Healthy Lives, Healthy People

Summary of responses to the consultations on our strategy for public health in England

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Document Purpose	For Information
Gateway Reference	16374
Title	Healthy Lives, Healthy People: Consultation responses
Author	Department of Health, Public Health Development Unit
Publication Date	27 Jul 2011
Target Audience	Directors of PH, Local Authority CEs, Directors of Finance
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Directors of Nursing, Directors of Adult SSs, Directors of HR, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	This is a summary of responses to Healthy Lives, Healthy People: our strategy for public health in England; Healthy lives, Healthy People: consultation on the funding and commissioning routes for public health; Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework; and Review of public health professional regulation.
Cross Ref	Healthy Lives, Healthy People: Update and way forward
Superseded Docs	N/A
Action Required	None
Timing	**N/A**
Contact Details	Public Health Development Unit G14 Wellington House 133-155 Waterloo Road SE1 8UG www.dh.gov.uk
For Recipient's Use	

First published July
Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications

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Summary of responses to the consultations on our strategy for public health in England

Prepared by the Public Health Development Unit

Contents

1. Introduction

1.1 The public's health is the Government's priority. Sustaining growth and wellbeing depend on good health. On 30 November 2010, the Government published *Healthy lives, Healthy people: our strategy for public health in England*, which set out a bold vision to make wellness central to all we do – in health and across government.

1.2 Too many people die too young, spending too long suffering from preventable ill-health, and the gap between rich and poor is not improving. In the past, too little focus, too much central prescription, lack of clarity over our aims, and uncertain funding have all got in the way of making progress.

1.3 We need a new approach to fighting health inequalities, rooted in local communities and with the wider determinants of health – economic status, education opportunity, employment, housing and environment – integral to our efforts. Through the White Paper, we responded to the challenges set out in Professor Sir Michael Marmot's powerful *Fair Society, Healthy Lives* report[1].

1.4 The Government's vision for an improved public health system is focused on tackling health inequalities and the causes of ill health, helping all the people of England to enjoy longer, healthier lives. The fundamental principles of the approach are:

- empowering individuals and communities to address their own needs, giving them the tools and support to help them do so effectively
- A locally driven system, with Directors of Public Health in local authorities, influencing and driving action in partnership with local partners across the full range of services and issues, which impact on, and determine, health and well being in local populations.

1.5 Alongside the *Healthy lives, Healthy people* strategy document, we published associated consultation documents, which provided more detail on the funding and commissioning routes for public health services, and proposed how we might create a public health outcomes framework. We also asked for views on Dr. Gabriel Scally's report on the

[1] Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, www.marmotreview.org

regulation of public health professionals. The associated documents were entitled:

a. Dr. Gabriel Scally's *Review of the Regulation of Public Health Professionals*
b. *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*
c. *Healthy Lives, Healthy People: Transparency in Outcomes*, *proposals for a public health outcomes framework*.

1.6 This publication is a summary of the responses we have received to the questions raised in the White Paper and associated consultation documents. Whilst its focus is on the responses to the specific questions, this summary includes also responses raised on wider issues. These are captured largely in chapter 2. We have published alongside this our policy statement, *Healthy Lives, Healthy People: Update and way forward,* which sets out the details of our plans for public health in light of the consultation, next steps towards developing policy, and a timetable for implementing our proposals and which is available on line at www.dh.gsi.gov.uk. The consultation responses will continue to inform our work as we develop our plans further.

Consultation process

1.7 We wanted to ensure that we engaged extensively on our proposals for public health and involved as wide an audience as possible. Therefore, the consultation was carried out at both the national and local level involving the public health sector, NHS organisations, local government, third sector organisations and patient representative groups. Summaries of *Healthy lives, Healthy people* were made available in accessible formats, including plain English, easy-read, alternative languages, large print and braille. Alongside this, we provided materials summarising the proposals for national stakeholders to use in running their own national and local consultation events. One such example is Regional Voices, which ran a series of events for patient representative groups, the voluntary sector and community organisations.

1.8 The Department of Health was directly involved in over 60 consultation events, with groups including the Department's Social Partnership Forum, the National Stakeholder Forum, Directors of Public Health, Local Government Group, the Public Health Taskforce, British Medical Association, Faculty of Public Health and other key partners. Regional Directors of Public Health and their teams led on engagement with local stakeholders – involving local Directors of Public Health (DsPH), and

members and senior officials in local councils. We sought to ensure that engagement and consultation events took place at the most appropriate level, were responsive to local circumstances and as far as possible worked to existing geographical footprints.

1.9 We have had feedback from stakeholders that the localised approach combined with key national events did mean that key partners felt more fully engaged than ever before.

1.10 We received over 2000 responses to the consultation documents, either in returns to the online consultation platform, by email to the public health mailbox, or by post. Many included responses to each of the documents. We received responses from a wide spectrum of individuals and organisations, including patients and the public, clinicians and NHS organisations, local authorities, pharmacists, independent providers of health care and services, professional bodies including Royal Colleges, and trade unions. A list of organisations from which we received responses, either on behalf of the organisation or from people working within it, is published alongside this document.

The wider context: The Health and Social Care Bill and the NHS Future Forum

1.11 The consultation on *Healthy Lives, Healthy People* took place during initial passage of the Health and Social Care Bill 2011 through the House of Commons. The Bill sets out the basic architecture of a reformed public health system by conferring new duties and powers on the Secretary of State and on local government. Many of the most important aspects of the system can be designed and delivered within the legal framework as it stands - for example, Public Health England can be established, public health outcomes defined and funding allocated to local authorities without changing the law in any way. This means that the Bill does not include every detail of the new public health system.

1.12 As part of the Bill's passage through the Houses of Parliament, the Government held a listening exercise on its plans for health care in England. The NHS Future Forum reported in early June and the Government accepted its core recommendations. Subsequently, the amended Health and Social Care Bill has resumed its passage through Parliament.

Broad summary of themes raised in consultation

1.13 Overall, there were clear endorsements from many organisations and individuals, as well as from views expressed at the consultation events, welcoming the recognition of the importance of public health, and the direction of travel. Key professional organisations, such as the NHS Confederation, the Health Protection Agency (HPA), the Royal College of General Practitioners, and the Local Government Group were broadly supportive of the vision set out in the public health white paper. Indeed, the Local Government Group reported that, *"134 of the 150 first-tier authorities have expressed an interest in joining the group of Health and Wellbeing Board 'early implementers'. This is a clear indication of the strong support from local government to be at the forefront of translating aspirations into action."*

1.14 The Institute for Health Promotion and Education said, *"The creation of Public Health England and the imminent transfer of PCT responsibilities for local health improvement to local authorities offer an opportunity to increase the quality and quantity of health improvement activity."*

1.15 There was support for incorporating the functions of the Health Protection Agency (HPA) into Public Health England. The HPA said this, "*will strengthen the new organisation and allow it to deliver, from the start, high-quality health protection services at local, national and international level*."

1.16 However, there were issues raised about lack of clarity over roles and responsibilities, including those for managing health protection incidents and emergency preparedness, resilience and response. The Local Government Group commented the relationship between health organisations has often been unclear in the past, with both gaps and duplication, *"We urge the Government to consider how national and local roles can be defined and coordinated."* The HPA raised wider issues also, including about Independence and identity, external income, and the importance of integrated research.

1.17 The Outcomes Framework received broad support in terms of the overall purpose, criteria and domains of the Outcomes Framework. We have received several campaigns proposing the inclusion of particular indicators, notably breastfeeding and sexual health indicators. A summary of consultation responses on Public Health Outcomes is in chapter 2.

1.18 Our proposals for commissioning routes also received many responses. There were some concerns that responsibility for commissioning whole programmes, or pathways of care, would be split across the system, with local authorities responsible for commissioning some public health services and the NHS responsible for others. Some respondents underlined that the division of responsibilities between commissioners would need to be clear. For a summary of consultation responses on commissioning routes please see chapter 3.

1.19 On funding for public health, *Healthy Lives, Healthy People* set out the Government's plan for a public health ring-fenced budget. Although the Local Government Group was opposed to ring-fencing the public health grant, there was wide support for the ring fence from most other stakeholders. In particular, others were concerned local government would use the public health grant in order to fund their current responsibilities. A group of sexual health commissioners from Yorkshire and the Humber commented, *"We are concerned that under the banner of localism, local authorities may not retain ring-fenced public health budgets"*.

1.20 Uncertainty about the size of the public health grant to local authorities and how the health premium will work were a source of anxiety for many stakeholders. For example, the Local Government Group requested to know details of the budget as soon as possible, and commented they were anxious about the number of unanswered questions about the health premium. A summary of consultation responses on public health funding is included in chapters 3 and 4.

1.21 On the diverse provider market, overall respondents were positive about widening the range of providers to enable diversity and effectiveness of local provision which could generate quality and innovation of services and provide service users choice and control over their care. The Voluntary, Community and Social Enterprise (VCSE) sector was of particular interest for the majority of respondents. Whilst respondents welcomed the use of VCSEs as providers of services and recognised their expertise and knowledge of their local area, they raised a number of concerns about their ability to compete in a competitive market place. This was felt particularly in the face of the public sector funding challenges and general financial constraints that may weaken the VCSE sector further and make it more difficult for them to compete against other sectors. Many argued that local authorities needed to provide financial support, access to business and development and tendering support to enable the VCSEs to compete for future service provision of

health and wellbeing services. A summary of consultation responses on the diverse provider market is in chapter 4.

1.22 On the role of GPs and the role of the NHS, there was widespread recognition of the critical role of GPs and general practices in improving public health. A number of respondents highlighted that GPs are also in an ideal position to tackle health inequalities by systematically monitoring patients to encourage a greater focus on prevention. A summary of responses on this issue is provided in chapter 5.

1.23 On Information and Intelligence, there was broad support among a range of stakeholders for our proposal that Public Health England might play a role in drawing together existing sources of public health evidence and making it more easily available to all through a single, accessible and authoritative web-based evidence system. Respondents were keen to see better signposting of existing information on public health as well as opportunities to share learning across different localities. Respondents were keen to see such a web portal signposting information clearly, providing accessible summaries and drawing out key messages for public health commissioning.

1.24 We also received many useful suggestions as to how Public Health England could address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities. In general respondents identified the following key gaps:

- Cost-effectiveness of public health interventions
- Mental health
- Children and young people
- Behaviour change science

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1.25 There was also general support for the proposal of partnership-working on information and intelligence across services in relation to public health. For a summary of consultation responses on information and intelligence please see chapter 2.

1.26 In response to the question in Dr Gabriel Scally's report on the regulation of public health professionals, there was generally more support for statutory regulation rather than voluntary, but no consensus on the best organisation to provide this. A summary of consultation responses on this issue is set out in chapter 7.

1.27 Many equalities groups, including Mencap, Men's Health Form, Zacchaeus Trust, Age UK, Catch 22, and Stonewall endorsed the vision of the White Paper, the focus on The Marmot Review and the wider determinants of health. For example, Afiya Trust and Rota commented, *"We welcome the Coalition Government's strategy for public health, Healthy Lives, Healthy People. We particularly welcome the attention paid to taking a life course approach to public health, the focus on social determinants of health inequalities, and the linkages made between health, wellbeing and mental health. The idea that local communities have a key role to play in determining the agenda for and ways of promoting public health is in line with the argument we have consistently made that local knowledge needs to be at the heart of policy development and practice".* Nevertheless, some respondents felt that the White Paper overlooked Marmot's focus on minimum incomes for healthy living. Equalities responses are summarised in chapter 8.

1.28 As mentioned above (paragraph 1.6) a range of additional or cross-cutting issues was raised which will inform our work to create a robust public health system. These Include:

- the future status of the Health Protection Agency;
- fragmentation of the wider public health system;
- public health advice to NHS Commissioning;
- responding to health protection incidents and emergencies; and
- risks to the system through the transitional period.

These responses are incorporated into chapter 2.

2. A robust public health system to improve public health outcomes

2.1 *Healthy Lives, Healthy People* set out a vision for a new approach to public health, supported by an improved system and structure. Many respondents made general points about these plans, which we detail in the second half of this chapter. We start, however, with the focus on outcomes.

2.2 In *Healthy Lives, Healthy People: Transparency in Outcomes*, we proposed that we should establish a public health outcomes framework taking a life-course approach. This outcomes framework will have three purposes:

- to set out the Government's goals for improving and protecting the nation's health, narrowing health inequalities and improving the health of the poorest, fastest;
- to provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection, and inequality reduction; and
- to provide a mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

2.3 The consultation responses were broadly supportive of the proposed overall purpose, criteria and domains of the Outcomes Framework. Key points were made in relation to:

- the integration and alignment between the public health, NHS and adult social care outcomes frameworks;
- the focus on health inequalities;
- the life-course approach (including the emphasis on child and maternal health measures); and
- the relationship between local authorities (and Directors of Public Health) with Public Health England and their respective roles in improving outcomes for public health.

2.4 For example, on the issue of alignment, the British Dental Association said, *"We welcome the recognition that close alignment between these*

frameworks is essential to prevent fragmentation of care systems, and that there must be input from all three frameworks into the JSNA."

2.5 On health inequalities, Breast Cancer Care said, "*We were pleased to see the White Paper make a commitment to reducing the inequalities that currently exist in public health*." An individual respondent said "*I support the ambition to improve public health and reduce health inequalities. I am pleased that the key findings of the Marmot Review, Fair Society, Healthy Lives are being adopted.."*

2.6 On the life-course approach issue, Oxford City Council said, *"The indicators provide a good reflection on the life course approach to public health."* North Warwickshire Borough Council said, "Those indicators identified above include people at all life stages and, therefore, should ensure that a whole-life approach is adopted."

2.7 Finally, on respective roles, Stockton on Tees Health and Wellbeing Partnership Board said, *"The connectivity of all partners in addressing the public health outcomes is important."*

2.8 There were contributions also on the range and scope of indicators proposed within each of the five domains, including some proposals for new and additional indicators. Please see Annex A for further information on the five domains and details of specific suggestions for indicators and improvements.

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

2.9 The majority of respondents clearly believed the chosen indicators broadly reflected a life course approach. A typical response came from North Warwickshire Borough Council, which said "*Those indicators identified above include people at all life stages and, therefore, should ensure that a whole-life approach is adopted."* A number of respondents urged closer alignment to themes from 'the Marmot Review' and in particular a stronger emphasis on the early years and young people.

2.10 Four themes emerged in relation to this question:

- more emphasis on indicators of wellbeing in very young children
- more emphasis on indicators of wellbeing in the elderly

- the importance of developing measures of population physical activity in both the young and in elders.
- a stronger emphasis on mental health, including maternal mental health.

2.11 There was concern that because key indicators life stage indicators are distributed throughout the five domains, the balance between life course indicators and other indicators was sometimes lost.

Do you agree with the overall framework and domains?

2.12 There was overwhelming support for the publication of an outcomes framework for public health that was broad in its scope across the whole range of public health. On the whole there was also support for the five domains for public health, although some public health stakeholders pointed out the potential for confusion with the *three pillars (sometimes called the domains) of public health*[2]. A number of respondents also felt that the rationale for dividing Domains 3 and 4 as an artificial and unhelpful split. On this point the Faculty of Public Health (FPH) said, "*For example, the distinction between 'Domain 3 (Health improvement)' and 'Domain 4 (Prevention of ill health)' seems unnecessarily artificial, particularly as there is some overlap between the two: non-accidental injury (NAI) in children aged 5-18 year olds appears in Domain 3, whilst NAI in the under 5s is placed in Domain 4".*

2.13 There was recognition that the five domains recognised the journey of people's health from the causes of ill health (in Domain 2), right through to the long term impacts of poor public health resulting in premature mortality (in Domain 5).

2.14 Many respondents believed that equality considerations should be at the heart of each domain and recommended that public consultation on indicators be carried out from the very beginning of the development of the indicator set to ensure that equality issues can be measured appropriately in the final set.

[2] The three pillars are health improvement, health protection and population healthcare, or healthcare public health.

2.15 The vast majority of responders were pleased that DH had proposed indicators that were not seen traditionally as 'health' measures, and welcomed the increased focus on the wider determinants of health. For example, Cambridgeshire County Council "*agree[s] with the overall framework and domains and find the way they are presented helpful and logical. We welcome the focus on the wider determinants of health and health inequalities*." Others partly agreed, for example, St Mungo's said "*Yes, however, we would like to see greater concentration of addressing the needs of the most deprived and those experiencing the worse health inequalities*." Gateshead council said, "*Yes, we support the concept, although integrated outcomes frameworks would be preferable*."

2.16 However, NHS Wiltshire disagreed, "*No. It is widely accepted by public health practitioners that their work falls in to 3 domains. We see no reason why these domains should be further subdivided in the way that has been done for this new outcomes framework. We are concerned that within the 5 domains proposed there is too much focus on the health improvement aspects of public health, to the detriment of other areas in particular improving healthcare services*."

Indicators for public health

2.17 We asked specific questions about public health indicators. How should we select them? Are there ones we should omit or include? Should we incentivise any, and if so, which ones and by which criteria? The responses on these detailed issues are summarised in Annex A and will help to inform the further development of the Public Health Outcomes Framework.

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?

2.18 We proposed that whatever the outcomes framework includes, an essential principle for public health is joint and partnership working. We want to make sure the final framework enables and encourages partnership working, and does not hinder it.

2.19 The following themes emerged in the responses:

- there should be shared indicators across the public health, NHS and adult social care outcomes frameworks reflecting those priorities that all parts of the system have a shared responsibility to achieve.;
- the need for clarity on responsibility and accountability; and
- the need for a much stronger emphasis on outcomes for children and young people – both to respond more fully to the Marmot Review recommendations on early years, and also to ensure the current lack of a children's outcomes framework should not be a barrier to focusing on outcomes for them.

Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

2.20 There was an overwhelming view that there needed to be greater integration between the public health, NHS and adult social care outcome frameworks, including perhaps a single framework for health and well-being with the local health and wellbeing boards leading a joined up approach. Citizen's Advice said, "*We believe that the future direction of travel is a single outcomes framework that reflects overlapping needs and responsibilities across the three sectors to support integrated working and an overlapping of needs and responsibilities..".* NHS Hertfordshire stated that "*We believe the most effective delivery of the three sets of outcomes (NHS, Public Health, And Social Care) requires integration both nationally, and also locally…"*

2.21 In addition, some responders – mainly those interested in child health issues – wanted to see the introduction of a children's outcomes framework.

2.22 There was interest in the way that the domains took a 'cause to care' approach to achieving improvements in people's health and wellbeing. For example, some respondents welcomed the potential for the outcomes framework to demonstrate the impact of wider determinants, such as fuel poverty, on high-level indicators of premature mortality and excess seasonal mortality. Some respondents saw an opportunity to relate these measures to indicators within the NHS or Adult Social Care Outcomes Frameworks.

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

2.23 All respondents who felt able to comment on this proposal agreed with our idea to align the public health and NHS outcomes framework by sharing a specific domain on preventable mortality. Respondents pointed out that preventable mortality was an outcome of the whole health system rather than local authorities' responsibility alone.

