Public Health White Paper Consultation Questions

Healthy Lives, Healthy People

Closing Date: 31st March

1. **Role of GPs and GP practices in public health: are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?**

   The GP contract needs to ensure that GPs and GP practices continue to play a key role in areas for which Public Health England (PHE) will take responsibility. However, elements of this contract need to change in order to ensure it is in line with the objectives of PHE. For example, at the moment for most child immunisations, 95% herd immunity in the population is required; however, there is no financial incentive within general practice to achieve this when there is a two tier payment structure and full target payment at 90%.

   Outcome measures within the GP contract needs to reflect all of the domains within the public health outcomes framework.

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

   Through the continuation of national review bodies (e.g. NICE) or regional data analysis teams (e.g. Public Health Observatories) pulling together intelligence, evidence-based practice and data that can then be accessed via an up to date and accurate data observatory. Regional and/or central teams would need to be able to liaise with local areas. Overlaying health outcomes data with data around wider determinants needs to be much more developed as this will be crucial for robust JSNAs.

   Public health evidence needs to be more timely and directed by local decision making and commissioning processes and timescales. In terms of data, this needs to be at a level that makes sense in terms of data quality and for local organisations e.g. at MSOA or LSOA levels as appropriate.

   There is a need to protect and maintain public health expertise at a local level and have this within a critical mass across different organisations. This will allow for career progress, ensure that professional standards are maintained, and allow specialist areas to be developed.

   There also needs to be recognition, as health improvement responsibilities move to local authorities, that ward councillors have

knowledge of their local communities that can be used to compliment traditional streams of health information and intelligence. 'health information and intelligence' therefore needs to be seen in its broadest sense.

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

   PHE needs to continue the work that NICE has completed in respect of public health evidence, but develop it further to ensure briefings are relevant to both the NHS and local authorities. Better analysis and guidance on return on investment by different agency is required.

   There is a need to work in partnership and recognise which agency(ies) influence which determinants. Ensure that local areas are able to shape how wider determinants are tackled – there needs to be local flexibility as solutions and priorities will be different depending upon the area. Cost effectiveness can be achieved through promoting joint working, and also robust procurement framework being in place. Economies of scale can be generated by commissioning services at the widest level as appropriate. Ensure that resources are tailored rather than a one size fits all approach – this will better ensure that resources are delivering outcomes.

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

   There is a need to identify what information and data is held by partners that contribute to public health evidence – for example Accident and Emergency data. This data then needs to be available to the partners that require it – e.g. via information sharing protocols or via public health observatories as a central conduit for this information. GP consortia through acute contracts will also need to ensure that providers are sharing the information – e.g. in contractual terms

   There is also a need to support, both financially and through infrastructure, the development of intelligence from different organisations, particularly in the third sector. For example, local small third sector providers may be in an ideal position to effectively deliver services that meet the needs of a local population, but may not have the capacity, expertise or equipment to collect and analyse the necessary data to evidence outcome.

   There will also be a need to develop robust and shared data quality standards across agencies so that the data provided can be relied upon.

Furthermore, there needs to be a focus on the quality of analysis as opposed to a focus that concentrates on data collection alone.

5. **Regulation of public health professionals: we would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?**

   As a local authority, we do not have a view on which organisation would be best suited but would stress the need to maintain and when required, improve professional standards across the whole range of competencies for public health specialists.

   There does need to be an approach to providing Public Health specialists with a grounding in how local authorities work – e.g. the role of elected members, decision-making, and governance. This will be key as local authorities take over health improvement responsibilities.

Consultation on the funding and commissioning routes for public health

Closing Date: 31st March

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

   Yes – as long as it is representative and clear governance arrangements are in place. It appears that H&WB Boards will have more teeth compared to what Local Strategic Partnerships have had in the past, and therefore are the right place.

   It is important that funding is then allocated against clear and ranked locally-driven and needs-based priorities.

   Public health is everyone's business, therefore if H&WB Boards drive and shape joint commissioning decisions and also the priorities for a local area, they are best placed to consider how budgets should be distributed.

2. **What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and well-being services and minimise barriers to such improvement?**

   Local authorities already have strong relationships with the voluntary and community sector. There may be a need to support the voluntary and community sector by building capacity and infrastructure into the sector to enable them to be in a position where they can bid and be successful for provision of services. There may also be a need to grow and develop the market so that a range of providers are able to provide services – including the voluntary and community sector. This is essential for the prevention of a provider-led market.

   We would suggest provision of investment for the purpose of growing capacity in the sector, and also to attract new people and organisations to be in the position where they can provide services e.g. social enterprises. The capacity could either be provided through local authorities (with additional funding) – who already have a role in developing the voluntary sector; or resource that could be accessed nationally or through the sector themselves – e.g. infrastructure organisations such as CVS. It is important that the role of the Voluntary and Community Sector (VCS) as providers is considered when developing commissioning strategies and frameworks.

