kind of issue. This links to the response to questions b. and c. and links to wider programmes such as QIPP and the development of practical tools such as Standard Evaluation Frameworks.

Further consideration and discussion is required to ensure that programmes and services can respond to changing evidence and adopt standardised evaluation approaches. This is particularly problematic in Any Willing Provider approaches and where the use of standard NHS contracts does not permit the flexibility required to adapt and develop services in light of emerging evidence.

e. **Regulation of public health professionals: we would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary registration for public health specialists?**
The view put forward is that Local Authorities require individuals who have the appropriate skills to undertake the role and that the registration of public health specialists was not considered to be particularly important.

Appendix 2 - Response to '*Healthy Lives, Healthy people: consultation on the funding and commissioning routes for public health'*

Draft response to consultation questions

Q1 Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?
The Health and Wellbeing Boards (HWBs) will facilitate this as they are a means of integrating LA responsibilities for public health with their wider functions that impact on public health (housing, social care, education, environmental health etc). Health and Wellbeing Boards will also ensure a measure of democratic legitimacy and accountability.

The relationships between Health and Wellbeing Boards will require further consideration as many issues would be most appropriately resolved at a supra-Health and Wellbeing Board level. There is not currently provision for this to happen and this would be challenging requiring several HWBs and GP Consortia to come together.

The board could in time prove to be the means for determining a synergised approach to local public health through the Joint Strategic Needs Assessment, which should also consider the role that other services play in improving public health outcomes. However, different funding regimes apply to these functions and in the first instance priority must be to assess the adequacy of funds ring-fenced to support transferred public health functions. To ensure clarity, other budgets should be kept separate at the outset, until roles and relationships in service delivery are established.

It is likely that future government funding policies on Formula Grant- based services will cause changing priorities within the council, and flexibility to respond by diverting funds should be retained. This would be best ensured by retaining clearly separate funding streams until a view on adequacy of funding provided through the health funding formula has been established.

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?

Local Authorities are supportive of the using voluntary and independent capacity to support health improvement, and do so at present. It has however been fedback that, opening services to 'any willing provider' can bring the risk of fragmentation if a range of different providers are delivering different aspects of what should be an integrated service. Ultimately it should be for Local Authorities to strike the right balance between encouraging diversity of supply, which can bring flexibility and innovation, and securing an integrated public health service.

The lack of flexibility within the existing NHS contracts is a further barrier which may prevent voluntary and community sector providers from providing some public health programmes. Having an agreed approach and consistent procurement advice for public health contracts under a certain value would help to minimise barriers for voluntary and community organisations.

Having in place an organisation to provide support to the voluntary and community sector is beneficial. Locally we have this provided by an organisation called Catalyst, who help different voluntary and community sector groups to work together for the benefit of the locality by bringing their different ideas and strengths to bear on a range of strategic issues and opportunities.

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

Developing excellent relationships with the GP Consortia is essential. The Directors of Public Health will be pivotal in achieving this. Defining clearly the public health responsibilities of GP Consortia is also important this should be a key aspect of their commissioning plans. The Health and Wellbeing Boards should also be a key forum to foster and develop this relationship. Sharing tangible examples to outline the importance of working together will help GP consortia to see the benefits of working collaboratively and taking a public health approach. For example, delivering effective flu vaccination campaigns.

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?

Ensuring that local knowledge, issues and need are factored into GP provided services is essential. Enhanced services must have local involvement in their development to ensure that they support delivery of local strategies/priorities and tackle local health inequalities. Sharing information about services that are commissioned in other areas of the country would be helpful to support the rollout of best practice and avoid duplication of effort.

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?

None noted.

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?

Concern has been raised about the following areas:

- Sexual health – Across the 4 PCT areas in Tees we have worked together to develop an integrated sexual health and contraceptive service which has recently been procured. Splitting up responsibility for contraceptive service provision and STI testing and treatment could mean that our innovative local approach is undermined. This would be a major risk and would potentially challenge the viability of our new 5- year integrated sexual health service contract that has been put in place locally.
- Children's services – the local approach taken under Transforming Community Services has been to develop a holistic service specification for children and young people that would commission a range of services, including the aspects currently provided through the health visiting service. By splitting up the commissioning responsibility for health visiting and other services such as school nursing it makes this approach very difficult.

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?

See response to Q6.

We support the consultation paper proposal that the default position is that, wherever possible, public health activity should be commissioned by local authorities according to locally identified needs and priorities.