2.24 This shared domain was seen as essential to:

- co-ordinate preventive activity for public health across sectors
- ensure that NHS services supported preventative action
- engage the wider NHS in prevention.

2.25 A number of respondents such as Wolverhampton City Council and PCT raised the issue of accountability for shared indicators or domains, including the need for clarity over responsibility and how this would relate to democratic accountability.

2.26 Respondents were clear on the need to adopt a longer time scale in the approach to and influence on mortality. For example, Cancer Research UK said. "*Whilst we appreciate the greater impact achieved by a focus on mortality, many chronic conditions such as cancer have a long lag time between successful prevention interventions and any measurable changes in mortality.*"

How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

2.27 The focus on wider determinants (in Domain 2) was seen as a positive step forward on health inequalities and as the most effective way to respond to Professor Sir Michael Marmot's recommendations in *Fair Society, Healthy Lives*. There was support for the intention to provide analysis of each of the measures within the outcomes framework by geographical and social deprivation, although there was recognition that for many indicators this would be difficult to do without further development on data availability and

analysis. Respondents recognised that disaggregating data by equalities characteristics for all of the proposed indicators would be very challenging.

2.28 There was a suggestion that the Public Health Outcomes Framework should adopt the indicators developed by London Health Observatory and Marmot Review Team, which demonstrate the extent of inequality at Local Authority level. Others also suggested that the OECD (Organisation for Economic Cooperation and Development) could be explored as a source of information for calculating the health premium. Some respondents recommended the inclusion of inequality dimensions such as ethnicity, age, gender and disability.

2.29 Groups such as the Afiya Trust, Race on the Agenda (ROTA), Mencap and others suggest that the final framework needed to make clear to local authorities, the NHS and wider public services that they had clear duties under the Equality Act to ensure that outcomes are improved for all.

2.30 Key additional concerns raised were:

- the White Paper overlooked the Marmot Review's focus on minimum incomes for healthy living;
- the potentially detrimental impact of local government cuts, with services under the greatest risk being those that best support the needs of the most deprived;

A robust new system - general issues

2.31 Beyond the questions we posed in the consultation exercises respondents raised a number of additional concerns, the most important of which we discuss below. Whilst supporting the aim of creating an enhanced new public health system at national and local level, respondents highlighted the risks they perceived to achieving this vision. These risks included a lack of independence at national and local level; the possibility that public health staff would not be appropriately qualified; and a lack of clarity around roles and responsibilities, in particular for outbreaks and emergencies. Each of these concerns features strongly in the policy statement *Healthy Lives, Healthy People: Update and way forward,* which we published on 14 July 2011, and we will continue to take these issues into account as we further develop and implement our new public health system.

Public Health England (PHE)

2.32 At the national level, a number of respondents were concerned that bringing the functions of the Health Protection Agency (HPA) into a central government department would threaten the ability of public health professionals to give authoritative independent scientific advice. Thus, the HPA argued that PHE should have a *"strong separate identity as an expert body"* and that there should be *"proper arrangements to safeguard the independence of its staff in providing expert scientific and public health advice at local, national and international levels."*

2.33 The Faculty of Public Health argued that PHE "*should be established either within the NHS as a special health authority or, if that is not accepted, as an executive agency of the Department of Health, employing the existing public health specialist workforce currently working within primary care trusts (PCTs) and strategic health authorities (SHAs).*" PHE would provide support to the local public health system through PHE teams seconded to work with DPHs in local authorities and NHS commissioning through local agreements.

The Local Public Health System

2.34 With regard to the local public health system, the Faculty of Public Health commented: *"in order to influence effectively throughout the local authority, the DPH [Director of Public Health] must be appointed at corporate or strategic director level (accountable directly to the local authority chief executive) and have direct access to the authority's cabinet, councillors, CEO and executive directors."* The Faculty argued that the DPH must have the skills to do the job effectively. They said, *"the need for training and registration at specialist level in public health must be made explicit and a requirement by primary or secondary legislation . . . a statutory appointments process, along similar lines to the Advisory Appointments Committee process currently used for all DPH and other consultant/specialist appointments in the NHS, must be implemented by all organisations employing public health specialists at this level."*

2.35 Accordingly the Faculty recommended that the DPH:

- *"Provide strategic leadership for all three domains of public health at local level*
- *Be trained and registered to specialist level in public health.*

- *Be required to produce an independent, public annual report on the health and health needs of their population.*
- *Be a statutory member of the Health and Wellbeing Board.*
- *Be directly accountable to the local authority CEO and have direct access to the authority's cabinet and councillors.*
- *Have responsibility for managing the ring-fenced public health budget and public health staff, which should be appropriate and adequate to support them in delivering the health and wellbeing of their population.*
- *Not be sacked for any reason without the approval of both the local authority and the Secretary of State for Health.*
- *Have appropriate contractual relationships with PHE and the local authority.*
- *Be appointed jointly by the local authority and PHE, through a statutory appointments process, accredited by the FPH, which mirrors the existing process for DPHs and consultants/specialists in public health.*
- *Have an active role in safeguarding children and vulnerable adults, and in commissioning complex, multi-agency services."*

2.36 The Faculty also argued that local authorities should be accountable for protecting and improving the health of their populations, including outbreak and emergency situations. A large number of respondents supported the Faculty's approach.

2.37 The need to ensure public health expertise is available to NHS commissioners was a general theme of the consultation. NHS Swindon and Swindon Borough Council in a joint response noted that the local DPH was already a member of the authority's board and could already influence and develop corporate policies. They said, "*We believe this to be a good model that ensures credibility of the DPH function and contributes to whole organisational decisions that ultimately impact upon the health and wellbeing of the local population".*

2.38 However, some respondents called for a more localist approach. Brent Council for example was "*disappointed that the Government has been so prescriptive in the proposed transfer of public health services to local authorities"*. They said, *"Brent Council believes there needs to be flexibility in the way that public health staff are integrated within councils. We would not support any centrally or regionally transfer of public health staff from the NHS to the local authority as this could have serious financial implications at a time when we are reducing our staff and costs."* They opposed the idea

of split accountability for the DPH to PHE and the local authority and argued that they should be accountable to the Chief Executive and elected members, as other local government employees are.

Emergency Preparedness, Resilience and Response

2.39 A number of respondents were concerned about a lack of clarity around roles and responsibilities for planning for, and responding to, health protection incidents and to emergencies. The Local Government Group commented that the relationship between health organisations has often been unclear in the past, with both gaps and duplication, *"We urge the Govt to consider how national and local roles can be defined and coordinated."* Respondents also raised the need to ensure that the response to public health emergencies remained robust through the transition to the new system.

3. Funding and commissioning routes for public health

3.1 The consultation on funding and commissioning routes for public health sought views about our proposals for commissioning and funding arrangements for delivery of public health services. This chapter summarises the responses to questions on what activity should be funded from the new public health budget and the division of commissioning responsibilities between local authorities, Public Health England and the NHS.

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?

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?

3.2 Many respondents answered these two consultation questions together. They explored combinations of what should be considered ‘public health’, what should be public health funded, or which part of the new system should become responsible for commissioning different services/activity. Of those who responded specifically on what should be public health, most were broadly content that we had labelled the right activities as ‘public health’ for the purposes of funding. Responses relating to individual areas of activity are summarised in the thematic paragraphs which follow the general responses below.

3.3 The answers to both of these questions are pivotal in ensuring that future public health budgets and allocations are of an appropriate size. One frequently expressed concern was whether local authorities would be appropriately funded to deliver their new functions, or whether the grant to local authorities would be adequately ring-fenced. The concerns are

summarised by the Family Planning Association, who said, *"FPA strongly recommends that the formula used to assess the funding required to deliver public health services is robust enough to take account of all of the activities to be delivered through public health. We are concerned that local authorities and Public Health England are being asked to take on additional responsibilities to those currently identified as relating to public health...FPA recommends that clear conditions for reporting how public health funding is spent are established both for NHS organisations and for local authorities to ensure that the ring-fenced budget is only allocated to public health functions. We are concerned that there is a risk that the definition of public health could be stretched to cover other services that are facing budget pressures to the detriment of the public health services for which the funding is intended. We believe that ensuring there is transparency and accountability in how funding is spent should mitigate some of this risk."*

3.4 Concerns over 'cost-shifting', should responsibilities not be clear, were also raised. One response noted, *"There is significant potential for cost shunting through reclassification of activities as public health to plug gaps in services whose funding has been cut. NHS service providers will be less motivated to play their vital role in public health improvement, and failure to define and clarify responsibilities for delivering services at the interface of local government and NHS carries with it great risks to significant and vulnerable populations."*

3.5 Overall, splitting health commissioning between local authorities and the NHS commissioning architecture raised concerns about fragmenting the system, and undermining a whole system overview. The Association of Directors of Public Health said, *"We are concerned that the proposed new system should not result in service fragmentation, which would have detrimental impacts on the very areas the reforms seek to improve: the quality of services, education and training, patient choice, efficiency and equity. It also has the potential to exacerbate any existing postcode lottery in health services."*

3.6 Respondents noted that co-operation between commissioners would be vital to ensure successful delivery. For example, Age UK said, *"We largely agree with the provisions set out in table A in the consultation, although we would highlight that success for many of these initiatives will rely on close co-operation between local authority commissioners and GP services. For example, falls prevention provides a vital service for many older people at*

risk of falling, however identification of those at risk and referral to a service is often likely to happen via an individual's GP." The BMA said; *"We believe that public health interventions require whole system oversight. It is important to separate the concept of coherent commissioning from active procurement and contract management. Therefore, we would view the Director of Public Health as a key stakeholder at a local level for the commissioning of all services set out in Table A. However, this does not mean that DsPH are the responsible commissioner, the procurer of the contract or the contract account holder."*

3.7 The transfer of public health responsibilities to local authorities raised concerns both that inequalities will not be addressed adequately in NHS commissioning and that such a transfer could exacerbate issues around postcode lotteries, which could aggravate health inequalities. For example, the Bolton Children's Trust Board said they were "*concerned that the potential fragmentation of local commissioning activity may harm the capacity of local agencies to reduce health inequalities*."

3.8 The Race Equality Foundation reported that participants at a regional seminar "*were concerned that their local authorities were not necessarily well informed about the diversity their local population and about the range of needs that exist there. Genuine consultation with black and minority ethnic groups and with the third sector should help to ensure that local authorities are able to become better informed about their communities and be able to commission in a more effective and equal way"*.

3.9 We list below, in alphabetical order, specific service areas with our proposed commissioning routes, followed by comments from respondents.

Accidental injury prevention

3.10 *Proposal:* Local authorities will become responsible for local work on accidental injury prevention, for example local initiatives such as falls prevention services. There was broad support for this proposal, for example the Faculty of Public Health said they *"support the local authority focus. Much injury prevention work is already undertaken through local authorities..."* The Royal Society for the Prevention of Accidents said, *"We welcome the inclusion of accident prevention in the list of activities that should be funded at local authority level."*

Alcohol and drug misuse

3.11 *Proposal 1:* Local authorities to be responsible for commissioning alcohol misuse, prevention and treatment services. Responses to the consultation generally supported these proposals. For example, the Faculty of Public Health said they *"support the local authority lead role but consider this underfunded area needs additional funding from budgets pooled by GP commissioners, social services and criminal justice agencies."* Some respondents highlighted that there should be a continuing role for the NHS in providing brief interventions. For example, Heart of Birmingham PCT said, *"We believe GPCCs have an important contribution to make to commissioning prevention services e.g. brief interventions for alcohol services but at present lines of accountability for commissioning primary care based prevention service and achieving health outcomes which are highlighted as priorities within the JSNA are unclear."* NHS Derby City said, *"Concern about potential disengagement of GPs from health issues such as sexual health, drugs and alcohol if local authorities take them over."*

3.12 *Proposal 2:* Local authorities to take responsibility for commissioning services to prevent drug misuse and help people recover from dependence. Responses to the consultation also broadly supported this proposal. For example, the Faculty of Public Health said they *"...support the local authority as lead, as proposed. Existing Drug and Alcohol Action Team (DAAT) arrangements for pooled and additional budgets should continue to apply."* The UK Drug Policy Commission were supportive of the proposed commissioning route for drug misuse services, but were concerned with the split between these services and mental health treatment services. They said, *"The UK Drug Policy Commission broadly welcomes the approach in the strategy document Healthy Lives Healthy People, which places drug misuse and dependence in a public health context that recognises the role of inequality and disadvantage, and a range of social, environmental and economic factors in promoting and sustaining poor health outcomes.* They had concerns about the lack of reference in the consultation documents to harm reduction services and to drug dependence and related services. They were concerned also that: "*As mental health services are to be commissioned through GP consortia while drug treatment services will be within the Public Health remit, there is a danger that the difficulties already encountered by people with mental health and substance misuse dual diagnosis will be exacerbated, and they will increasingly suffer from the gap between services."*

3.13 Turning Point highlighted that, "*people who misuse substances are often subject to high levels of stigma which can affect their ability to reintegrate into the community" and expressed concern that "local disinvestment will create services which do not meet the complex needs of those who misuse services*."

Children's and young people's public health

3.14 *Proposal 1:* Public health services for children under 5 would be public health funded. This would include health visiting services, including the delivery and leadership of the Healthy Child Programme for under 5s (working closely with NHS services such as maternity services and with children's social care and Sure Start Children's Centres); health promotion and prevention interventions by the multi-professional team and the Family Nurse Partnership programme. In the first instance, we proposed that these services be commissioned on behalf of Public Health England *via* the NHS Commissioning Board (NHS CB) so that the NHS CB could oversee the workforce growth needed to meet the Government's commitment to an extra 4200 health visitors by 2015. We said that we expect these services to be commissioned locally in the longer term.

3.15 *Proposal 2:* Public health services for children aged 5-19, including public mental health for children, to be funded by the public health budget and commissioned by local authorities. This will include the Healthy Child Programme (HCP) 5-19, health promotion and prevention interventions by the multi-professional HCP team and the school nursing service.

3.16 Respondents were generally supportive of the proposal that local authorities should commission public health services for 5-19s. However, a number of responses commented that having different commissioning routes for children's public health services from pregnancy 0-5 and 5-19 at the outset could lead to fragmentation. The Association of Directors of Public Health, the British Medical Association, and a number of local authorities and NHS organisations echoed the comment from NHS Telford and Wrekin who said, *"there is a real risk of fragmented delivery if the commissioning of services for under 5s and 5-19 year olds are led by different agencies"* and that *"they should continue to be commissioned at local level in accordance with local needs, knowledge and experience".*

3.17 Some respondents expressed concern about fragmentation of commissioning of support for vulnerable children, and of safeguarding arrangements. Bolton's Children Trust Board calling this "unhelpful" with the potential to undermine an integrated approach to commissioning and provision of the Healthy Child Programme. The Borough of Poole also raised the issue of the potential disruption to planned integration of health visiting services with other Sure Start services by placing them outside local public health commissioning arrangements. A number of respondents, including many NHS organisations and the Association of Directors of Public Health felt the single commissioner for children's public health should be the local authority to ensure consistency with current Children's Trust arrangements.

3.18 A number of children and young people stakeholders commented on the safeguarding arrangements, including National Children's Bureau (NCB), Royal College of Paediatrics and Child Health (RCPCH) and NHS Confederation. The NHS Confederation said, "*In the new system it is not clear which commissioners will do what. For example, who will commission designated safeguarding children professionals and how will they work with other commissioners?"* They went on to suggest, "*Establishing a specialist subgroup of the health and well-being board to encompass responsibilities for providing integrated children's services and safeguarding may be one way of achieving this*".

3.19 Others, including NHS confederation, the RCPCH, the Association for Young People's Health (AYPH) and Young Minds expressed concerned about lack of focus on adolescent health. AYPH said they were "*very concerned that the health needs of young people will fall between services and be overlooked in the commissioning process. But it is this age group, bridging the gap between childhood and adulthood, which would be one of the greatest beneficiaries of opportunities such as those highlighted above. Adolescents are the only age group not to have made significant improvements in overall health outcomes in the last few decades (Viner and Barker, 2005)*." Young Minds felt that, "*There needs to be user-friendly approaches to helping young people appreciate the importance of looking after both their physical and mental health, knowing how to get help and understanding what effect their behaviour has on other people. Research also demonstrates that lessons in looking after our emotions and promoting resilience can raise awareness and reduce negative attitudes to mental health*."

Community safety, violence prevention and social exclusion

3.20 *Proposal:* Using their ring-fenced budget where they decide it is appropriate, local authorities to be responsible for working in partnership to tackle issues such as social exclusion, including intensive family interventions; social isolation amongst older people; community safety including road safety awareness; and violence prevention and response. We also set out that this could include supra-local commissioning of service such as Sexual Assault Referral Centres (SARCs), or female genital mutilation (FGM) clinics, where appropriate.

3.21 A number of respondents supported these proposals, including the Faculty of Public Health who said, *"Local authority leadership is essential. With the demise of primary care trusts as responsible bodies in community safety partnerships, the public health component is also assimilated into the local authority role. The commissioning of community safety via this route is therefore supported. However, NHS partners, especially GP commissioners must be partners in the community safety partnerships and must be able to contribute additional pooled budget towards major health damaging crime problems such as alcohol harm, domestic violence and offenders with mental ill-health.*

Sexual assault response centres (SARCs) are best commissioned at a sub-national level. It should be noted that SARCs have not generally received NHS mainstream funding and that funding such centres will become a new, additional call on the public health ring-fenced budget - and therefore appropriate funding should be included in the budget to ensure this vital service continues to be supported."

3.22 The BMA supported the proposals for community safety and supported the proposal for supra-local commissioning of some aspects, saying,*"We welcome the outline described. However, it is important that a population perspective underpins the commissioning of these services and we recognise that some, such as SARCs, are best commissioned at a sub-national level. We reiterate the guidance in working together which strongly suggests that there should be a named public health lead for safeguarding within the public health team who would be well-placed to support this commissioning."*

3.23 Lancashire County Council also agreed with these proposals. They said, *"We agree. This provides an opportunity to align these services with our existing community safety responsibilities and those commissioned through Supporting People and to take a broad holistic approach to the needs of individuals. We would request that public health funding for Sexual Assault Referral Centres be included or specifically identified in this area of work."*

3.24 Some respondents (such as the BMA and Faculty of Pubic Health) welcomed the proposal that local authorities could commission services to tackle social exclusion using funds from their ring-fenced budget. Other respondents were concerned about the difficulties of clearly demarcating services for social exclusion from other services in terms of funding, and others thought that the NHS should continue to play a part in funding and commissioning such services.

Dental public health

3.25 *Proposal:* Local authorities to be the lead commissioners for dental public health and should conduct consultations on proposals for the fluoridation of water. It was proposed that Public Health England would lead on coordination of oral health surveys whilst local authorities would lead on providing local dental public health advice to the NHS as well as commissioning community oral health programmes.