   Procurement frameworks, as long as regulations allow, could also favour local or voluntary and community sector providers to help assist the sector in successfully winning tenders to provide services. A small

amount of funding could also be put aside for the purposes of providing small grants for community-based groups that wish to take on a relatively small project – with a view to growing these 'grass-roots' groups to take on larger work in the future.

The H&WB Boards will promote joint commissioning and the opportunity to commissioning pathways of care rather than small projects here and there. Developing the market to respond to pathways may encourage collaboration, without takeover, amongst the third, public and independent sectors.

Local small third sector providers may not have the capacity, expertise or equipment to collect and analyse the necessary data to evidence outcome, therefore could benefit from infrastructure in the form of a larger third sector or private organisation doing this for them. They may be able to get this from the commissioning of a pathway.

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

Ensuring NHS commissioning is underpinned by public health advice requires a number of different public health professionals to work together. There are different skill sets e.g. critical appraisal, needs assessment, health economics, whole system understanding, that are required to deliver this effectively.

Therefore, there is a need to protect and maintain public health expertise at a local level and have this within a critical mass across different organisations. This will allow for career progression, ensure that professional standards are maintained and allow specialist expertise to be developed that meets the needs of NHS Commissioners.

Ensure that GP and NHS Commissioning Board commissioning streams are signed off by public health at the appropriate level – e.g. at a local level through the Director of Public Health. If the system works appropriately, this should occur if the JSNA and Joint Health and Well-Being Strategies are robust and shape commissioning plans. It would be helpful if Health and Well-Being Boards were to sign-off commissioning plans – particularly as the Director of Public Health is a statutory member of this Board.

4. **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?**

There is a need to improve the current performance management of the GP contract. There needs to be greater flexibility for PHE to hold GP practices to account when they are failing as well as create opportunities to do more to support the agenda of PHE.

Elements of the GP contract need to change in order to ensure it is in line with the objectives of PHE. For example, at the moment for most child immunisations, 95% herd immunity in the population is required, however, there is no financial incentive within general practice to achieve this when there is a two tier payment structure and full target payment at 90%.

PHE could ensure greater flexibility if outcome measures within the GP contract reflect the public health outcomes framework.

5. **Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment that we should take account of when developing the policy?**

   This is not clear.

6. **Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?**

   Yes, however the proposed commissioning routes will lead to fragmentation of public health programmes, in particular screening and immunisation.

   We do have concerns that it is very difficult to identify current spend within the NHS on certain public health programmes which could result in other agencies trying to commission something when funding remains buried within the NHS.

7. **Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:**
   - **Ensure the best possible outcomes for the population as a whole, including the most vulnerable; and**
   - **Reduce avoidable inequalities in health between population groups and communities?**
   - **If not, what would work better?**

   In order for the proposed primary routes for commissioning to ensure the best outcomes and reduce inequalities, it is essential that the H&WB Board is effective in commissioning pathways and can effectively influence the commissioning plans of the NHSCB and PHE.

   There are aspects of the third column that need clarification, namely:

   - Supporting role for local authorities in respect of infectious diseases, CBRN and emergency preparedness – is supporting role

that which is already within local authorities e.g. environmental health and emergency planning functions, or are there additional tasks required from local authorities?
- Reducing and preventing birth defects – is PHE the best commissioner of specialist genetic services? Should this not sit with specialist commissioning as a whole?
- Relationship that the local authority will have with regards to PHE in respect of the commissioning of drug misuse treatment services and national nutrition programmes e.g. Healthy Start.

Some aspects will not ensure the best possible outcomes for the population, namely:

- Splitting the commissioning of contraceptive services from the commissioning of sexual health services by the local authority. One agency should commission all sexual health services.
- Splitting up the commissioning, monitoring and promotion of screening programmes between the NHSCB and local authorities. Population screening is a key public health competency and should be commissioned in its entirety by the local authority.
- Public health care for those in prison or custody – this should not be separated from the community safety agenda and be commissioned by the local authority.

There are concerns over how emergencies will be responded to and how the response will be delivered – e.g. current category 1 responsibility held by PCT. We would like further clarification and discussion on this point.

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

- Local authority support for infectious diseases, CBRN, emergency preparedness.
- Alcohol, drugs, and tobacco
- Children's public health.
- Community safety.
- Prison health care.

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

- Should be targeted at areas of most need and focused on outcomes – that are locally driven
- Local authorities should have the flexibility of deciding, through the mechanism of the Health and Well-Being Board how the grant should be distributed – including who they need to employ

10. Which approaches to developing an allocation formula should we ask the Advisory Committee on Resource Allocation (ACRA) to consider

- Deprivation and need at MSOA level should be considered rather than at unitary or county council level.

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

The timescales for shadow and full budgets appear appropriate, however we recognise that their may be difficulties in unpicking the public health element out of certain NHS budgets that will not transfer. It is therefore important to take time and get the end result right, rather than have shadow and full budgets earlier than necessary.

We would recommend that the approach is reviewed regularly and that recognition is given to different areas requiring different approaches and/or moving at differing speeds.

12. Who should be represented in the group developing the [health premium] formula?

Representations from the following specialties:

- Health economics
- Public health
- Local authority representation – e.g. adult social care, children and families, environmental protection
- Health protection/PHE.