Clearly a critical issue is resources – it is essential that whatever public health responsibilities Local Authorities take on, they are properly resourced to carry them out. There will need to be transparency in the way the overall public health budget is constructed and how it is allocated between PHE and LAs.

Q8 Which services should be mandatory for local authorities to provide or commission?
Supportive of the approach in the consultation paper that any list of mandatory services should be as short as possible in order to give Local Authorities the maximum possible freedom.

Q9 Which essential conditions should be placed on the [public health] grant to ensure the successful transition of responsibility for public health to local authorities?
Suggest that conditions should be kept to the minimum necessary to ensure accountability for the way the grant is spent.

Q10 Which approaches to developing an allocation formula should we ask ACRA [the Advisory Committee on resource allocation] to consider?
The approach to take health inequalities into consideration is welcomed. It is crucial that Local Authorities and PCTs are involved in the development of the methodology. This should not just be at a consultation stage but should be true involvement in the development of the formula, in selecting indicators used, relative weightings etc.
As the formula is developed and adapted over time an iterative process should be followed to inform and consult LA`s when changes are contemplated in response to changing parameters. This should include illustration of the effects of each proposed change option for all individual authorities, so that potential effects can be seen and assessed by all, to allow informed responses to consultation, so arriving at a transparently developed formula.
Whatever formula approach is taken, the formula should be based on timely and relevant data, transparent calculations, and results should be applied with minimum intervention through damping, so that funding produced matches the need identified by the formula.

Q11 Which approach should we take to pace-of-change?
It is important that a balance is struck between the pace of change and ensuring that existing services are not destabilised.

However, if it is accepted that pace of change should apply, it should not be over so long a period as to seriously disadvantage authorities that are extreme outliers from target funding. Those overfunded authorities should be reduced at a pace that allows underfunded authorities to move up to target on a timely basis, without forgoing excessive amounts of funding in the interim. Ideally, pace of change arrangements should minimise the time needed for funding to flow from the formula at the correct level , in order that health benefits from the new arrangement can be recognised as soon as possible in meeting formula identified need.

The group developing the formula should recognise the need to avoid extreme outlier authorities as a prime consideration when assessing the effects of indicators and methodology options.

Q12 Who should be represented in the group developing the [Health Premium] formula?

Representatives of local government will need to have a prominent role in the group along with public health experts and other partners.

Alongside Health finance practitioners , the local government representatives should ideally include practitioners who have experience of the Settlement Working Group (which maintains Formula Grant with DCLG) as they will be familiar with the technical issues influencing formula allocations and the tensions involved in developing a national formula. Involving those with both health and local government formulae experience should prevent the shortcomings of existing formulae-based allocations from being replicated in this formula.

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

See response to Q14

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

This is a vitally important issue. While we support the principle of incentivising reductions in health inequalities, there is a clear risk that 'payment by results' may fail to take account of underlying inequalities and challenges; the multiplicity of factors contributing to poor health; and the long time spans needed to evidence improvement where there are serious underlying problems. Given that the funding for the health premium will come out of the public health budget, if the formula fails to take account of these factors there is a real danger that the outcome will be to transfer funding from authorities with deep-seated and intractable health inequalities to less deprived authorities where it is easier to make progress. It is imperative that lessons are learnt from the development and implementation of the LAA targets. Ensuring that targets are challenging and equitable will be an important balance. Ensuring wide buy in from partners will be essential; this will include key partners such as GP Consortia and schools.

Q15 Would linking access to growth in public health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

As the outcomes framework is still out to consultation and we don't know what it will look like in its final form it is difficult to provide a comprehensive answer to this question. In principle there ought to be a relationship between the outcomes framework and the health premium. However, as in the response to Q14 there is a concern about potential failure to reflect the real challenges of bringing about improvements in public health.

Q16 What are the key issues the group developing the [health premium] formula need to consider?

Will need to consider a range of factors including; the sensitivity of indicators and outcomes to public health interventions; the possibility of changes in indicators and

outcomes for reasons unconnected with public health interventions; and the relative weight to be given to long-term outcomes and progress in the shorter term.

The key point is to establish at the outset relative health needs and inequalities of areas by agreeing appropriate health indicators and weightings, which should be updated at agreed intervals.

The formula development group should aim for stability and validity of outcomes in matching funding to needs, transparency of process, reliability of data, clarity of logic and formulae, minimal scope for ministerial subjectivity and minimal adjustment between formula outcomes and grant amounts distributed. They should decide on frequency of review of formulae and update of data indicators.