3.26 The responses to the consultation supported these proposals, but a small number of responses expressed concern about the staffing implications. In particular, responses highlighted the small number of specialist dental public health consultants. For example, the British Dental Association referred to the 2008 *Workforce summary for dental public health* and said that, "*Dental public health teams should be developed to meet this target [of one whole-time Consultant in Dental Public Health per 600,000 population]. All vacant posts in (dental) public health should be secured and factored into the current baseline calculation for funding*." They had concerns also about how the ring fenced budget will be calculated. They said, "*We are looking for a clear indication of the budget for dental public health, and to ensure that it is adequate and safeguarded*." Respondents stressed that there was a need to maintain the contribution that the consultants make to the commissioning of NHS dental services for which the NHS Commissioning Board is to become responsible. NHS County Durham and NHS Darlington stated that *"to be effective, dental public health advice needs to be secured*

and integrated into services commissioned by local authorities, the NHS Commissioning Board…at a sub national level." The BMA set out that they believe that specialist dental public health expertise should sit at a sub-national level, *"we believe that this is a highly specialised field of public health that is best delivered at a sub-national level through Public Health England with local co-ordination of all health promotion through the teams of the Director of Public Health."*

Early Presentation and Diagnosis

3.27 *Proposal:* Public Health England to be responsible for designing and funding initiatives to promote earlier presentation and diagnosis, for example the planned national bowel cancer symptom campaign. It also proposed that local authorities might also choose to commission such initiatives from their local ring-fenced budgets. The consultation responses were varied - some welcomed the approach, the Roy Castle Lung Cancer Foundation said, *"We welcome the clarification in Table A, that prevention and early presentation will be the responsibility of the local authority. Prevention of lung cancer is a priority for [Roy Castle Lung Cancer Foundation] and we already work with local communities to provide stop smoking services."*

3.28 Some thought that, given that most of the responsibility for early diagnosis and treatment fell to the NHS, it would be more effective for the NHS to be responsible for promoting early diagnosis as well. The Audit Commission said that early prevention and diagnosis *"should clearly be commissioned by the NHS Commissioning Board and not local authorities."* They said, *"Campaigns for prevention and early presentation of conditions, such as cancer, must be fully integrated with any subsequent treatment services".*

Eye Health

3.29 The Royal College of Ophthalmologists, the College of Optometrists, the Optical Confederation and the UK Vision Strategy made a joint submission to the consultation. They fully endorsed the priorities of putting patients first and continuously improving healthcare outcomes, but were deeply concerned that eye health and prevention of sight loss were not addressed. They said, *"People with visual impairments are twice as likely to have falls as fully sighted individuals. The annual cost in the UK of treating falls due to visional impairment is £128 million." They proposed that "local authorities*

should be encouraged to engage with local optometrists, as well as with other local health professionals, to decide on the issues that are most important locally, to include them in the Joint Strategic Needs Assessment, and to work out how best to tackle eye health as part of the public health Agenda."

Functions of the current Health Protection Agency (including those related to infectious disease)

3.30 *Proposal 1:* (subject to Parliament) Public Health England to take responsibility for protecting the public's health including carrying out functions currently exercised by the Health Protection Agency (HPA). We set out that work would take place at all levels of the new public health system to mitigate the health impact of climate change, reduce excess deaths as a result of seasonal mortality and to protect the public from radiation, chemical and environmental hazards. The Sustainable Development Unit said, *"[we] strongly support the statement that 'Work will take place at all levels to mitigate the public health impact of climate change' in reference to Public Health England as they take responsibility for the Health Protection Agency's work."*

3.31 *Proposal 2:* In carrying out the functions currently exercised by the HPA, the prevention and control of infectious disease will be a key function of Public Health England. We proposed that the NHS would remain responsible for funding and commissioning infectious disease treatment and related public health activity; for example, all organisations providing services funded by the NHS will continue to need to have adequate infection control policies and procedures. The BMA supported the lead role we set out for Public Health England, as did the Faculty of Public Health, who also highlighted the important role that already happens at the local level. They said, *"FPH supports the lead role of Public Health England. However, the DH needs to recognise that there is a substantial body of health protection work that has been built up at local level to cover healthcare acquired infection in the community, immunisation, sexual health, tuberculosis control, blood borne virus and other communicable disease control not adequately covered by the Health Protection Agency. It remains imperative that these local health protection resources are managed and commissioned by local DPHs. The DPH and therefore the local authority also need to be able to command sufficient resource for outbreak control at a local level."* The Hepatitis C Trust said, *"vital that the HPA's work on infectious diseases, including Hep*

C, continues within PHE, which should offer guidance to local authorities. Local authorities can provide local targeted screening programmes."

3.32 The Faculty of Public Health also supported the proposals around the current HPA functions of standardisation and control of biological medicines, saying, *"FPH supports the proposal that PHE should lead"*, and on radiation, chemical and environmental hazards they said, *"FPH support the proposal that PHE leads, with local authority support."*

3.33 The HPA said, *"The response to certain health threats, e.g. diseases such as tuberculosis, will need to be underpinned by expert commissioning at national as well as local level. There will need to be effective interaction with the NHS with roles and responsibilities clearly defined."* The London Health Forum set out the need for local and regional knowledge in this area, *"where there is national level commissioning, e.g. PHE oversight of infectious disease, a regional approach may be needed to bring in local knowledge, e.g. TB in London."*

3.34 Some respondents raised concern about possible fragmentation. For example, NHS Berkshire West was concerned about fragmented pathways caused by splitting prevention and treatment of infectious diseases.

Health at Work

3.35 *Proposal:* Local authorities to be responsible for commissioning any local initiatives around workplace health. The consultation responses did not raise any significant issues with our proposal. The Faculty of Public Health said, *“Health at work services should be commissioned by local authorities with Public Health England support and through the work of the Department of Work and Pensions.”*

Immunisation

3.36 *Proposal:* Commissioning of immunisation programmes should be split between the local authority and the NHS depending on the delivery mechanism for the programme. School-based programmes would sit with school nursing in the local authority, programmes based on GP practices to be commissioned by the NHS Commissioning Board, which will hold the GP

contract. Hospital-based targeted neonatal programmes would also go to the NHS.

3.37 Many respondents were concerned about the proposed division of commissioning responsibility between local authorities for human papilloma virus (HPV) vaccination and teenage booster immunisations, and the NHS for other immunisations. For example, the NHS Confederation said, *"We are concerned that separating the commissioning of immunisation programmes through schools such as HPV and the teenage booster to be carried out by local authorities, from other vaccination programmes such as flu to be commissioned by the NHS Commissioning Board, would not make best use of expertise and resources required."* The Health Protection Agency was of a similar view. They said, *"Fragmenting commissioning could create unnecessary risks to consistency, priority and quality."* The Joint Committee on Vaccination and Immunisation (JCVI) said, *"We increasingly regard vaccination as part of the full life course. We suggest that it could be helpful to have one body oversee all vaccination commissioning to ensure continuity and quality".*

3.38 Respondents also pointed to the important role currently played by the PCT immunisation coordinator. They feared that this coordination role could be lost in the transition. The Health Protection Agency said, *"The co-ordinator function for local programme delivery is essential and will need to transcend funding and commissioning boundaries"*. The JCVI had similar views, *"We strongly believe that a coordinator – a champion of vaccination – is important in ensuring that changes to the management is also critical."*

3.39 Many respondents identified the need for public health expertise. There was concern that fragmentation of the commissioning routes could spread expertise too thin, and there was a feeling that the role of the Director of Public Health (DPH) should be protected and embedded. Thames Valley Immunisation Group said, *"The role for overseeing immunisation in an area….should be identified and include public health input."* The BMA said, *"We would recommend that there is a statutory requirement for consultation with the DPH about any service commissioned for provision in their geographical or population jurisdiction."*

NHS Health Check Programme

3.40 *Proposal:* Local authorities to be responsible for the risk assessment and lifestyle interventions part of the NHS Health Check programme, while the NHS should retain responsibility for any resulting follow-up treatment and ongoing risk management. The majority of respondents raised no concerns about the proposed route, but some, including the Audit Commission and the British Medical Association, proposed that complete commissioning responsibility should rest with the NHS Commissioning Board as they considered the NHS Health Check programme to be analogous to a screening programme (see below). The BMA said, *"we view the NHS Health Check as a screening intervention and therefore see no reason why this cannot be commissioned in the same way as all other screening programmes."* Some local authorities also regarded this as a clinical service. For example, Brent Council said, "*We believe that medical interventions…..are best commissioned from within the NHS. Other commissioning functions will see local government carrying out little more than a fund holding role. The NHS Health Check is a case in point, where a system is already well established, but commissioning responsibility will transfer to councils.*″

3.41 The Bow Group welcomed the Government's continuing support for the NHS Health Check programme, saying, *"As part of the national prevention strategy, we welcome the announcement that the NHS Health Checks programme will continue for those 40-74 years, and that community pharmacies should be included as an important point of access for this service."*

Nutrition

3.42 *Proposal 1:* Local initiatives relating to nutrition should be commissioned or undertaken with local authorities. Responses broadly supported this proposal.

3.43 *Proposal 2:* Public Health England to be responsible for running national nutrition programmes such as Healthy Start (this would also cover schemes such as the Nursery Milk Scheme, and the School Fruit and Vegetable scheme). The BMA had some concerns. They said, *"Although we welcome the local focus on generic healthy eating and breastfeeding campaigns there needs to be clearer accountability for performance management of primary care and post natal support services and we are concerned that the*

lack of community dietetics will remain a significant barrier to providing clinically evidence based interventions beyond the universal approaches."

3.44 Age UK highlighted the need for more targeted work around nutrition. They said, *"We would also like to seek clarification in relation to nutrition. The consultation ascribes primary responsibility for promoting good nutrition to Public Health England and envisages limited participation from local authorities. While we agree it is appropriate for Public Health England to continue its national work programme, as for example national Change4Life television advertising, the consultation does not appear to have taken into account more targeted work on nutrition such as prevention of malnutrition in older adults."*

Obesity

3.45 *Proposal:* Commissioning preventative obesity programmes, community based weight management interventions, including those targeting the workforce, and the National Child Measurement Programme to become the responsibility of local authorities; responsibility for funding and commissioning clinical interventions such as bariatric surgery would remain with the NHS.

3.46 Some concerns were raised about this. For example, the BMA said, *"we are concerned that separating the commissioning of obesity services will lead to incoherent and disjointed models of care. We would support a model in which Public Health England establishes a commissioning framework which is procured at a local level by local government, consortia and the NHS Commissioning Board, according to the relevant section of the pathway. We do not believe that the National Child Measurement Programme (NCMP) should be commissioned separately from the healthy child programme and would see this as a core deliverable for the health child programme at both measurement points - commissioned by Public Health England and procured by the NHS Commissioning Board in consultation with local government and consortia."*

3.47 The Faculty of Public Health said, *"FPH supports the proposal that local programmes to prevent and address obesity should be led by the local authority. However, there is potential for the commissioning of obesity services to be incoherent and disjointed. There will be contradictory local choices with some choosing to fund surgical intervention for a few ahead of*

preventive programmes for the many. Surgical interventions judged effective by NICE cannot be administered to the whole population, and a real and concerted national focus on reducing fat and sugar consumption is needed. Public Health England should be given the lead to establish a commissioning framework, which is procured at a local level by local government, GP commissioning consortia and the NHS Commissioning Board, according to the relevant section of the pathway. National campaigns should support this, and regulatory and legislative measures should support these. The National Child Measurement Programme should be commissioned as part of the healthy child programme"

3.48 However, the majority of respondents supported the proposals. For example, the Institute of Health Promotion and Education said, *"Nutrition, physical activity and obesity are all facets of the same issue. We therefore think it appropriate that the local authority should commission for all three. However we recognise that for all three there will also be some activities that are better commissioned at a national level by Public Health England."* LighterLife were also supportive of the proposed commissioning routes, dependent on there being appropriate cooperation; they *"welcome local authority responsibility for weight management. Note that treatment rests with NHS – it is important that there is cooperation between local NHS and local government to ensure the most effective and cost-effective treatments for obesity are made available. "*

Physical activity

3.49 *Proposal:* Local authorities to be responsible for physical activity programmes, including encouraging active travel. The majority of respondents raised no objections to these proposals. For example, the Institute of Health Promotion & Education, the British Medical Association and the Faculty of Public Health supported the model proposed but added, *“Existing local authority programmes of sport and fitness should not be included within the public health ring-fence.”*

Preparedness resilience and response for health protection incidents and emergencies

3.50 *Proposal:* Public Health England to be responsible for emergency preparedness and response relating to public health emergencies, and for working together with the NHS to offer support and technical expertise to

manage incidents, which impact upon both public health and NHS areas of responsibility. The NHS Commissioning Board to be responsible for mobilising the system in times of emergency and ensuring the resilience and preparedness of the NHS to respond to emergency situations, assuring, for example, that clear arrangements are in place, services are coordinated and lead individuals are designated. Working with the NHS, Public Health England would need to plan, prepare and be able to respond in a coordinated and effective way.

3.51 The perceived lack of clarity around roles and responsibilities for emergency preparedness resilience and response (EPRR) generated much comment and criticism as part of the consultation, including from the Health Protection Agency, the NHS Confederation, many PCTs and local authorities. The Local Government Group commented that the relationship between health organisations has often been unclear in the past, with both gaps and duplication. They said, *"We urge the Government to consider how national and local roles can be defined and coordinated."*

3.52 Derbyshire County Council said, *"Further clarity is needed in respect of local emergency planning and public health threats to communities. Clearly some emergencies need national co-ordination but local government must continue to have a strong role in local planning and response to public health emergencies. Joint planning needs to continue through Local Resilience Forums, otherwise there is the potential for parallel silos of planning and response".*

3.53 Many respondents also commented on which organisations or individuals should be category 1 responders.

3.54 *Proposal 2:* Local authorities to work closely with Public Health England local units (which will carry out functions currently exercised by Health Protection Units) to provide health protection as directed by the Secretary of State for Health. For example, this could include support in outbreak investigation and contact tracing, by providing training and mobilising staff, in community infection control, or coordinating the health protection response to flooding. We proposed that most incidents would be managed locally, with the public health response led by the Director of Public Health (DPH) and PHE Local. Many respondents, for example the London Borough of Greenwich, asked for *"greater clarity about how this relationship might*

work in practice", with some respondents preferring that either the DPH or the PHE local should have the lead role.

3.55 NHS Telford and Wrekin were clear that the creation of Public Health England should not undermine public health capacity and expertise at local level. They suggested that PHE local units should be the first line of response locally, and accountable to the DPH. The NHS Confederation said, *"There needs to be clear agreement on the roles and responsibilities for directors of public health and health protection units to ensure health protection work carried out in tier two of local authorities is connected with coordination and planning mechanisms organised in tier one of local government."*

3.56 The BMA felt that any further centralisation of the functions of the local Health Protection Units through PHE would provide insufficient capacity at the local level to provide a response to an outbreak. They said, "*It is important the Joint DPH retains, through their PHE capacity, leadership of the local health economy during outbreaks and incidents."* The Faculty of Public Health also felt that the DPH should play a lead role, and that further local arrangements should be drawn up in order to provide the necessary flexibility. They said, *"At local level only DPH management on behalf of the local authority can ensure that good professional advice is translated into an effective local response. Memoranda of understanding between PHE and local authority DPHs will be needed to recognise these different scenarios."*

3.57 Many respondents raised the risks around transition and resilience of emergency response. The Health Protection Agency said that whole system reorganisation "*could create considerable risks to the national capability to launch multi-agency responses to incidents and emergencies. These risks must be actively managed with effective coordination across government to safeguard effective response and resilience".*

Public health for those in prison or custody

3.58 *Proposal:* Where public health services are delivered in prison or for those in custody, these interventions would be funded from the public health budget but commissioned by the NHS CB, to facilitate an integrated service across a national prison network. Responses to the consultation were broadly supportive of this proposal, although a number of respondents raised concerns around commissioning public health interventions on a

national basis. Lancashire County Council said, *"We agree but consider that there needs to be a distinction between prison and custody. We agree the NHS Commissioning Board should have the major responsibility for commissioning of primary care services. However, public health interventions need to be commissioned by the local authority to enable the interventions for the prison population to be integrated with offender health programmes."* A group of London councils believe the responsibility for public health for those in prison or custody should be a shared responsibility. They said " *this should be a shared responsibility between the NHS Commissioning Board and local authorities to reflect the links between prisons and the wider community and to make links with the health needs of prisoners' families, including partners and children."*

3.59 Some respondents expressed concern about shift of offender health to the NHS CB. They noted that offenders are a key socially excluded and vulnerable group and, for example, said, they required a "*holistic approach to health services which encompass health promotion, primary care, substance misuse, mental health and sexual health services*. " They felt that there are synergies with areas that will move to local authorities. Turning Point had a similar view, that there might be a disconnect between services for offenders in prison commissioned by the NHS CB and local authorities taking on responsibilities for services such as for drug and alcohol misuse; they highlighted the need to avoid people falling through cracks in the commissioning architecture. They said, "*there needs to be greater integration and case management between services within prisons and the community*."

3.60 Newcastle City Council highlighted the need for a joined up approach to offender health, *"We would prefer Public Health England to recognise the need for joined up efforts to address offender health and for local authorities to receive an allocation for this, rather than just focussing on Prison Health."*

Public mental health

3.61 *Proposal:* Local authorities to be responsible for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities. Respondents expressed a variety of views in response. For example, the Audit Commission were unclear what exactly would be included under the banner of public mental health. The BMA welcomed the local focus for delivery, but commented that

because suicide rates are relatively low across the majority of areas, public mental health services might best be delivered through sub-national networks.

3.62 Fragmentation was raised as a concern, with the NHS Confederation expressing the need to retain links with drug and alcohol commissioning, as well as linking up public mental health with mental health treatment services. The NHS Confederation said, *"To reduce health inequalities it will be important for the new system to improve the public's mental well-being, meet the physical health needs of people with mental health problems and the psychological needs of people with long-term conditions. Such important areas should be jointly commissioned by one organisation and delivered through different bodies with clear accountable lines rather than fragmented across the system"*

Reducing birth defects

3.63 *Proposal:* that Public Health England should be responsible for the surveillance of birth defects and anomaly registers. The BMA stated, *"We recognise that this is a complex area which requires whole system oversight from preconception through to maternity services and screening to post natal follow up and genetic counselling. Consortia are not tied to geographical populations and so if they each commission maternity services independently then there will be substantial challenges in coherent coordinated services at a local level for women. The Director of Public Health will provide a population perspective as well as be able to provide a level of engagement with local providers. We therefore recommend that the Director of Public Health has explicit responsibilities in relation to maternity services and that they advise the commissioning of the interventions by the relevant parties."* The Faculty of Public Health agreed, "*FPH supports the proposed model for interventions at population level: local authority and PHE. There are essential national and regional surveillance systems in place for this work, which should not be interrupted through organisational change*." The Institute of Public Health, University of Cambridge said, " *IPH is pleased to see the inclusion of population level interventions for the prevention of birth defects, as this recommendation accords with the World Health Association resolution in May 2010 calling for action to address the global burden of birth defects*."

Screening

3.64 *Proposal:* all national screening programmes to be funded from the public health budget with the NHS CB commissioning the programmes. A number of consultees supported this but highlighted the need to ensure local input to screening to reflect local perspective. The British Medical Association and the Faculty of Public Health both supported PHE and the NHS Commissioning Board working together to commission all screening programmes at a sub-national level. The UK National Screening Committee said, "*We very strongly support the proposals to allow the NHS Commissioning Board to commission screening services on behalf of Public Health England. We believe that the NHS Commissioning Board and sub structures will be the organisation with most expertise and experience in NHS commissioning, finance and contract management and will allow for commissioning of the whole pathway (i.e. integration of screening, diagnosis and treatment)".* Others suggested that screening programmes would be best commissioned locally, for example by local authorities. The need to ensure public health expertise is available to NHS commissioners was a general theme of the consultation, and was raised specifically for screening.

Sexual Health

3.65 *Proposal 1:* Local authorities to be responsible for commissioning sexual health prevention and outreach services, contraception services (outside of the GP contract), testing and treatment for sexually transmitted infections, and fully integrated termination of pregnancy services. The services commissioned would include, where appropriate, sexual health aspects of psychosexual counselling similar to current arrangements.

3.66 There was broad support for local authority commissioning of services (including abortion services) as the best way forward to ensure not only the best provision of sexual health services but also as a way of tackling health inequalities. The Terrence Higgins Trust said, *"There is a rational argument that local authorities can make a success of this commissioning as many of the determinants of poor sexual health fall within their remit, for example, social deprivation and sex and relationships education. As such, we are optimistic about the transfer of public health responsibilities to local authorities."*

3.67 The Lesbian and Gay Foundation pointed out that for many members of the lesbian, gay, bisexual and transgender (LGBT) population STI prevention is

of a higher priority than, and is separate from, contraception. They said that preventative activities that contribute to LGBT people's sexual, mental and physical health ultimately save the NHS money and therefore targeted preventative work must be maintained and developed. For example, there is evidence that free condom provision for medium and high risk groups is a cost-saving preventative measure.

3.68 Some respondents questioned whether abortion services are public health services and whether they would be commissioned more appropriately by clinical commissioning groups. Others felt that it was important to align commissioning responsibility for abortion services with responsibility for STI testing and contraception provision to improve women's sexual health and reduce the risk of future unintended pregnancies. The Family Planning Association considered that there might need to be special arrangements for late abortion services if local commissioning was not appropriate. However, they welcomed the recognition of the role of abortion services as an integral part of sexual health services, and said, they *"play an important role in providing contraception and sexual health services to women with an unplanned pregnancy."*

3.69 Some respondents asked for clarification about why we proposed that contraception should be commissioned by both local authorities and through the GP contract by the NHS Commissioning Board (NHS CB).

3.70 *Proposal 2:* HIV treatment to be commissioned and funded by the NHS CB. A number of respondents noted the split of commissioning responsibilities for HIV testing and treatment carried the risk of service fragmentation, and many raised the importance of joint working. The British Association of Sexual Health and HIV said, *"Achievement of sexual health outcomes will depend on effective joint working and communication, which facilitates the delivery of sexual health care that is of a high standard, clinically safe, and is cost effective… Health and wellbeing boards will play a vital role in ensuring that this process of joint working is as effective as it could and should be."*

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?

3.71 The consultation document asked whether there was a case for increasing the flexibility in relation to commissioning services currently provided through the GP contract and, if so, how this might be achieved. Many respondents were supportive of this suggestion, but others were neutral, recommending caution in the approach to this issue and only decommissioning services from GPs where delivery was poor.

3.72 The Association of Directors of Adult Social Services was supportive of greater flexibility in this area. They said, *"Yes. All contracts and commissioned services should be regularly reviewed to ensure that they remain fit for purpose."* Others were supportive also, for example, Hampshire County Council said, *"Yes. It will be essential for Public Health England to have flexibility to ensure the service currently under the GP contract can be commissioned in the most effective way. The approach needs to be transparent, proportionate and engage local partners. The approach of working to outcomes rather than numbers of contacts must also be applied to the GP contract and GP business delivery."* The City of London Corporation focussed on improving local flexibility: *"The [City of London Corporation] supports flexibility and choice and the regular review of services to ensure value for money and quality of provision as well as the option of local flexibility. The CoLC would therefore give support to flexibility that allows GP Consortia to 'opt out' of the GP contract if they and the Health and Wellbeing Board feel an alternative option is more appropriate. The funding for this would need to be negotiated between the Health and Wellbeing Board and the NHS Commissioning Board"*

3.73 A few respondents highlighted the need to be cautious in any approach to future commissioning of services currently in the GP contract. Age UK said, *"Removing services from the GP contract should be approached with a significant degree of caution. There is a strong case that services such as screening need to be fully integrated into the general health management that a GP should provide. While there may be incidences where alternative providers believe they could achieve better reach into specific population groups for example, there would need to be an extremely robust process in place to ensure communication between providers of such services and GPs."*

3.74 The Royal College of General Practitioners said, *"Clearly this is a discussion which needs to form part of future GP contract negotiations. We are committed to the generalist role of the GP and the primary care team, and*

their engagement with patients at all stages of their life, and do not believe there is good evidence for removing these population health services."

4. The relationship with local authorities

4.1 *Healthy Lives, Healthy People* described a key leadership role for upper tier and unitary local authorities in the new public health system. The consultations sought views on elements of the framework in which local authorities would take on their new functions to help shape further development of the detailed design of the system. You can find our developed proposals in the policy statement, *Healthy Lives, Healthy People: Update and way forward*, which is available on line at www.dh.gsi.gov.uk.

4.2 Health and wellbeing boards will bring the system together at a local level, maximising opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population. Health and wellbeing boards will be the forum for the development of comprehensive Joint Strategic Needs Assessments and robust Joint Health and Wellbeing Strategies, which will in turn set the local framework for commissioning of health care, social care and public health services, and wider ranging local interventions to support health and well-being (eg local planning and leisure policies).

4.3 The following sections summarise responses to the consultation questions that deal with local authority issues. At the end of this chapter we also detail responses around diverse provision of services.

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

4.4 The majority of respondents agreed that health and wellbeing boards are the right place to bring together public health and other budgets. The Care Quality Commission said, *"The health and wellbeing board does appear to be the most logical option to act as the budget holder for public health, bringing together the ring-fenced funding and other budgets."* The City of London Corporation also suggested, *"that it may be appropriate for the health and wellbeing board to consider budgets for other services which have a bearing upon public health".* The Royal College of General Practitioners view is that there was a need for strong health and wellbeing

boards with formalised cooperation between interested parties, *"... to ensure that the grant is spent to maximise public health benefit and, where invested in shared projects, that there is clear oversight."*

4.5 Although a majority of the Faculty of Public Health membership agreed, or strongly agreed, that health and wellbeing boards were the right place to combine the public health ring-fence with other budgets, they did express concern that the future funding of public health services would be put under pressure by other groups. They urged, *"Caution should be taken against the local authority public health budget being used to fund services provided for in other government budget allocations or the expectation that the public health budget would be the only budget being 'pooled.'"* The Family Planning Association had the same concern, they said, *"there is a risk that the health and wellbeing boards could become a forum for Directors of Public Health to be put under significant pressure to share the ring-fenced public health budgets with health or social care services inappropriately. We fully recognise that there will be public health functions performed by the NHS or social care providers that could be funded from the public health budget but this will need to be carefully assessed and commissioned rather than simply being an opportunity for other service providers to use the public health budget."* See also paragraphs 4.13-4.15.

4.6 There was a general view that representatives from organisations working on issues covered by the Equality Act must be represented on health and wellbeing boards.

Ring-fenced local authority public health grants

4.7 *Healthy lives, Healthy people* and the accompanying consultations set out that from April 2013 upper-tier and unitary local authorities will receive ring-fenced budgets, weighted for inequalities, for their new public health responsibilities. Local authority grant mechanisms allow conditions to be placed which help to define how and on what these monies are spent.

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

4.8 The majority of responses supported our proposal to place some conditions on the grant. Responses centred on the following themes:

- role of the Health & Wellbeing Board
- the need to ensure the grant is properly protected and used for public health activities
- the need for transparency, monitoring and reporting about what the grant has been used for
- the need to align funding with needs identified through the Joint Strategic Needs Assessment and the joint health and wellbeing strategy
- the need for the Director of Public Health to be given an important strategic role in the decision-making about what the grant is spent on, and
- the need to prioritise expenditure on outcomes identified in the Public Health Outcomes Framework.

4.9 A key theme was the need for grant conditions to provide clarity about what the grant should be spent on. The Faculty of Public Health said*, "It should be explicit what will fall within this grant, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other/existing local authority and GP commissioning consortia budgets..."* One respondent stated that the conditions should *"define the current public health responsibilities to be resourced from the grant."* Others, such as RAISE and Regional Voices expressed concern that, "*by ring-fencing public health, the wider determinants of health will not be truly integrated with public health*", or that other existing local authority activities would be redefined as public health to come within the ring-fence.

4.10 On the other hand, a number of respondents stressed the need to allow for local decision making about what the grant is spent on. For example, the NHS Confederation thought the conditions *"should be clear but not so restrictive so as to deter innovation or the setting of local priorities."* The Audit Commission stated that, *"the principles of 'localism' reflected in the consultation paper and other government policies should apply, giving each area the maximum flexibility to address their local priorities and contexts."* The Local Government Group (LGG) made a statement along similar lines, *"the more conditions there are on the use of the grant, the less flexibility councils will have for innovation."* They further proposed that, *"the grant be made with as few conditions as possible as this will enable local authorities maximum flexibility in how they use the grant. Such freedom will enable*

them to develop local solutions which make best use of local assets and resources to meet local health challenges."

4.11 A number of respondents thought it was important to ensure the grant was aligned with priorities identified through the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS), with a clear link between what the grant is spent on and achieving the outcomes set out in the Public Health Outcomes Framework.

4.12 Many respondents recognised the need for the Director of Public Health to be involved in the key decisions, particularly on how the grant would be spent. For example, one respondent said, *"Directors of Public Health need to be appointed in a sufficiently senior position and with sufficient authority within the local authority to deliver against the expectation of their new role...Grant conditions should include specifying the role of the Director of Public Health in relation to spending decisions from the grant."* The Local Government Group was more cautious, however, saying, *"We would not support the use of the grant to be ring-fenced to the Director of Public Health as this is an unnecessary level of prescription. We propose that the public health grant can be used for any activity, service or function which is included in the current Joint Health and Wellbeing Strategy as a priority for improving health and wellbeing outcomes and/or addressing health inequalities."*

4.13 Some respondents recommended that the health and wellbeing board play an important role with the necessary power to coordinate the use of the public health budget effectively. The Faculty of Public Health said, *"The [Health and Wellbeing Board] will be the principal vehicle for agreements on the spend of the public health ring-fenced budget, but should be based on the recommendations of the Director of Public Health".*

4.14 Another key theme was the need to ensure that the grant was accounted for properly and spending appropriately monitored. Some respondents highlighted the need for transparency, monitoring and reporting about what the grant had been used for. The Royal College of General Practitioners said, *"...in a time of considerable financial pressures for local authorities, and given the identification of wider determinants of health in transport and housing policy etc, there is a real risk that the ring-fenced public health grant may be misused".*

4.15 The NHS Confederation supported the need for mechanisms to ensure the budget was spent on public health activities. They said, *"If public health budgets are to be ring fenced, it will be important that there are mechanisms to audit and safeguard their use and any initiatives funded from this budget are based on a clear rationale of how they will contribute to improving mental and physical health and well-being across the local population. "*

4.16 Some respondents suggested that Director of Public Health's annual report would be an appropriate vehicle for reporting what the money was spent on.

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

4.17 Subject to Parliament, the Health and Social Care Bill gives the Secretary of State the power to "mandate" local authorities to carry out certain steps in the exercise of any of their health improvement functions, or to do so in relation to any of Secretary of State's public health functions (which cover duties for protecting the public from disease or dangers to health, as well as a power to take steps to improve health). This would be done through secondary legislation (regulations).

4.18 Responses ranged from suggestions that all services should be mandated in all areas, to respondents suggesting that none should be. In between, almost the full range of health improvement and health protection services were proposed for mandation. A number of respondents agreed with the Department's intention for the list of mandatory functions to be as short as possible in order to give local authorities the maximum possible freedom. Gateshead Council said, *"as an overarching principle … maximum flexibility should be afforded to local authorities to secure health improvement and reduce health inequalities within their communities."* South Cambridgeshire District Council questioned whether *"there is a conflict between localism and nationally set mandatory services?"* They said, *"there is a danger that services which are set as mandatory at a national level may not be relevant to all local authorities and may not meet local need."* Northumberland County Council also agreed saying that *"the list of mandated services should be as short as possible as this gives local authorities maximum freedom and flexibility."*

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

Allocation of funding to local authorities

4.19 *Proposal:* Advice on the design of an allocation formula for ring-fenced grants that sets a target, or fair-share, revenue allocation for local authorities' public health responsibilities to be sought from the Advisory Committee on Resource Allocation (ACRA). We outlined three broad approaches to allocating resources that might be considered by ACRA:

- utilisation;
- cost effectiveness; and
- population health measures

We invited views on these or other approaches to inform ACRA's deliberations.

4.20 On balance, the most favoured approach was to base the allocation on population health measures, as the pragmatic solution. For example, NHS Telford & Wrekin said, "*The "population health measures" approach is probably the most preferable of the three proposed. However, the methodology must ensure that areas which have been relatively successful in meeting relatively high need would not be penalised, not least because improving local trends could be undermined*."

4.21 Some respondents felt that the evidence base of what is cost effective in public health was not sufficient. It was felt that data on utilisation are also limited, which would risk allocations that reflected past commissioning decisions rather than current need. The County Councils Network highlighted that, "*Distributing funds based on historic levels of expenditure could be significantly hampered by the lack of reliable data at national and local levels*."

4.22 As well as population health measures, respondents felt the formula needed to reflect the demography of the local area (such as the age distribution) as well as health inequalities, both between and within areas. Other factors suggested for consideration included deprivation and rurality.

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

4.23 The consultation outlined that actual allocations might not reflect the ideal target allocation immediately. Giving all areas their target allocation immediately might involve cutting allocations in some areas, which would risk destabilising existing services, and giving other areas a rapid increase in funding that they could not use effectively. Rather, we would move actual allocations from current spend towards the target allocations over a period of time. We already take this approach for Primary Care Trust allocations, where it is known as the *pace-of-change* policy.

4.24 There was general support for the principle of moving local authority grants towards targets over a period of time. Heart of Birmingham cautioned that a slow approach should be adopted, they said, "*for fear of inappropriate, non-evidence based spending taking place" and because providers would need time to get up to speed*". The Association of Directors of Public Health who were very concerned about the pace-of-change shared this view. They said, "*this must be done slowly and carefully to avoid causing rushed disinvestment from areas that have traditionally invested well in public health measures. The approach to pace of change should:*

- *ensure robust emergency preparedness and response is maintained – including robust interim arrangements to ensure a stable transition;*
- *ensure there is no loss of momentum in delivering public health programmes;*
- *ensure safely managed transition arrangements which avoid the loss of vital expertise and cohesion;*
- *ensure no action is taken that threatens or undermines the good work that already takes place across the country on integrated health and social care delivery;*

and be informed by:

- *urgent clarification on funding arrangements for public health;*
- *shared learning from early implementation;*
- *a clearer picture of what functions go where and early resolution of very complex resource issues."*

4.25 Other respondents, including Darlington Borough Council Health & Wellbeing Scrutiny Committee agreed saying, "*The momentum should not be lost, but it was felt that change should be made slowly and gradually, at a measured pace*". The NHS Confederation said, "*A direct move to a national formula would likely leave some local authorities with significant overspends and others with significant underspends. To avoid the problems this will cause, some form of a pace of change policy is required. This*

requires an accurate assessment of current spend. In the NHS, pace of change policy has involved differential levels of growth rather than direct redistribution of funding from over funded areas to under funded areas. This approach could be problematic if growth is nil or very limited resulting in movement to target taking place slowly."

4.26 There was consensus that whatever approach was adopted should be transparent and give local authorities as much certainty as possible.

The Health Premium

4.27 As *Healthy Lives, Healthy People* described, we will incentivise action to reduce health inequalities by introducing a new health premium, which will apply to that part of the public health budget, which is for health improvement. Building on the baseline allocation described above, local authorities will receive an incentive payment, or premium, which will depend on the progress made in improving the health of the local population and reducing health inequalities, based on elements of the Public Health Outcomes Framework.

4.28 The detailed design of the health premium will depend to a large degree on which outcomes are chosen for this kind of incentive, which cannot be confirmed until the Outcomes Framework is finalised. Nevertheless, we took the opportunity offered by the consultation to seek views on the design of the health premium, and the factors we should consider, with partners, when selecting measures for inclusion in the health premium. We will use these as the first step in working with the stakeholder group, which will develop the formula.

Who should be represented in the group developing the formula?

4.29 The consultation document described the health premium in high level terms. The premium will be simple and driven by a formula developed with key partners, representatives of local government, public health experts and academics. We will develop the formula in a transparent and evidence based way. We proposed establishing a working group to develop the formula and asked for your views on who should be represented on that group.

4.30 Some respondents such as NHS Greenwich and West Midlands Speciality Registrars suggested that public health experts should be represented, including academics and the Marmot review team. Other public health experts were suggested also, such as the Regional Directors of Public Health, as well as those with a specific interest in key areas, such as substance and alcohol misuse and child health. For example, The Fitness industry association said that the Physical Activity Network/Evaluation Group should be consulted. Joint Greater Manchester Infrastructure said, "*Representation should be comprised of people involved with tackling the wider determinants of Public Health such as housing, the voluntary sector, education, academics, youth services, fire service & the police. Key people responsible for developing the (Greater Manchester) City Region's economic strategy should be included where relevant*."

4.31 Respondents felt also that local authorities and the NHS should be represented on the group. North East Public Protection Partnership said, "*The DH should draw on the expertise that already exists in respect of local government financing as well as including representation of the wider interests of public health and NHS organisations*." The London Borough of Hillingdon said, "*The group developing the formula should include sufficient representation from regional and local tiers [of local government] to ensure variations in needs are well understood*."

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

4.32 St Mungo's said, "*The premium should reward local authorities that have made efforts to improve the outcomes of those with the lowest health outcomes. This would be consistent with the stated goal of reducing health inequalities*."

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

4.33 There were some recommendations that we should consider inequalities both within, and between, areas. For example, Heart of Birmingham thought we should concentrate on linking the health premium to progress in reducing health inequalities within local authority areas rather than between local authorities.

4.34 NHS Derbyshire County felt the premium should reward relative improvements and identify and reward value added activity or outcomes. However they were concerned, *"...over potential unintended consequences and that the health premium must not become a reward for previous poor performance*." A group of respondents thought funding should not be withdrawn if outcomes were not met. NHS Tameside & Glossop, Tameside Metropolitan Borough Council (TMBC), High Peak Borough Council, New Charter Housing Trust Group and Tameside Third Sector Coalition (T3SC) said, "*If outcomes are not met, the funding should not be taken away since this would have a detrimental impact on local people – instead, support should be provided to improve delivery. The health premium should take into account the costs of achieving specified outcomes in determining what fair shares would look like. There is a need for clarity in who is being paid the health premium as it may disincentivise smaller organisations. It is suggested that the health premium should be provided for all partners who have contributed to delivery*."