It would also be useful if it was possible to produce indicative projections of revenues for planning purposes.

Appendix 3 - Response to '*Healthy Lives, Healthy people: Transparency in Outcomes'*

Consultation Questions

Q1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

The connectivity of all partners in addressing the public health outcomes is important. GP Commissioners will be relatively new partners to these arrangements and need to be able to be brought up to speed on the local arrangements and be clear about their contribution and connectivity within this process. There needs to be clear review of how well engaged GP Commissioners are within the local partnership arrangements.

We need to offer clear and consistent messages with the range of partners on their contribution and role. This should be for local discretion to address but where possible national messages/ oversight from Commissioning Boards or other functions will need to endorse and support this approach.

There is a requirement for the health and wellbeing boards to be effective and connect appropriately with other structures including criminal justice and children's trust board arrangements where they remain.

The effectiveness of these arrangements will be significantly affected by the culture and experience of partnership arrangements.

The Boards will need to have the flexibility to prioritise the important elements within their community, they need to be able to minimise any bureaucracy and not be prescribed to.

Q2. Do you feel these are the right criteria to use in determining indicators for public health?

The criteria seem reasonable however there are concerns about the reliance on some indicators which may be monitored on a "short to medium term" – where some indicators will take longer to show progress against e.g. mortality data. There may be issues with the time lag for some data collection elements e.g. cancer registry information and cancer mortality.

A number of the proposed indicators do not seem to follow the principles and criteria for the selection of indicators described in paragraph 16 and 17.

Q3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

There are concerns that the health premium may be presented to communities in such a way that they only focus on the easy areas or "low hanging fruit" and do not consider some of the more difficult areas as these are more challenging but have a greater impact on health inequalities and inequity. Care needs to be taken to ensure stretch but not to penalise aspiration for local communities.

Equally developing a health premium which operates across a level playing field nationally will be challenging. The determinants may be similar in geographical regions which may enable a better co-ordination/ equitable approach to targets and health premiums.

Q4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?
We welcome the link with adult social care and public health and the NHS. The connection with prevention and early intervention within adult social care and public health is beneficial and is a direction of travel that has been highlighted via CQC assessments etc.

There does seem to be a missing element of children and families which may need to be strengthened.

We would continue to highlight that interconnected issues need local discretion to focus on the priorities.

Q5. Do you agree with the overall framework and domains?
There seem to be too many domains which overlap or are not clear separate entities. The number of indicators are significant and do not seem to reduce bureaucracy in considering the range and requirements for data collection.

Q6. Have we missed out any indicators that you think we should include?
No – see response to Q5.

Q7. We have stated in this document that we need to arrive at a smaller number of indicators than we have had previously. Which would you rank as the most important?
We would want to focus on outcomes and not process indicators which may be a better mechanism to rank the relative importance of indicators.

Q8. Are there indicators here that you think we should not include?
In addition to those principles and criteria described in paragraph 16 and 17 indicators should also be; based on outcomes and not outputs; measureable indicators which where possible have routine data collection methods already in place; minimise the burden of data collection, allow for the comparison of performance across organisations and benchmarking.

It should be noted that those indicators that rely upon surveys as the means of measurement should be treated with caution. Experience form these types of indicators shows that data quality is often an issue; sample sizes are often small and unrepresentative.

Q9. How can we improve indicators we have proposed here?
The timeliness of indicators is important but we need to have a macro assessment and understanding of the context we are operating in regarding health inequalities.

Q10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems).

It would be helpful to consider the factors that most impact on health inequalities and health improvement. As highlighted in the response to Q3 there are concerns about:

- Equitable approach to targets
- Setting challenging targets when financial incentives are at stake
- Robust and meaningful performance review mechanisms to enable appeals/ reviews to take into account the range of factors which may have influenced poor or good performance.

Q11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

There is already a collective responsibility in place for some frameworks e.g. NHS and Social Care. This proposal builds on this. However, the nature of public health outcomes are cross cutting so it is imperative that the Health and Wellbeing Boards are effective and address the shared requirements around preventable mortality.

Q12. How well do the indicators promote a life-course approach to public health?

The actual indicators proposed do not specifically promote a life course approach but we would question if this is important and does it matter? There are enough proposed measures which can be identified for a life course approach if required. The key factor is about making sure that the outcomes support the effort of the community in tackling its public health challenges.