4.35 There were other suggestions that the design should include process measures where up-front investment was needed, where there was a clear link to the determinants of ill-health or to address data lag issues, so that local authorities could be rewarded for shorter-term activity which should contribute to longer-term beneficial outcomes. NHS Derbyshire County said, "*Overall, there may be a need to rely less on outcomes and more on process indicators. A focus on process indicators would also recognise the issue of the time frames required to significantly change outcomes*."

4.36 Respondents raised a number of key issues to be considered in developing the formula. One issue was the characteristics of different areas, for example, NHS Wiltshire said, "*Local authorities and localities within them are very diverse so one size will not fit all. The funding formula needs to take account of these other things that can impact on what can be achieved*." South Tyneside Council had similar views. They said, " *As an area of high deprivation, facing major challenges in improving public health, we are particularly concerned that the model should take into account how the ease/difficulty of making a difference varies between areas with different characteristics*." Similarly, Telford & Wrekin Council said, "*when determining the formula it is important that reliable and comparative data is used e.g. that an area should be compared with another with similar socio-economic characteristics. It was also recognised that data should go down*

to ward level as there must be clarity about local issues, which may differ between wards, assumptions should not be made about local needs based on national trends."

4.37 A number of respondents noted that attention should be given to demographic change and population turn-over (in an area of rapid population turn-over many individuals will have moved on before the impact of the public health intervention can be felt). This is exemplified by the NHS Confederation who said, "*Demographic flows may have a far greater impact on health inequalities than any public health efforts. Previously disadvantaged groups choose to move out of a deprived area once their economic circumstances have improved and we know from the Marmot Review that the social gradient in health means that the people with the least resources have worse health and less access to services. This mechanism thus risks rewarding areas that find population health improvement easier to achieve such as places with low levels of deprivation and may penalise areas with high levels of population movement that will find it difficult to make progress...Patterns of deprivation in different parts of England vary. Levels of deprivation can be found in pockets of more affluent areas and across whole boroughs and the health premium would work very differently in such areas*."

4.38 Some other respondents felt the characteristics of likely interventions (e.g. cost effectiveness) were an important consideration. Durham County Council said, "…*there was a need to consider how to incentivise areas of multiple deprivation and how to filter out the impact of non public health interventions".*

4.39 Another key issue for consideration was how the public health interventions would support reductions in health inequalities. There was a range of concerns about the impact that the health premium would have on health inequalities.

4.40 Some organisations recommended piloting. The Campaign Company said, *"Incentives need to be big to make a difference. Use the transition period to pilot what will work in terms of incentives*."

4.41 A typical response came from Nottingham City Council and One Nottingham who said, "*The formula to calculate the public health budget needs to recognise the totality of responsibilities being proposed for local*

authorities, the outcomes required of them, and should be adjusted for levels of need and deprivation to ensure that areas with the biggest challenges are resourced accordingly. The health premium needs to be designed so that local areas determine their top priorities for improvement and negotiate on levels of improvement rather than any imposition of national priorities or unrealistic improvement targets. The premium should be awarded on the basis of progress made and improvement on baseline position, rather than absolute improvements. This would mean that the premium mechanism would recognise the distance travelled by those areas with the biggest health inequalities challenges".

4.42 Many respondents recommended that local areas be given autonomy to allocate their resources including the health premium. Respondents suggested that the health premium should be predictable, i.e. organisations should be aware how it would be allocated in the short term and also how it might change over time. The Public Health Observatories said, "*It is vitally important that the resource allocation formula is 'predictable'. By this we mean that local authorities and other local champions should not just be aware of how resources will be allocated in the short term, but also how it might change over period of several years, perhaps dependent or their success or otherwise. In this way, local authorities and other local champions can plan adequately for and prioritise interventions for which the benefits may not be realised within the current financial year, but are nevertheless substantial….If the funding formula is subject to frequent changes, or local champions perceive that Public Health England might be tempted to make frequent changes, then this will encourage short-termism*".

4.43 Some respondents thought there was a risk the premium could create perverse incentives. The Association of Directors of Public Health said, "...*in the event of a set of indicators being selected and agreed for a Health and Well Being Board, we are unclear as to how the premium would be applied if some indices improve and others do not – and are concerned that any weighting could have the perverse incentive of narrowing down the focus to those which carry the promise of financial reward*". Age UK also thought there was a need to incentivise interventions that offered greater long-term benefits. They were concerned that if the period for local authorities to demonstrate improvements to receive the premium was too short, they could end up focusing activity on unsustainable quick wins. They said, "*it is fairly easy to lose weight but hard to maintain a healthy weight in the long-term. Also, interventions where the results become*

apparent within a short time could be favoured above those that take longer, for example interventions aimed at pregnant women will by their nature show results within 9 months." The Institute of Health Promotion supported these views. When developing the health premium, they said, *"Key issues are:*

- *what indicators are both important and measurable*
- *the need to select indicators which respond quickly to intervention but are also determinants of ultimate health outcome*
- *the need to avoid spending large sums on data collection*
- *the need to avoid perverse incentives and game playing"*

4.44 The transparency of the formula was another consideration according to many respondents. The NHS Information Centre said, "*We have commented elsewhere about the need for transparency for the purposes of local authority budget setting. The process requires robust data for the purposes of designing and using the formula. It must also be underpinned by effective engagement with those to whom the allocations will be made, in order to ensure there is confidence in the outputs*."

4.45 Some respondents suggested that the improvement required to trigger payment of the premium must be achievable, as Cheshire East Council said, "*Levels of award should be set to reward progress towards a goal rather than only on achievement of agreed goals, as many measures may be achievable or demonstrable in the medium or long-term*." This was an opinion shared by many respondents, for example, Bury Council said, "*We would favour an approach which weights premiums according to the baseline starting point for authorities, relative deprivation and the relative difficulty involved in shifting certain behaviours. With some outcomes taking years to materialise it may be necessary to consider applying premiums to intermediate (or proxy) measures for some aspects of work (eg immunisation rates) where such activity is known to be effective*."

4.46 The NHS Confederation said, "*A one-size-fits-all approach won't work; areas need to be treated differently to achieve public health outcomes. Many of the public health outcomes that have most impact on health inequalities will not be achieved in a short timeframe, which would complicate how the health premium might work. Progress in some cases may be measured over decades rather than months or years. It is difficult to robustly measure changes in health inequalities over a short period of time and there is currently no established measure of health inequality at local*

(ie within-district) level that is both robust enough and responsive enough to be a basis on which to calculate a health premium. Many of the health outcomes that have most impact on health inequalities will not be achieved in a short timeframe. Intermediate outcome measures would therefore support the NHS Commissioning Board, GP commissioning consortia and health and well-being boards work towards more achievable goals."

4.47 Finally, respondents considered that the premium payment needed to be large enough to offer an incentive, but not so large that it undermined the general alignment of resources with need. Public Health Directorate NHS Suffolk said, "*we need to ensure that areas becoming less healthy do not get less money*".

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

4.48 One of the main comments was that that the health premium should use robust, evidence-based, properly defined outcome measures. The Institute of Health Promotion & Education said, "*The health premium should be a small part of total allocations. It should focus on client outcomes rather than population outcomes and proportion of activity focused on deprived groups since these are easier to measure accurately*."

4.49 When selecting outcomes for inclusion in the health premium some respondents felt that we should use a small number of indicators to avoid diluting the incentive effect. For example, the Council of Isles of Scilly said, "*We also request that the proposed health premium will be a genuine incentive for authorities like ourselves...It is important that the health premium is seen as worth pursuing both in terms of the value of the indicator to local people and the financial benefits of achievement*."

4.50 There were concerns that the premium should not be focused just around indicators that only delivered improvements in the short term but on those that delivered over the long term as well. NHS Telford & Wrekin and Colchester Borough Council exemplified this view. Colchester Borough Council said "*We are also concerned about how incentivisation will be implemented within a system where the proposed outcomes are set locally; it will be difficult to compare like with like across the country. It also seems to encourage local decision makers to select, and focus resources on,*

short-term easily achievable targets rather than those that are more challenging but could lead to more significant health improvement. Whilst we recognise that the document does acknowledge these issues, we think that in practice it is going to be extremely difficult to achieve your objectives of a system that is both simple and fair. Cheshire East Council echoed this view. They said, *"[The] Health premium should be awarded where the goals contained in the outcomes framework have been achieved, and outcomes have been accomplished. While some goals and outcomes may need to be agreed and set nationally to demonstrate national priorities, others should be determined locally on the basis of local priorities. Levels of award should be set to reward progress towards a goal rather than only on achievement of agreed goals, as many measures may be achievable or demonstrable in the medium or long-term. Consideration will also need to be given for short, medium and long term outcomes*." St Helen's Council also shared this view, they said, "*We would support the intention for the health premium to incentive actions that are most likely to reap long term and sustainable benefits*."

4.51 Another theme from the responses was the importance of using well-defined, transparent, auditable measures. For example, the NHS Information Centre identified "*Clarity of purpose, and robustness of the underlying data and information and the methodology used for indicator development*" as important considerations.

4.52 There was a strong view that it would also be important to take account of local challenges and allow for locally selected outcomes. The BMA shared this view and said, "*Local variation, and hence differing priorities and trajectories which reflect local need, must be considered. Some elements of the outcomes framework may be less or more relevant to some localities than others. This may have the effect of making these areas ineligible for the health premium or eligible only for a reduced amount given the sliding scale*." The Association of Directors of Public Health also thought local priorities should be an important factor. They said, "*We consider that it would be appropriate for there to be range of indicators from which local Directors of Public Health could identify those that are most appropriate for their local communities – alongside some 'core' compulsory indicators. This would accord with the emphasis in the White Paper on the importance of local communities performing Joint Strategic Needs Assessments and Health & Well Being Boards identifying priorities based on those needs assessments*." NHS Telford & Wrekin added, "*Allowing flexibility within*

local authorities to tackling their local health inequalities should be a fundamental premise of the health premium."

4.53 NHS Telford & Wrekin thought also that a key factor in the application of elements of the PH outcomes framework to the health premium should be the published evidence on key interventions known to reduce inequalities. They said, "*Measures should be included in the formula where there is strong evidence of interventions known to reduce inequalities*."

4.54 East Midlands Councils thought that desired outcomes would be easier to deliver in areas with better social-economic circumstances than elsewhere. They said, "*Poorer areas should not be penalized for this, and a failure to address it could widen inequalities rather than reduce them. It is essential that the outcomes framework provides sufficient flexibility to reflect greater needs in communities with the fewest assets and greatest challenges in terms of health needs, balancing payment by results with additional resources where they are most needed*."

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

4.55 The consultation document described some of the features we believed the health premium would need to have. Critically, it would be an incentive system, not a target regime, with no penalties for choosing to focus local resources elsewhere, other than not receiving the health premium payment. We asked for views on whether linking access to growth in health improvement budgets to progress in improving population health would provide an effective incentive mechanism.

4.56 A minority felt that an incentive scheme should not be needed; we should simply trust public health professionals to do the right thing. For example, Thurrock Council said that they disagreed with the proposition Instead they said, "*Growth should be linked to deprivation and need*."

4.57 However, many responses supported introducing an incentive scheme, albeit with some caveats. Some respondents, such as Wolverhampton County Council and PCT, felt that the health premium must be communicated clearly with stipulations for when things went wrong. They said, "*Clarity needs to be made regarding recurrent and non-recurrent*

funding. In order for the system to be stable, there should be clear rules around additional payments or reduction in payment." London Borough of Hillingdon said, "*the ineffective deployment of incentives can have undesirable side effects, undermining localism. Firstly, local priorities can end up limited or disqualified as a result of by enforcing central priorities rigidly and at their expense. Secondly, there is also the risk of creating a new reporting industry relating to incentive sets. Both undesirable factors should be used as tests when considering the introduction of incentives*."

4.58 Others felt that there must be a mechanism for adjusting the baseline allocation to reflect demographic change in a local authority. For example, The Royal Society of Public Health were concerned that basing the health premium on performance would not take into account local factors, such as the population changing, or local employers going bust.

4.59 Many respondents believed that disadvantaged groups were more likely to benefit from a mechanism that targeted inequalities (the health premium). East Midlands Councils said, *"We welcome government's intention for the funding formula to recognise that disadvantaged areas face the greatest challenges, and will therefore receive a greater premium for progress made."*

4.60 Nottingham City Council and Director for Public Health highlighted how existing public health improvement budgets might be cut between now and 1st April 2013, which would impact on health improvement activity in the community. "*Re-establishing public health programmes takes time and we risk losing several years of health gain in the meantime. If the existing public health budgets are cut and future allocations are based on the final position at April 2013, this risks insufficient funding being transferred to local authorities*." They said that cuts to budgets in non-health areas would have an impact on public health e.g. cuts to budgets for sports, housing, Sure Start, leisure, and Supporting People programmes.

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?

4.61 The consultation sought views on what mechanisms would best enable local authorities to utilise the voluntary, community and social enterprise (VCSE) sector and the independent sector to support health improvement plans.

4.62 Several respondents such as the Audit Commission expressed a desire to ensure that local authorities had adequate and appropriate engagement with organisations such as the VCSE sector in the designing, planning and construction of service development and not simply to pay them lip-service by engaging at the end of the commissioning process. This view was also shared by One East Midlands who stated the importance of the *"…VCS…to be involved…in the early stages of development of the new structures and process*…[and whilst] *there is reference to the VCS at an operational level (as a service provider),…the sector needs to be involved at a strategic level."* The Audit Commission advocated that consideration be given to *"how best to use wider initiatives…..to improve the cooperation between public commissioners and voluntary organisations."* Overall, respondents felt that the value of consulting organisations such as VCSEs should not be underestimated; because of their understanding of local communities, they are often best placed to provide pertinent information, for example on hard to reach groups.

4.63 The NHS Information Centre in their response recognised that *"…these organisations [VCSE and independent sector] should be regarded not only as providers of services, but also as providers of intelligence to inform Health and Wellbeing Strategies*." Platform 51 also reflected this view. Whilst supporting the duties to be placed on local authorities to improve the health of their populations and for commissioners to have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS), Platform 51 went on to say, "*it is essential that the VCS is involved at all stages of this process in order to ensure that a full picture of local health needs is established, that the right priorities are drawn up, to engage the voices of the most marginalised, to gain a clear picture of existing services and to inform commissioning so that effective, responsive and appropriate decisions are made that will improve the health of everyone*". This view was also shared by Turning Point, who strongly advocated the need to build "*JSNA's [on a] partnership approach from all key stakeholders as well as community representatives. This will ensure that going forward JSNA's are built on local intelligence, ideally at the neighbourhood or community level*."

4.64 A number of respondents such as the BMA, advocated the inclusion of the VCSE sector and, to some extent, the independent sector, on Health and Wellbeing Boards in addition to HealthWatch representatives. Respondents thought that the inclusion of VCSE on Health and Wellbeing Boards would provide a proper mechanism for the voice of the VCSE sector to be heard and that inclusion should be mandatory and not optional. The British Heart Foundation said, "*charities, patients, the public and academic institutions should be fully engaged and involved throughout the commissioning cycle from the development of the JSNA through mapping needs against existing provision, service planning, re-design, service specification and contracting, delivery, monitoring and evaluation*."

4.65 The Race Equality Foundation said that, "*Relationships with local VCS should be formalised and financially resourced in order to facilitate information flows between local authorities and the communities that they represent and to ensure that the VCS has the 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?

How do we minimise barriers to such involvement?

4.66 We received a number of responses on using a wide range of providers in the provision of health and wellbeing services. Overall, respondents, including organisations such as the Audit Commission, the British Medical Association and the NHS Confederation, were positive about widening the range of providers, particularly through the use of the VCSE sector and independent sector providers, to enable diversity and effectiveness of local provision which would generate quality and innovation of services and provide service users choice and control over their care. There were issues raised around: private-sector provision, fragmentation, access, developing a local database of providers, performance management and value for money, proportionality and the different approach that VCSE sector can bring. Some typical comments are included below.

4.67 Whilst respondents were largely positive about creating a diverse supply base, views ranged from opening the market up as fully as possible, to disagreeing with the drive to bring non-statutory providers, including the VCSE, into the health and care market. Some respondents suggested that all providers should be non-profit-making whilst others expressed concern that the diverse provider model may lead to fragmentation of clinical pathways if a range of different providers delivered different aspects of what should be an integrated service.

4.68 Respondents raised a number of concerns about access and their ability to compete successfully in an open, competitive market place. A key concern revolved around VCSEs' ability to compete for contracts and that public sector funding challenges and general financial constraints might weaken the VCSE sector further and make it more difficult for them to compete against other sectors. There were suggestions that the commissioning and bidding process be 'opened-up' to reduce the advantage *'established networks'*. Many respondents also felt that there should be a specific duty for health and wellbeing boards to engage with the VSCE sector, particularly to ensure that groups covered by the Equalities Act are considered fully in commissioning health and wellbeing services. Respondents highlighted that some voluntary sector organisations might require additional support in understanding the commissioning process and requirements and that funding needed to be in place to support adequately those voluntary organisations to be effective. Other respondents expressed concern about the funding difficulties currently experienced by the third sector. To help counter this there was wide recognition for the need for local authorities to provide financial support, access to business development and tendering support to enable the VCSE sector to compete for future service provision of health and wellbeing services.

4.69 Similar concerns relating to funding and capacity pressures were raised in relation to small and medium size enterprises (SMEs). Respondents recognised the role SMEs might play in delivering services. There was a general desire for local authorities to ensure that SMEs were not marginalised by funding constraints that would preclude them from participating in the provider market and that the procurement process was proportionate and not overly complicated to enable SME's to compete. The NHS Confederation said, *"larger national organisations will have significant advantages when bidding against smaller local organisations."*

4.70 A number of respondents suggested that local authorities establish a database or 'directory' of voluntary and independent sector providers, or utilise existing VCSE databases, to facilitate widening the use of such organisations in the provision of health and wellbeing services. One East Midlands favoured this and referred to the VCS sector directory Greater Manchester had established, which included a section on health and social care, and the NHS London database of VCS organisations. One East Midlands highlighted the importance for local authorities to invest *"….effort and resources into understanding the range of work VCS organisations have the capacity to carry out in order to tap into that knowledge and understanding".* They recommended that local authorities continue to support existing VCS networks to ensure that the current mechanisms that worked effectively were maintained and strengthened.

4.71 The Audit Commission, whilst welcoming the use of the *"thriving voluntary sector"* to help *"create a more diverse and competitive supply base"*, highlighted the lack of evidence at both national and local level on the performance and value for money secured from voluntary sector providers and advocated that commissioners develop systems for evaluating VCSE provision. They said that the VCSE sector should *"improve their understanding of their costs and evaluate their own value for money to make a better case for service delivery through the voluntary sector."* A recurring suggestion complementing this view was the desire that local authorities develop a governance and quality assurance framework that would oversee all commissioned activity covering all sector providers encompassing audit and service evaluation.

4.72 This should, however, be proportionate. Respondents highlighted the need for procurement processes to be proportionate to ensure that small and medium size enterprises (SME's) and the VCSE sector are not put at a disadvantage. As the National Information Centre who said, *"if local authorities were required to put in place any more complex or bureaucratic commissioning, reporting or accountability arrangements, that may undermine the ability of these local organisations to protect the level of service availability."*

4.73 The BMA whilst appreciating "…*the benefits that a range of providers can offer…..would [however] caution against there being a preference for the private or voluntary group as opposed to the public sector*." The BMA also reflected the views of a number of respondents that "*Decisions concerning*

choice of provider must always be based on quality" and not cost. Local authorities when tendering for services should take into account factors other than cost and tendering decisions *"….should be based on quality and local priorities as well as best value*."

4.74 Many respondents highlighted the different approach that the VCSE sector can bring to reach wider groups. As, the Lesbian and Gay foundation said, the VCSE sector "*often exist because 'traditional' health and social care providers have, in the past, not recognised or not met a pressing community health need*…..*The VCS are often recognised and championed as the provider who can best engage with marginalised groups*.." FaithAction raised a concern about seeming class bias in some health messages and highlighted that the VCSE sector is good at delivering messages in a way that the communities "*won't feel bombarded with information written for a middle class or professional audience*." They also highlighted that the faith sector offers a holistic perspective on addressing the needs of the whole person, which helps identify wider determinants of health.

5. The relationship with the NHS

5.1 In the *Consultation on the funding and commissioning routes for public health* we discussed how we envisaged some public health services being commissioned *via* the NHS and how public health would be a key part of NHS funded and commissioned services. We also asked questions about the crucial role of GPs, and how to ensure their public health contribution is enhanced.

5.2 Recognising that every healthcare intervention is public health opportunity, we set out a number of ways in which the Department of Health would work to strengthen the public health role of GPs and GP practices, including:

- The Department/PHE and the NHS Commissioning Board (NHSCB) working together to support and encourage clinical commissioning groups to maximise their impact on improving population health and reducing health inequalities;
- making information on achievement by GP practices available publicly, including on the effectiveness of their public health advice;
- using the Quality and Outcomes Framework (QOF) in the GP contract – from 2013 at least 15% of the current value of the QOF will be devoted to evidence-based public health and primary prevention indicators; and
- increasing the focus on public health in the education and training of GPs.

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 the Public Health England will take responsibility?

5.3 There was widespread recognition of the critical role of GPs and general practices. One respondent said, *"It is inconceivable that the Government's public health aspirations could be realised without GPs playing central and constructive role both as commissioners of care, and in their traditional clinical role as the local healthcare professional with whom most patients typically first come into contact."* NHS Halton and St. Helens remarked that *"…if the benefits of the White Paper "Healthy lives, healthy people" are to be maximised, then GPs and GP practices must not only continue to play a key role, their role and involvement must be increased".*

5.4 A number of respondents highlighted GPs' ideal position to tackle health inequalities by systematically monitoring patients to encourage a greater focus on prevention. Respondents suggested that GPs would need to work closely with public health teams, engage with hard to reach groups and focus more on root causes of ill health in consultations, signposting patients towards appropriate health and non-health support.

5.5 Some respondents highlighted the role of GP practices in health protection. GP practices are well-placed to provide a public health monitoring function, for example of influenza-like illness, as happens at present, and this needs to continue in future. GP IT systems should have closer links to Health Protection Units to promote, for example, rapid sharing of information on notifiable diseases. Similarly, there should be better links to child health systems for data on, for example, vaccination. Another respondent highlighted the importance that GP practices can play in robust responses to extreme events such as flooding, and the importance of PHE supporting them in this work. London Specialised Commissioning Group said, "*GPs and GP practices have a vital role in promoting health and preventing disease*."

5.6 Some respondents raised concerns that GPs were not in general very focused on public health, that their public health role would be squeezed out by the new responsibilities of commissioning, and that there would be fragmentation of the existing public health resource. A respondent noted the pressures on GPs' time and argued that GP involvement in public health would need to be a contractual responsibility. A number of respondents felt that GPs were reluctant to get involved in what they perceived to be individual, lifestyle issues, and one respondent suggested research into differing attitudes of GPs towards public health.

5.7 Respondents also pointed out the importance of considering the wider primary health care team and of engaging the experience and insight of a range of other professionals who have a critical role in promoting public health.

5.8 A number of respondents also pointed to the wider services that some GPs link closely with, which can have a very positive impact on people's health, such as money advice and debt management services. The example of Bromley by Bow in East London was cited, where a GP surgery co-exists

with a children's centre, a healthy living centre, adult education services, housing and welfare advice and a range of other services. The potential role of community health champions and health trainers was highlighted, as were the opportunities offered by engaging more with the voluntary and community sector. The Marmot Review team said, "*GPs are well placed to participate in local communities and act to improve community health and wellbeing. There are some excellent examples of practices…..which have undertaken this role, but they are not widespread enough*." Other respondents agreed that GPs were in a strong position to do more. For example, the Nationwide Foundation said "*The charities feel strongly that GPs should be more instrumental in referring older patients (those aged over 50yrs) to local charitable services which provide support that will help to keep them healthy and in their homes for longer. Such services include: befriending; advice on how to make their homes warmer and avoid fuel poverty; care and repair schemes to maintain homes; and guidance on eligibility for welfare benefits*."

5.9 Similarly, the Royal College of Nursing (RCN) noted that GP practices were ideally placed to reduce the costs of sickness absence and the associated costs of becoming benefits-dependent through signposting their patients on to appropriate services. They commented that, with appropriately trained occupational health nurses, GPs could make a significant impact on the occupational health of their localities. Moreover, the RCN said, "*there may be capacity for a new worker to promote public health who could take a holistic health promoting role*".

5.10 Concern was expressed about the loss of local influence over GP contracts. For example, the Public Health Directorate of NHS Bristol said the local influence over GP contracts is a "*key point in the health and social care system for vulnerable groups and essential in improving equity and access*". They highlighted also unintended negative impacts on vulnerable groups as a result of diversification in the NHS market and that partnership working, goodwill, ingenuity and flexibility are essential for equality issues and vulnerable groups.

5.11 The Lesbian and Gay Foundation pointed out that, "*local data is often not captured for LGBT communities, which results in LGB&T people's needs not being captured in a detailed way within local joint strategic needs assessments*." They suggested that NHS and public health commissioners

should use contracts that embed full monitoring of service users across all protected characteristic groups.

5.12 The response from members of the Research Department of Epidemiology & Public Health at University College London recommended that GP consortia have mechanisms "*in place to improve population health and address the social gradient across the life-course. This will require: commissioning requirements for routine data on service access and uptake to be collected by socio-demographic group…at each significant point in patient user pathways*".

5.13 FaithAction pointed to the need for greater awareness among GPs of non-medical provision since they are "*aware of the role that third sector organisations and faith based organisations play and the importance of opportunities for socialisation"*.

5.14 The Race Equality Foundation said that,"*[black and minority ethnic organisations and representatives on the current changes in health and social care] were concerned that many GPs do not have enough understanding and knowledge of local communities to fully understand and provide needs on an equal basis to all groups. Where this is the case, it was suggested that as a result there could be increased discrimination and inequality in health".*

5.15 Respondents welcomed the proposal to focus a defined area of the quality and outcomes framework (QOF) on public health. However many respondents highlighted possible improvements and potential risks.

5.16 The NHS Confederation welcomed the use of a proportion of QOF on public health, but cautioned that the 15% current proportion could become a ceiling, rather than a floor. On a similar theme, another respondent argued that more of the QOF should reflect public health, with a concomitant reduction in QOF outcomes elsewhere. They said, *"We support Public Health England having greater flexibility regarding commissioning services as a whole as well as those services provided through the GP contract. However, dialogue between the NHS Commissioning Board and Public Health England will be essential to ensure that such changes to the QOF are negotiated in line with the rest of the contract and are managed so as not to disenfranchise GPs."* The BMA response was also supportive of greater flexibility, *"In certain circumstances it may be preferable for Public*

Health England to commission services currently provided through the GP contract to avoid duplication and facilitate integrated care pathways."

5.17 The University College London Marmot Review Team suggested taking the opportunity to shift the focus of the GP contract. They said, *"We would recommend revision of the current GP contract to shift the focus onto the social determinants of health. QOF may prove to be a useful mechanism to achieving this shift to improved population health."*

5.18 The Royal College of Nursing (RCN) suggested a higher proportion of QOF should apply to public health indicators in geographical areas where needs are greatest. The King's Fund argued for ensuring that each new QOF indicator should be judged against its potential for reducing health inequalities. Some respondents suggested that QOF could also incentivise action on the social determinants of health, eg through encouraging discussion of issues such as housing and debt and referral to specialist services.

5.19 A number of respondents argued that a revised QOF should focus on outcomes rather than process targets. One suggestion was to link payments to GPs to successful outcomes such as weight loss.

5.20 Many respondents highlighted that QOF achievement thresholds in primary prevention would need to be set high enough to incentivise real improvements at a population level, and that exception criteria need to be carefully set out and monitored to avoid disadvantaging those patients with greatest needs.

5.21 NHS Halton and St Helens suggested quality rewards for practices achieving locally agreed high uptake/coverage across the majority of programmes, and weighting of QOF payments to reflect the difficulty in achieving high uptake of screening in deprived areas.

5.22 A number of respondents noted the importance of encouraging GPs to carry out evidence-based brief interventions such as for smoking cessation. For example, one respondent argued that advice to quit smoking is given in only 20-30% of consultations with smokers.

5.23 Some respondents noted that GPs are only able to advise those who attend for treatment, leaving a gap in the wider population who we will need to reach in other ways.

5.24 The London Mayor's view was that the GP contract should incentivise leadership in public health. Another respondent pointed to the value of Local Enhanced Services in involving GPs in locally-driven public health efforts promoting evidence-based activities such as identifying cardio-vascular disease risks in the local population.

5.25 Respondents highlighted the importance of timely information on how practices are performing to promote interest in public health. There was a call for PHE to seek regular contact with GPs, giving them evidence of what works across the range of public health.

5.26 A number of respondents highlighted the importance of training. One respondent suggested encouraging GPs to take up a special interest in public health, and ensuring that public health becomes part of medical training, given that around half of medical students will become GPs at some point in their lives. Training in public health would be particularly helpful for GPs engaged in commissioning. A respondent noted, "*most of us do not know what we do not know, until told it!*" Another suggested dual accreditation, so that practitioners could train in general practice and public health, and for training on the social determinants of health to be part of continuous professional development for GPs. A public health consultant suggested trainee GPs should have a mandatory one-month placement with a public health team prior to qualification. However, there was also concern that GPs might try to do too much and that it was important GPs did not try to replace highly specialised public health resource.

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

5.27 There was consensus amongst respondents on the importance of public health advice to the NHS at all levels. But there was a common perception that *Healthy lives, Healthy people* had failed to recognise the centrality of public health input into successful healthcare services, the so-called 3rd pillar. There was concern that existing valuable work led by public health experts had no clear home in the new system. Many respondents highlighted the role of the consultant in public health in clinical

commissioning, and called for this to be recognised in legislation. There was also recognition of other work that public health staff currently carried out, such as participation in individual funding requests and exceptional case panels, which could perhaps in future be provided on a cluster basis.

5.28 For example, the NHS Confederation said, "*GP commissioning consortia will need to make use of public health expertise in commissioning health services more broadly. We are concerned that there is currently no mechanism for connecting the expertise of public health professionals with NHS commissioning decisions*". They went on to say, "*to deliver on the public health outcomes framework directors of public health and GP commissioning consortia will need to coordinate commissioning functions to invest in upstream interventions*".

5.29 The All-Party Parliamentary Group on Primary Care and Public Health were concerned with the transfer of public health responsibilities to local authorities that the NHS might move away from its public health responsibilities, and recommended that GP consortia have full access to public health expertise, information and intelligence.

5.30 Similarly, the Local Government Group highlighted the risk that "*the creation of the NHS Commissioning Board and PHE at national level, and the respective roles of GP commissioning consortia and HWBs [Health and Wellbeing Boards] at a more local level may lead to a division between healthcare and public health improvement. This separation could detract from a coordinated approach linking interventions from prevention to health treatment. It could also result in commissioners and providers of health services no longer being seen as agents of public health improvement*".

5.31 The Association of Directors of Public Health commented, "*current reorganisation of the NHS and of Public Health significantly underestimate the role of the NHS in addressing inequalities.*" NHS Bristol pointed out the "*separation out of public health from the NHS is likely to have a negative impact on NHS commissioning ability to address inequality and in ensuring the needs if equality communities and vulnerable and excluded groups are addressed*."

Local Public Health Support to the NHS

5.32 At local level respondents noted public health colleagues could support clinical commissioning groups, in a number of ways, including:

- profiling the local population and identifying those at greatest risk,
- advice on prioritisation,
- evaluation of services, and
- using evidence on clinical and cost-effectiveness to challenge secondary care clinicians.

5.33 There was support for the idea of a clear "offer" from local authority public health teams to clinical commissioning groups. This could be underpinned by a service level agreement or a Memorandum of Understanding of what would be provided. NHS Greenwich suggested a prescribed minimum input from local authority public health departments, and called for public health advice to be sourced from the local authority public health department to avoid unnecessary duplication and waste of highly qualified staff. Another respondent called for a public health presence in clinical commissioning consortia.

5.34 One respondent noted the potential role of commissioning support units to provide population healthcare advice and mitigate the risk that public health skills and evidence will not be an intrinsic part of commissioning appropriate healthcare interventions.

5.35 NHS Derby City and Derbyshire commented that local clinical commissioning groups would each appoint a senior public health specialist jointly with the local authority. They said, "*This post would provide consortia with access to a broad range of public health advice and support, assist them in delivering their statutory partnership responsibilities, contribute to the Joint Strategic Needs Assessment and ensure that the Health and Wellbeing Strategy takes account of their aspirations. The post would also ensure that there is expert public health support available for situations that may require a response from consortia, such as health emergencies and serious untoward incidents*."

5.36 A number of different models were suggested, including nominated health improvement leads in clinical commissioning groups (CCGs), or a collection of CCGs having the dedicated public health professional expertise required to support population-oriented activities. Respondents suggested that one way of ensuring close linkage between public health and clinical

commissioning groups would be to make DsPH members of CCG management structures.

5.37 To ensure that CCGs receive advice, the Audit Commission suggested that there might be a statutory duty on local DsPH to ensure provision of public health advice to clinical commissioning groups in their area, with PHE having a similar role with respect to the NHS Commissioning Board.

5.38 Many respondents highlighted the important role of public health intelligence and information in ensuring that need and evidence of what works inform decisions. Clinical commissioning groups would need local public health data at practice, ward and super-output level on both health needs and health use. Conversely, the wealth of practice-level data should be made available to public health colleagues. The London Public Health Analysts Consultation Team raised concerns about what will be the core population for data in future, eg the registered population or the local authority population. NHS Greenwich highlighted the importance of retaining local intelligence capability, supported by the national PHE resource, which could offer powerful benchmarking tools, "*Local capability to model and cost PH interventions is a very powerful tool for change. If PH intelligence expertise is gathered centrally JSNAs will become 'painting by numbers' needs assessments and their local influence diminish*".

Public Health Support to the NHS at a National Level

5.39 We proposed that public health would contribute to the NHS Commissioning Board's mandate, with public health support for NHS commissioning nationally and locally. Respondents said that the NHS Commissioning Board would need public health expertise around a range of issues, including:

- ensuring that national primary care contracts promote the reduction of health inequalities and equity of access to health services,
- encouraging health promotion,
- commissioning specialised services,
- allocating NHS resources equitably and
- translating NICE Quality Standards into commissioning guidance.

5.40 For example, the Faculty of Public Health said that Public Health England should ensure dedicated public health resources are available to *"The NHS*

Commissioning Board and GP commissioning consortia to inform and support the effective commissioning of health services." The Nuffield Trust said, *"The National Commissioning Board will need to collect evidence that consortia have taken and acted upon appropriate public health expertise such as aligning commissioning to population needs, taking into account inequalities in commissioning services, using the best evidence to inform interventions and identifying health service and treatment priorities."* Redcar and Cleveland Borough Council agreed*, "It will be critical to ensure that NHS commissioning is underpinned by the necessary public health advice."*

5.41 Respondents also argued that PHE should be represented in the NHS Commissioning Board at the most senior level. For example, a Consultant in public health medicine said that public health input into NHS commissioning processes is critical, *"Public Health needs to be represented at executive level on the NHSCB and on commissioning consortia."*

6. Information & intelligence

6.1 The White Paper, *Healthy Lives, Healthy People* set out the Government's commitment to ensuring that the new public health system was based on doing what works, using an evidence-based approach to public health that works in tandem with the evidence-based requirements of healthcare. There are great opportunities for public health in drawing together the existing complex information, intelligence and surveillance functions performed by multiple organisations into a more coherent form.

6.2 Individuals and organisations responding to the White Paper and accompanying consultations provided both specific answers to the questions posed, and more general comments on the issues facing public health evidence, the risks to information and intelligence during transition and the opportunities and the challenges facing the new public health system. This feedback is helping the Department and its partners to refine understanding of what users of public health evidence will need from Public Health England (PHE) in terms of accessible, relevant and timely information, intelligence and advice.

6.3 This chapter summarises the consultation responses on the issues around public health evidence. To support the design of the future public health evidence structures, the White Paper sought views on the following three questions:

- What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?
- 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?
- What can wider partners nationally and locally contribute to improving the use of evidence in public health?

What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

6.4 In the White Paper, we suggested PHE might play a role in drawing together existing sources of public health evidence and making it more

easily available to all through a single, accessible and authoritative web-based evidence system. There was broad support among a range of stakeholders for this proposal: respondents were keen to see better signposting of existing information on public health as well as opportunities to share learning across different localities. Respondents were keen to see such a web portal clearly signposting information, providing accessible summaries and drawing out key messages for public health commissioning. Welwyn Hatfield Council said, *"The proposed role for Public Health England to draw together existing complex information from a number of sources into one place is potentially very powerful. Appropriate output could then be available to the public on line and in community libraries. Having one widely publicised central repository of information broken down at a local and national level will facilitate any targeted public health work."*

6.5 In addition to the specific White Paper proposals on improving access to public health evidence, many respondents suggested that a kite-marking approach for providers of public health evidence could ensure such evidence was of high quality, while enabling a variety of providers to develop evidence and ways of presenting evidence that met different audiences' needs. For example, on the quality issue, the Institute of Home Safety said, *"PHE should provide clear guidance and support to localities on developing appropriate levels of local evaluation and skills necessary to achieve sufficiently robust evaluation, so as to add to the evidence base. Danger that many good initiatives lost because they have not been evaluated, and provision of local services becomes patchy and of questionable quality."* On the issue of meeting the needs of different audiences, the Royal College of Speech and Language Therapists propose that to overcome the need for greater access to public health information *"service users could be involved in developing public health messages to ensure that they are accessible and easy to understand for the wider public audience."*

6.6 On public health research, respondents were keen to see a greater focus on translating academic results into active interventions, so their evidence was converted into actionable insights. One opportunity to support this increased integration is through the workforce. As the Faculty of Public Health said, *"links between service and academic staff have often been weak in the past".* Several respondents suggested that joint posts for

public health academic and practitioner roles could lead to better integration of public health research and practice.

6.7 In order to make public health evidence more useable, another suggestion was to include a section within the web portal for users to post research questions that were most relevant to their local area. Respondents were also keen to enable greater access to peer-reviewed research, much of which is currently subject to subscription fees. Yorkshire & Humber Postgraduate School of Public Health Specialty Registrars' Committee said, *"We must continue to ensure that there is consistency of access to information across all potential healthcare providers i.e. information from private providers is accessible as from public providers."* St Helen's Council said, *"Improving access, quality and utility of data, and clarifying accountability and data sharing protocols will be a will be a significant challenge."*

6.8 In terms of making public health evidence accessible and useful for members of the public there were some specific suggestions:

- many stakeholders highlighted the importance of enabling children and young people to access information that was relevant and useable in a format that made it accessible and delivered in young people-specific settings, such as Children's Centres, schools and youth groups. For example the Royal College of Obstetrics and Gynaecology said, *"…[we] would like to see public health education to begin in schools, supported by evidence-based information, so that children grow into confident respectful adults who are equipped to take personal responsibility and make good behavioural and lifestyle choices";*
- similarly, health visitors and schools nurses were highlighted as an excellent source of advice and information delivery for children and young people;
- the community and voluntary sector was identified as a valuable part of the system for translating information into a relevant and accessible form for a variety of hard-to-reach and vulnerable groups;
- the existing work of the regional Public Health Observatories, and specialist Observatories, such as ChiMat (children and maternal health) and NOO (national obesity observatory) was highlighted as good practice upon which PHE might build in the future to promote accessibility of public health evidence; and
- there was some support for increasing the use of social media to enhance the availability of public health information. Although, equally,

as one respondent summarised, there was a general feeling that *"people are inspired by people, not by computers*" and there would continue to be a need for individuals to deliver and promote public health information in order to inspire others to act on it.

6.9 Many respondents were keen that PHE focussed effort on how to engage locally elected officials in public health evidence. The BMA suggested that targeted summaries of information and evidence should be provided to councillors, alongside complementary technical and scientific reports that could be used by Directors of Public Health to inform and facilitate further discussion. Many respondents were also keen to see evidence on cost effectiveness to support commissioning made available to locally elected officials, particularly in the context of business cases for investment in public health services at a local authority level. Many stakeholders expressed the same sentiment as the NHS Information Centre, which said, *"It is important that information and intelligence is not seen as an end in itself, but as a tool to support decision-making."*

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?

6.10 In response to this question, a number of priority gaps were identified:

- Cost-effectiveness of public health interventions;
- Mental health;
- Children and young people; and
- Behaviour change science.

6.11 A number of respondents identified district councils as a valuable source of information for understanding local communities and therefore designing interventions that were more likely to work. The community and voluntary sector was highlighted by a number of respondents as offering a significant amount of information and evidence about hard to reach groups*: "In the arena of public health, third sector organisations hold a vast amount of untapped information and intelligence about public health issues in their locality, target population and/or area of expertise"* (anonymous). Respondents suggested that tapping into such information could help to plug the gaps in evidence about what worked for different groups with regard to public health interventions.

6.12 Some respondents cited ‘non-health’ examples of where lessons could be learnt from successful approaches to change behaviour:

- London Councils suggested lessons could be taken from the drive to increase recycling rates and how this has led to a fundamental shift in people’s day-to-day behaviour;
- The Chartered Institute of Environmental Health (CIEH) identified the wealth of information Environmental Health Officers would be able to share with public health colleagues including “*housing conditions, local air quality, bathing water quality, health and safety in workplaces, food safety, antisocial behaviour issues*.”;
- Other respondents noted that local authorities might also provide evidence from their interactions with the criminal justice system and community safety.

6.13 Building on this, some respondents were keen to see an information-sharing system developed to enable groups to share case studies and experience from service delivery. This could be part of the web portal system, enabling national sharing of learning from experience and encouraging local areas to build on one another’s successes.

6.14 In the context of making best use of information and intelligence, some respondents were concerned about the risk of not evaluating local interventions properly, which could lead for example to poor value for money. Others suggested that to address gaps in public health evidence there was a need to incorporate a greater proportion of qualitative research. For example, one response said, *“Qualitative research can provide rich information about quality of life issues and case studies can quickly (and relatively cheaply) provide an accurate and detailed picture of the effectiveness and outcomes of new interventions.”* There was support for robust evaluation at a local authority level, and many respondents were keen to see strong links developed between the new National Institute of Health Research School of Public Health, PHE and local government. There was support for the proposed new National Institute for Health Research (NIHR) School of Public Health Research. The BMA noted that the contribution of the new School *"will be significant in creating an evidence base".* The Faculty of Public Health echoed a number of respondents when saying that the new arrangements should enable *"public health research and practice communities to engage more*

effectively with each other" adding that the NIHR School *"is potentially an excellent vehicle for bridging the divide".*

6.15 To support increased research into public health some respondents suggested research should be a compulsory requirement for all public health trainees. This could both increase the amount of research conducted and increase awareness among the public health workforce of the role and value of research evidence. The Academy of Medical Sciences agreed that *"the whole of the public health workforce [require] evaluative skills"* and they identified a long list of future opportunities for public health research, noting that *"extraordinary recent advances in science and technology offer major research opportunities in public health."* This reflected a number of respondents' views that there was much more that could and should be done in the domain of public health research.

What can wider partners nationally and locally contribute to improving the use of evidence in public health?

6.16 Many respondents identified the National Institute for Health and Clinical Excellence (NICE) as a key partner in terms of providing evidence on what works in public health. They supported the White Paper's vision of a close working relationship between PHE and NICE, which would seek to maximise the output of useful guidance and information while minimising duplication between the two organisations.

6.17 Similarly, there was significant support for the close working relationship between PHE and academic public health envisaged by the White Paper.

6.18 There was a wealth of support for close partnership working at a local level between Directors of Public Health in upper-tier authorities and clinical commissioning groups, including with regard to data sharing and use of evidence to inform Joint Strategic Needs Assessments and commissioning strategies. Many respondents identified the need for clear data-sharing protocols to be developed, particularly where clinical commissioning groups and local authorities were not coterminous. NICE identified the potential for partnership working with the NHS saying, *"much evidence could be obtained at relatively little cost by improved data*

collection and analysis within the NHS and with its partners", reinforcing the need for local ties between public health and healthcare services.

6.19 Similarly, at a national level some respondents pointed out the role of the NHS Commissioning Board as a key partner for PHE. The NHS Confederation said, *"Adequate data sharing and collaboration between the NHS Commissioning Board and Public Health England will be required to make the best use of data and evidence. There are opportunities in the new system to strengthen national intelligence and evidence by centralising and amalgamating data and information to make it easily searchable"*.

6.20 Wider partners identified some potential gaps in evidence where they might be able to play a useful role. For example, the Lesbian and Gay foundation pointed out that there is a lack of sexual orientation and gender identity monitoring of public service users. They said, "*lack of information about LGB&T people's issues and needs is a major barrier to discovering and meeting those needs*." They felt that lesbian, gay, bisexual and transgender (LGBT) people are largely ignored by central and local government datasets. FaithAction pointed out then when gathering evidence for particular communities the voluntary sector and the faith sector in particular is often not consulted.

Broader comments

6.21 Respondents raised a number of wider issues around information and intelligence:

- The importance of evaluation and data sharing;
- Risks to the workforce; and
- Independence of advice and information.

Data sharing

6.22 Many stakeholders identified the need for data to flow easily and freely between relevant organisations and not just traditional health groups, for example, schools, the voluntary sector and broader local government. Frustration with current challenges on data-sharing were shared by many respondents:

- *"A significant hurdle in the development of local services has been the barriers, perceived or otherwise, of sharing information across organisations and professions"* (ADCS and ADSS joint response)
- *"severe difficulties [that] exist in sharing data between professionals, organisations and sectors*" (UK Public Health Association)
- many respondents noted the lack of any incentives or levers in the new system to require or encourage horizontal data-sharing, e.g. between local authorities and clinical commissioning groups.

6.23 The importance of access to accurate, relevant and recent data was stressed. There were concerns about access to health service data if public health staff were local authority employees. The loss of co-terminosity between the local authority and clinical commissioning groups in some areas was thought to create difficulties if data were available only at Local Authority level.

6.24 On the other hand, the Information Commissioner's Office said, *"We would like to know more about the types of information concerning gun and knife crime that will be shared between hospitals and the police. While we can see the benefits of sharing relevant information, where the information involves personal data (and especially sensitive personal data) it needs to be specific and proportionate."*

Information and Intelligence workforce

6.25 Many respondents expressed concerns about risks to the public health information and intelligence workforce, particularly those currently employed by primary care trusts. There was a concern that such staff would not be employed by local authorities and that the skills and insight they offered at a local level on evidence for needs assessment and service design would be lost. The Association of Directors of Public Health summarised the need for such staff saying, *"Public health professionals need a comprehensive and intimate understanding of their local population if they are to identify the need for – and to effect – change in any one of the three public health domains."*

6.26 Many respondents highlighted the importance of training and education for public health intelligence. For public health trainees and other non-intelligence specific staff, stakeholders were keen to see, for example,

increased training on information and intelligence in order to increase accuracy of data collection.

6.27 In relation to intelligence specific staff, respondents were clear that strategic leadership will be needed in the future. A typical comment was, *"accreditation of PH information staff and putting a structured career pathway in place is essential for recruiting and retaining skilled staff"* (anonymous).

Independence of evidence and advice from PHE

6.28 A number of respondents highlighted the value of high quality independent advice, and expressed concern that this might be lost if PHE were formed within the Department of Health. For example, the Faculty of Public Health was concerned that it would prevent public health professionals from challenging "*powerful interest whose actions risk the health of the population*".

6.29 The King's Fund, on the other hand, felt that, on balance, PHE *"needs to be a part of government in order to wield the influence it needs to on public health".* They and other respondents noted the current role of the Chief Medical Officer as an integral part of Government, and yet providing a professional, independent and authoritative voice within Government.

6.30 These views, and others raised in response to the consultation, will continue to inform our work as we develop our plans as set out in the policy statement, *Healthy Lives, Healthy People: Update and way forward*.

7. Regulation of Public Health Workforce

7.1 Alongside Healthy Lives, Healthy People, we published the review by Dr Gabriel Scally of the regulation of public health professionals. We said that the Government believed statutory regulation should be a last resort and its preferred approach was to ensure effective and independently-assured voluntary regulation for any unregulated public health specialists. This section summarises the consultation responses on the regulation of the public health workforce.

We would welcome views on Dr Gabriel Scally's report[3]. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary registration for public health specialists?

7.2 Of those respondents who expressed a view on regulation, there was more support for some form of statutory regulation than for a voluntary system, but across all respondents there was no dominant view about who should operate such a register, whether voluntary or statutory. The most commonly suggested organisations were the Faculty of Public Health, the UK Public Health Registry and the Health Professions Council.

7.3 The Faculty said, "*Consultants and specialists in public health, including DPHs, give important advice and take decisions, which have a profound impact on the lives of many thousands of people. Although doctors and dentists working at this level must have statutory registration to demonstrate achievement and maintenance of satisfactory standards of competence and ethical behaviour – to safeguard the public and minimise the risk to them and to their employers – this is not currently required for those from backgrounds other than medicine, although their responsibilities are often identical. It is therefore a logical and necessary progression to make both subject to statutory regulation, underpinned by one set of FPH specialist standards. Public health specialists from backgrounds other than medicine*

[3] Review of public health professional regulation. November 2010

and dentistry should be registered by the Health Professions Council (HPC)".

7.4 However, others were in favour of a voluntary approach. The Council for Healthcare Regulatory Excellence said, "*We consider that a system of voluntary registration for public health practitioners is the most appropriate system of assurance for this group. We disagree with the recommendation from Dr Scally's report that all public health professionals should be regulated by the HPC. This, in our view, would be an overly burdensome solution for a risk that has not been properly identified or quantified*."

7.5 Responses to the Public Health White Paper and the NHS Future Forum identified a number of mechanisms to achieve a system of registration or regulation for non-medical public health consultants that is proportionate to the risk that they pose to the public. For example, the Royal Society of Public Health said "…. *a number of the public health organisations have discussed an alternative approach to enhanced regulation in the event that statutory regulation is deemed to be inappropriate at this point in time. This contingency approach aims to deliver benefits that are as close to statutory regulation as possible, but without the need for primary or secondary legislation. This involves utilising an amended Royal Charter, such as that providing the constitutional framework for the RSPH, to offer Chartered, Certified or Credentialed status to suitably qualified and competent individuals.*"

8. Equalities

8.1 We published an Equality Analysis to support Healthy lives, Healthy People, which focused mainly on the policy intentions relating to the creation of the new public health system. We anticipate undertaking and publishing further Equality Analyses as policy decisions are developed and finalised and as we move towards implementation. This will include an Equality Analysis for the Public Health Outcomes Framework.

8.2 Many respondents, (including for example Mencap, Men's Health Forum, Zacchaeus Trust, Age UK, Catch 22, and Stonewall) endorsed the vision of Healthy Lives, Healthy People, the focus on Professor Sir Michael Marmot's report Fair Society, Healthy Lives and the wider determinants of health.

Are there any additional positive or negative impacts of our policies that are not described in the equalities impact assessment and that we should take account of when developing the policy?

8.3 Key themes relating to equalities that emerged in the consultation were:

- the need to ensure targeted actions are used in commissioning to correct situational imbalances;
- the importance of involving the voluntary, community and social enterprise (VCSE) sector to ensure that the needs of disadvantaged and hard-to-reach groups are addressed;
- the need to ensure the Outcomes Framework and health premium do not have a negative impact by marginalising low volume groups / minority communities which have high inequalities but which are too small to contribute to overarching outcomes; and
- the White Paper and accompanying EIA did not address the current economic situation with its funding constraints and its impact on disadvantaged groups adequately.

8.4 Although most respondents were in favour of the transfer of public health to local authorities, many expressed concern about how the transition to the new system would operate, particularly around the loss of public health expertise from the NHS, which was seen as having a potential negative

impact on vulnerable and disadvantaged groups and people. A typical comment was, "*For many services a whole pathway approach to commissioning is vital to ensuring that efficiency savings are met e.g. tackling increasing alcohol admissions needs to be addressed through interventions along the entire pathway from prevention to treatment.*"

8.5 Platform 51 highlighted that "*the focus on localism, and meeting local area's needs, should not be to the exclusion of recognising 'communities', which often stretch beyond limited localities. There are distinct minority group concerns which will stretch across geographical areas that need to be taken account of as part of this.*" The Lesbian and Gay Foundation echoed this and highlighted that LGBT people often preferred to travel outside their local area to access high quality LGBT specific services.

8.6 A recurrent comment from respondents was that public sector organisations such as local government lacked an understanding of the needs of minority communities. The view was expressed that councillors were not representative of the population as a whole. CHIVA, for example, commented "*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.*"

8.7 Smaller scale commissioning bodies can represent a challenge for organisations that serve a community of interest over a larger geographical area than, say, a local authority. The Lesbian and Gay Foundation pointed out that specialist services could provide cost effective services to marginalised people and that these services can be vulnerable to changes and reduction in public sector funding.

8.8 Race on the Agenda (ROTA) recommended, *"In order to achieve its vision of a fair society, Government must base all policies and subsequent action on the concept of substantive equality*." They say that substantive equality *"…recognises that entitlements, opportunities and access are not equally distributed throughout societies. Substantive equality acknowledges that where policy is tailored to the majority group, other people with different needs and circumstances may not be considered. It recognises that different groups may need to be treated differently and encourages*

positive action to correct situational imbalances and ensure equality of outcomes."

8.9 Many respondents raised concern about the involvement of patient and user groups in commissioning services. For example, The Terrence Higgins Trust whilst recognising, "*The move to localism brings the potential for a range of improvement.*", were concerned that, "*there is a risk that services will be determined locally on the basis of how visible groups are*." They went on to recommend that, *"..a stakeholder/patient involvement approach to Public Health is equally as important as that applied to NHS service provision and that this would help to address any equalities concerns*."

8.10 ROTA cited evidence of under representation of black and minority ethnic (BME) communities in local democratic structures and processes. Their work suggests patchy engagement of BME organisations in Local Involvement Networks across London boroughs.

8.11 The Race Equality Foundation was concerned about the barriers faced by asylum seekers when accessing health care. They were concerns that the impact assessment "*fails to mention the potential impact of public health policies on BME led VCS groups, particularly small and community focused support services, who are currently providing preventative health care and help combat health inequality ... there is no mention of the risk of depleting interpreting and translation services in health and social care, or of how this would exacerbate existing health inequalities.* " They went on to say, "*Finally there is a lack of information about how public health bodies and services plan to ensure BME and VCS consultation and participation in a meaningful and accessible way*."

8.12 Many respondents highlighted that the White Paper and its associated documents, failed to make adequate reference to the current economic situation, which would be one of the major determinants of population health at local level. For example, one respondent said, "*with unemployment rising, and reform to the benefits system, major changes could negatively impact the most vulnerable in society.*"

8.13 As part of the Department of Health's commitment to equality, diversity and human rights, we have reviewed responses from organisations focused on defined equality groups, which will specifically help to inform

our further equality analyses. Some examples of responses are given below.

Age

8.14 Age UK highlighted that, "*older people are not just diverse in age; they are also diverse in other respects such as ethnicity, faith, sexual orientation, and whether they live in a rural or urban area. All of these will affect their health needs and concerns and should be reflected in public health interventions*".

8.15 Age UK also raised a number of wider issues which might impact on the health and well-being of this age group. These issues include; working well, housing services, crime and access to local amenities. They said, "*public health professionals should remember that it is never too late to benefit from healthy living as well as address specific health problems that are particularly prevalent in older populations".* They cited a 2008 survey by the British Geriatric Society of 200 doctors, which found that more that half would be worried about how the NHS would treat them in old age and that 66% thought older people were less likely to be considered and referred on for essential treatments.

Carers

8.16 The Standing Commission on Carers "*welcome[d] both the emphasis upon prevention of ill health and the recognition of the need for publicly accessible information to allow councils and local people to compare progress both over time and in relation to other councils*". However, the commission raised concerns around how patients and their carers often had great difficulty in interpreting even high quality data and in many cases would simply ask their GP or preferred adviser for advice. The commission highlights that "*if we are to fulfil the new ambitions around patient, user and carer empowerment, then we want to explore new ways of presenting data and facilitating real choice*."

8.17 Additionally the commission was keen to achieve genuine citizen participation through "*user/carer representation on planning fora, the Health and Well-being Boards and of course on GP Commissioning Boards*". Thus, the commission "*strongly recommend that carers should be a priority within the remit of the Health and Wellbeing Boards and that Health Watch should*

recognize their crucial role in developing a more responsive and community orientated NHS". This role would include working with the voluntary sector in engaging with "*a wide range of citizens (including the traditionally hard to reach') in strategically planning and delivering a wider range of preventive services*" and "*that membership alone will not ensure full representation unless the Boards have sufficient resources to regularly consult with and feed back to local communities*".

Disability

8.18 The Standing Commission on Carers referred to a study by The Disability Rights Commission's investigation, which confirmed, *"that prevention of primary and secondary disability and ill-health is vital not only for the well-being of individuals and families, but also for the communities and the State*". Furthermore the commission noted that the "*average difference in disability-free life expectancy is seventeen years between the richer and poorer areas, with more than three quarters of the population unable to expect a life free of disability or limiting illness after the age of 68*".

8.19 Mencap stressed that, "*people with a learning disability are at a higher risk of being obese, of smoking and of experiencing mental ill health. They continue to have worse health than the general public. For those with the most complex health conditions, help is often needed from across health, public health and social care provision. Ensuring that the new public health system responds to the unique needs of people with a learning disability is therefore critica*l". Moreover, "*people with a learning disability are 58 times more likely to die before the age of 50 than the general public. This is not only because this group has a higher incidence of certain illnesses (i.e. epilepsy) but is also down to certain parts of the NHS failing to truly value the lives of people with a learning disability".*

Gender

8.20 A recent report by Platform 51 showed that in England and Wales, 64% of girls and women have been affected by mild to moderate mental health problems of some kind. They pointed to evidence that showed single-sex health services could provide better outcomes for women than mixed-sex services. Platform 51 states, "*In an internal survey we conducted with our service-users, 94 per cent told us they believed it was important to have a women's centre to go to. This is supported by independent polling: of the*

2,000 women we polled for our recent report into women's mental health and wellbeing, 82% felt it was important to have access to women-only services. Women-only space is particularly important for women who have experienced abuse or isolation as they can feel unsafe in mixed settings."

Pregnancy and Maternity

8.21 Unicef highlighted the rationale for improving breastfeeding prevalence in England citing that, "*not breastfeeding contributes to infant mortality, hospitalisation for preventable diseases, increased rates of childhood diabetes and obesity, and adult disease such as coeliac and cardiovascular disease*" and that, "*breastfeeding rates are both an outcome and a cause of health and social inequality*."

Race

8.22 Race on the Agenda (ROTA) expressed concern that the White Paper and its Equality Impact Assessment seemed to conflate race inequality and socio-economic disadvantage. They point to evidence that even when socio-economic factors are taken into consideration there are still unexplained differences in health and related outcomes across ethnic groups so "*policy focused on socio-economic status alone is unlikely to adequately ensure "fairness" for BAME communities*."

8.23 ROTA argued that the interim findings from their ongoing work with MiNet on the impact of the recession and public spending cuts on BME communities had highlighted its detrimental impact on health.

8.24 ROTA's Building Bridges and Female Voices in Violence Projects on serious group offending also reported the under-engagement of BME organisations in the development of relevant policy and practice.

Religion and Belief

8.25 FaithAction raised concerns that, "*some GPs need to have training to raise awareness of providers beyond medical surgeries and hospitals. Faith based organisations play an important role in preventing medical illness*". They pointed out also that when gathering and disseminating evidence, "*faith groups access parts of the community that others cannot and*

therefore the evidence that they can provide on their behalf is fundamental in disseminating public health information as well as gathering evidence".

Sexual Orientation

8.26 The Lesbian and Gay Foundation pointed out that many of the public health areas disproportionately affect LGBT people. They said lesbian, gay and bisexual people are "*more likely than heterosexuals to say their health is poor: more likely to experience tension and worry; to abuse drugs; suffer from asthma be victims of sexual abuse; or to smoke*".

8.27 A criticism of the White Paper Equality Impact Assessment was that sexual orientation and gender variance were not given the same level of focus as other protected characteristics. This was raised as a concern because it was felt that other groups covered by the Equality Act, for example gender and race, are better established in the minds of policy and decision makers.

8.28 Stonewall said, "*Lesbian, gay and bisexual people can face barriers to accessing services which is linked to how public health messages have been targeted currently and in the past" and that "GP's do not currently have enough awareness of LGB health needs and barriers to access*". Moreover, they said, "*One in five lesbian and gay people expect to be treated worse than heterosexuals when accessing healthcare for a routine procedure. Gay women are twice as likely to expect discrimination because of their healthcare (Serves you Right, 2008). Health providers must actively target health campaigns at both lesbians and gay men*".

8.29 The Lesbian and Gay Foundation and Stonewall felt that the lack of evidence relating to sexual orientation and gender variance can be considered a major barrier to securing equal access to services for LGBT communities.

Transgender

8.30 Again, a criticism of the White Paper Equality Impact Assessment was that gender variance was not given the same level of focus as other protected characteristics.

8.31 The Newcastle Voluntary and Community sector response suggested that this characteristic is so comparatively rare that voluntary groups are

"*unable to prove public health improvement over a long term by their intervention, but they do bring an awareness of need for socially excluded individuals who are 'below the radar' and would not show up in a general needs analysis, for example hidden needs*."

Inequalities by socio-economic group

8.32 A number of public health professionals supported the focus on wider determinants of health within the outcomes framework and thought that it is in line with the social model of health as devised by Dahlgren and Whitehead in 1991, which talks of the layers of influence on health.

8.33 The Zacchaeus 2000 Trust "*welcome[d] the Coalition Government's commitment to public health… [and] the approach to outcomes and evidence, and the focus on health inequalities, and the creation a new, integrated, national public health service, Public Health England".* They also raised concerns that the *"White Paper has ignored the powerful research evidence available from government enquiries, universities, and MPs' constituency surgeries that very low incomes create both mental and physical ill health and also billions of pounds of related costs for the tax payer in the health service*".

8.34 The Zacchaeus 2000 Trust cited research by the Joseph Rowntree Foundation's which shows that the "*minimum income food standard is currently £45.65 a week for a single adult*". Such a healthy diet includes five helpings of fresh fruit and vegetables a day and two fish meals a week. This is compared to Job Seekers Allowance which "*is only £51.85 aged 18-25 and £65.45 a week aged 26-60*" and has to cover other essential expenditure such as debts and fuel. They highlighted that, "*The Institute of Brain Chemistry and Human Nutrition has shown that fish, and oily fish in particular, are essential in the diet of women before they conceive and while they are pregnant to help prevent the development of poor cognitive ability and serious brain disorders, such as cerebral palsy, in their babies, which are associated with poor maternal nutrition and with consequent low birth weight*". Additionally they pointed out that, "*The Government Office for Science, in their Foresight report on Mental Capital and Wellbeing has shown that there is a relationship between debts and mental illness and that mental illness costs the economy £105 billion a year*".

8.35 The King's Fund "*highlighted concerns that the move to GP commissioning consortia, and the implementation of any willing provider policy, may exacerbate health inequalities*".

Other vulnerable groups

8.36 Several respondents raised the issue of other vulnerable groups, ie.not "protected characteristics" under the equalities legislation. Particular reference was made to the homeless people and the unemployed. The College of Medicine, Faculty for Homeless Healthcare expressed concern that "*virtually no*" consideration was given to the needs of homeless people. They said, "*health outcomes in the homeless will be a sensitive barometer of the new public health system's ability to deliver on the promise of improving the health of the poorest fastest*."

8.37 St Mungo's pointed out that "*homelessness and poor housing exacerbate and cause health problems which are then poorly managed as a result of a person's homelessness*" where individuals are "*trapped in a cycle of poor health and homelessness*". They expressed concern that the Public Health Outcomes Framework would drive local assessment of need so that if "homeless people do not feature within an indicator…it will be less likely that their needs will be separately included in the JSNA".

8.38 The College of Medicine were also concerned that "*requirements for JSNA make reference to statutory homelessness but no reference to single homeless people who by current definitions are not recognised by local authorities as statutorily homeless*."

8.39 St Mungo's welcomed the approach of localism saying, "*local authorities often have a better understanding of the needs of homeless people than the health establishment as they are a more regular service provider through housing*."

Annex A

Improving public health outcomes – comments on domains and indicators

A.1 In our *Proposals for a Public Health Outcomes Framework* we set out five domains for public health and asked a number of questions about public health indicators, including the criteria proposed to select them and how we can best use these to improve public health outcomes.

A.2 The five domains are:

- Domain 1 Health protection and resilience
- Domain 2 Tackling the wider determinants of health
- Domain 3 Health improvement
- Domain 4 Prevention of ill-health
- Domain 5 Healthy life expectancy and preventable mortality.

A.3 The criteria listed in *Transparency in Outcomes* will form the basis for final selection of the outcome indicators to be included in the framework. This was therefore a key part of the consultation. The key themes and responses to these questions are summarised here.

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

A.4 Stakeholders were largely supportive. Suggestions were made about the prioritisation of the criteria with a strong emphasis on the fact that the final set of indicators needed to reflect the best available evidence we have on the impact on overall health outcomes.

A.5 A significant proportion of respondents and, in particular, those responders interested in equalities issues such as the Afiya Trust, Stonewall, Mencap. ROTA and Terence Higgins Trust were keen that each indicator in the final set could be disaggregated by equalities characteristics (as set out in the Equalities Act 2010). For example, ROTA suggested that "*public health initiatives should be focused on and success should be monitored in terms of addressing inequalities by socio-economic group, but also…by characteristics protected under the Equality Act 2010*."

A.6 Some stakeholders had concerns over what we meant by outcomes, saying we should make this clear so that a balance could be achieved between outcomes where improvements can only be seen over the long term, such as mortality measures, and those where impact could be measured in the short-term, such as smoking prevalence. Wirral Council said, "*It is also important to make the distinction between outcomes, i.e.*

the difference that is to be achieved, and measures of progress towards those outcomes. As a principle comparator data should be able to be generated to allow for contextual analysis of progress".

A.7 Many stakeholders were interested in a tiered approach to presenting indicators for public health, with a small set of top-line outcomes and a second tier of indicators representing those activities that would help drive delivery.

Have we missed out any indicators that you think we should include?

A.8 In developing the proposed indicators within the consultation document, we took advice from a wide range of stakeholders including Directors of Public Health, colleagues across Government, and the voluntary and independent sectors. We wanted to ensure stakeholders had an explicit opportunity to identify other indicators to be considered for inclusion within the final framework.

A.9 In response, a wide range of additional indicators were proposed, including:

- Walking instead of cycling
- Smoking uptake
- Additional national dietary indicators (saturated fat intake, urinary sodium, etc)
- Access to leisure services
- The number of people with mental illness in prison and the number of people entering prison with a drug dependence issue
- Adults moving off benefits into meaningful work
- Homelessness rates
- Turn out at local elections (as a proxy measure of people feeling and playing a part in their local neighbourhoods)
- Prevalence of depression and anxiety
- Dementia and its impact
- Deaths attributable to smoking and children exposed to second hand smoke
- Young people's physical activity levels
- Termination of pregnancy rates
- A long list of specific child and maternity indicators
- The percentage of looked after children who achieve 5 GCSEs
- Standardised admission ratio for fractured neck of femur
- School attendance rate rather than "truancy"
- Preventable sight loss.

A.10 There was a significant lobby in favour of the importance of the breastfeeding indicator.

Which indicators do you think we should incentivise through the health premium?

A.11 Responses to this question have been included in the chapter on funding and commissioning so that all feedback on funding issues can be presented together. Please see chapter 4.

We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

A.12 Views on the need to reduce numbers of indicators ranged widely. Some thought that there was no need to reduce the number of indicators if we were not intending to performance manage them. Some felt that a breadth of indicators would encourage local areas to tackle wider determinants to health, and others felt that too many indicators would dilute focus on the most pressing public health needs. Stakeholders were keen not to be constrained by a pre-determined limit to the number of indicators. The King's Fund responded that the intention to reduce the number of indicators "*runs counter to the declared intention for more public transparency of outcomes. Rather local areas and populations should have access to the widest array of comparable information that the centre can provide from which they can choose their priorities and understand how they compare with other, similar areas*."

A.13 Some stakeholders were clear that trying to keep the overall number of indicators small ran the risk of failing to cover important areas. The King's Fund said, "*there is little rationale for limiting the indicator set for the Public Health Outcomes Framework if local areas are to be able to prioritise their actions across the huge sweep of public health. Given the breadth of what public health encompasses, there is a risk that reducing down to a core indicator set will disincentivise local authorities from taking a broader approach by considering other indicators as well*."

A.14 Many respondents did describe their view on the priority indicators; for example, Blackburn with Darwen Council and NHS Teaching Care Trust Plus said, "*Indicators relevant to the wellbeing of children and pregnant women must be a priority as Marmot has indicated."*

A.15 This question attracted several responses campaigning for indicators deemed most important to one particular interest group or another. For example, Leicestershire Aids Support Services argued that the "*Proportion of persons presenting with HIV at a late stage of infection*" is a very important indicator, given the impact on life expectancy, increased infections etc. from late diagnosis.

Are there indicators here that you think we should not include?

A.16 Following considerable engagement with stakeholders, we proposed a final set of over 60 indicators with the understanding that they would receive varied support from across the

public health sector due to the breadth of their focus on public health. For instance, in developing the proposed set of indicators we were aware that some stakeholders were keen that alternative and new measures should be developed to replace old measures that were thought to be outdated.

A.17 A typical response to this question came from an anonymous individual who said, *"This is tricky. We feel that the drafting team has shown real imagination in compiling a list of indicators, which identifies the wide range of factors determining people's health: many of these might easily have been overlooked. It would be a pity to lose this holistic vision of public health and narrow down too tightly on traditional "health" measurement."*

A.18 There were questions about the inclusion of measures that were considered process focused, rather than focused on outcomes. For example, cycling participation was mentioned on a number of occasions as being a good approach to improving outcomes for obesity, but it was felt that this was in itself not the outcome we should be trying to achieve. In addition, there were a number of indicators that were thought to be backed by stronger evidence in their effectiveness to improve public health outcomes.

A.19 A number of new development indicators were included in the consultation. Whilst some of these were well supported, for example the proposed measure on child development at 2 - 2.5 years, others were not seen as strong enough measures in their own right, such as social connectedness, as the issues these measures represented would be picked up in other measures.

How can we improve indicators we have proposed here?

A.20 The responses to this question overlapped significantly with the question on the overall framework and domains. There was wide support for the approach and the range of indicators. The Association of Greater Manchester Authorities said, "*We are supportive of the existing indicator set, it appears to provide a reasonable compromise between a good range of wider determinants without being over bearing*".

A.21 A broad theme in the responses was that the proposed indicators should be modified to ensure elements of inequity were measured and that they should be extended, where possible, to be applicable to children and young people. The British Medical Association said, "*There is a need to strengthen the sharing of indicators between frameworks and to ensure that there is an explicit set of outcomes for children and young people highlighted through the framework*." One anonymous respondent referred to work undertaken by the Scottish Government in 2008 and said, *"The public health outcomes framework does not adequately address the issue of measuring and monitoring health inequalities, despite reference to health inequalities in four of the five domains. Most of the listed indicators cannot be used alone to measure health inequalities. We would suggest that an agreed unified approach to measuring and monitoring health inequalities is introduced alongside*

the public health outcomes framework, such as the approach taken by the Scottish Government in Equally Well…….. The proposed indicators could be improved by ensuring that there is a sufficiently developed and robust evidence base which quantifies the effects of interventions and their contribution towards the proposed top-level outcomes of healthy life expectancy and reducing the healthy life expectancy gap between the least deprived and most deprived communities. The National Audit Office's value for money review of the Department of Health's strategic approach to tackling health inequalities [NAO, July 2010] concluded that progress towards high level targets was slow and variable"

A.22 Some respondents commented that data should be available at levels lower than local authority to assist local delivery. The Local Government Group said, *"we know that there are considerable geographical inequalities in health, often at a very local neighbourhood level, the information should be able to be broken down for individual neighbourhoods that are meaningful to local people, providers and commissioners. The area based break down of information may be complicated by the lack of co-terminosity between local authorities and the areas covered by Health and Wellbeing Boards, the areas covered by GP commissioning consortia and the areas covered by service providers. It will be important for this to happen in order to inform GPs and for them to make use of this information to inform their commissioning decisions*"

A.23 Others noted that it was difficult to comment on this as a number of the indicators were not yet specified in great enough detail. Many felt that new data collection should be kept to a minimum. One anonymous respondent said, *"Requirements for new sources of data collection should be kept to a minimum, and use of relevant and appropriate indicators for which data already routinely collected maximised."*

A.24 Examples of specific issues raised were:

- An anonymous individual said, "*recommend that the physical activity indicator be amended to reflect the new physical activity guidelines, to be published imminently by the Chief Medical Officer, which include measures across the life course.*"
- The College of Occupational Therapists believed that social connectedness was a strong candidate for measures of social capital that have a bearing on health. Their view was that evidence suggests that where individuals have an opportunity to discuss health issues in social groups they are less likely to make poor decisions about their own health. In a UK setting, this effect is likely to be measured best by using survey measures to assess social connectedness rather than, for example, membership of groups.
- Westminster City Council said, "*The healthy weight measure for children in domain 3 is challenging for Westminster and many London boroughs due to the complex pattern of school use in London with many children attending school outside their borough. To date the Department of Health has only returned school level data (through the national child measurement programme NCMP) not postcode data this*

makes it difficult to understand the true picture of healthy weight in the borough. In future it would be helpful if the Department provided postcode data instead so the issue for resident children rather than school population can be understood. It would also be helpful to include private schools in the NCMP." and

- "*The Council also has some queries over the fuel poverty indicator within domain 2. National measurements of fuel poverty by DEC do not work well for central London, particularly Westminster. More accurate measures are needed. These could include local borough wide surveys periodically (however this would entail costs), a measure of interventions at national and borough level or a measure of the effectiveness of fuel poverty policies and interventions i.e. measuring hospital admissions for fuel poverty associated illnesses at local level during the winter*".

A.25 To support local partnerships, many respondents were in favour of increased local determination of the indicators. The County Council Network "*urges the government to ensure that the Public Health Outcomes Framework is not overly prescriptive, thereby limiting the ability of local councils to respond to the public health needs of a particular area which they are best placed to understand. The framework needs to leave room for Health and Wellbeing Boards to identify their own locally appropriate outcomes through the development of a robust and inclusive Joint Strategic Needs Assessment (JSNA) process and to set out the direction of their plans through the Joint Health and Wellbeing Strategy (JHWS)*." Some suggested a small number of core indicators specified nationally and a wider basket of indicators from which local areas can select according to the needs identified within the JSNA; others suggest all indicators should be locally determined as this would increase local engagement from a wide range of partners.

A.26 There were views that indicators should not be too medicalised but should address the wide range of determinants of health. This will mean that partners from outside health services can understand their role in tackling public health and the particular indicator, therefore leading to more positive and effective local partnerships. For example, one anonymous respondent said, " *In our view the draft Framework acknowledges this, but it is important that, in the process of selecting the final list of indicators, these do not become so "medical" as to be impossible for local inter-sector partnerships to measure*".