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

There needs to be local flexibility – e.g. the health premium should be to ensure that the outcomes that have the biggest impact on health improvement are achieved. The outcomes that should be focused on will vary depending upon local area – and then at a sub-local area – e.g. by ward or MSOA defined area. It is important that the health premium allows for this and that it is not a 'one size fits all' approach to a specific number of outcomes, and that there is a local approach rather than a top-down approach applied.

There needs to be caution taken as the use of incentives could lead to a focus on short-term and measurable indicators only. A balance needs to be achieved here. There should also be consideration of using 'incentives' not just for achievement of outcomes, but to help fund necessary initiatives that will make the biggest difference to the areas and population groups with the greatest health needs.

There also needs to be some consideration of the adult social care and NHS outcomes framework in determining the health premium as some aspects may not be reflected within public health outcomes.

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

As above, it should be focused locally on the outcomes that matter most to that area. It should also give local areas the flexibility to incentivise individuals or groups of individuals to change their behaviour. Therefore there might be a consideration of an element of the money being 'up front'. Ultimately, targets should be achievable and should not be prescriptive.

A consideration is that incentivising a reduction in inequalities across the country may actually result in the inequalities at a national level widening.

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

No. Areas already doing well will suffer as they will fail to improve as quickly as poorer areas. This also does not take account of areas with a rapidly changing population – where inequalities can be exacerbated just due to new communities moving in to the area. Growth should be linked to deprivation and need which should be locally and not nationally determined.

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

How to apply to deprivation – and what elements should be included when looking at deprivation; how to allow maximum local flexibility by ensuring that 'conditions' are not prescriptive or top-down.

Consultation on proposals for a Public Health Outcomes Framework

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

Need to match the different outcome frameworks with funding structures and be clear about the lead organisation for the outcome, but also which partners are expected to contribute. Ensure that outcomes within the Department of Health frameworks also cut across policy documents and outcome frameworks published by other government offices.

The outcomes measures need to be outcomes and not process or performance measures that an individual agency will recognise. To prevent it being a barrier, the outcomes framework needs to be linked heavily with the H&WB Strategy and not the performance management of individual agencies.

The relevant agencies need to be involved in the development of the joint strategic needs assessment and also the health and well-being strategy. It is important that the outcomes framework is not prescriptive and is an aid to what is important locally.

2. **Do you think these are the right criteria to use in determining indicators for public health?**

   Yes, however need overriding outcome measure e.g. life expectancy, healthy life expectancy or slope of inequality as this will be the ultimate aim.

   Also, there is a need to ensure that the outcome measures are not purely driven by what can be measured or by what is available to be measured at least quarterly. There will be a need for some outcomes, if important locally but difficult to measure, to have measures developed over the year and therefore the framework should be reviewed and developed on a regular basis.

3. **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?**

   Absolutely needs to link to the JSNA and local area's joint health and well-being strategy – e.g. should be linked to local priorities and an overriding outcome measure e.g. life expectancy, healthy life expectancy or slope of inequality.

   Need to ensure that there is a real link between the NHS outcome framework, adult social care outcomes framework, and public health outcomes framework.

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

   No – there are other local authority responsibilities missing within these new frameworks, particularly children, education and families.

   There needs to be an aim to move towards closer integration between all three frameworks.

5. **Do you agree with the overall framework and the domains?**

There is a fine line between domains 3 and 4. Domain 4 is very process-led. Need to make sure that focus is on outcome e.g. a reduction in prevalence, rather than recording of something within QoF.

There is a need to make sure that the outcomes local areas use are those that are locally relevant and not end up with a situation where local areas report on indicators that are not a priority locally.

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

Need to make sure that focus is on outcome e.g. a reduction in prevalence, rather than recording of something within the QoF.

Domain 1:

- Comment - systems in place is not an outcome measure. Effective systems as assessed by nationally determine assurance, is more of an outcome measure.
- Missing - Rates/outbreaks of norovirus, influenza within care homes.
- Missing - Completion and consideration of health impact assessment as part of planning developments and strategic decisions.

Domain 2:

- Comment – there are other housing indicators which are equally relevant to public health e.g., appropriateness of housing to the resident, housing affordability, distribution of affordable housing, dwellings in need of major repair.
- Comment – how will employment of people with long term conditions be measured? If this isn't linked to benefits, it would be rather difficult.
- Comment – incidents of domestic abuse – this should be repeated incidents of domestic abuse.
- Comment – why just consider older people's perceptions of community safety? Perceptions by children and adults can limit 'free exercise'.
- Comment – split rates of violent crime from rates of sexual violence.
- Missing – traffic congestion.

Domain 3:

- Comment – there is a need for a better way of measuring healthy weight in adults.
- Comment - A&E attendances for alcohol rated harm is a better indicator than hospital admissions as most people get 'patched up and sent home'.
- Comment – need long term outcome measure/follow up of people leaving drug treatment free of drug(s) of dependence. Could have

outcome measure such as % entering drug treatment with previous attempts.
- Comment – there is a need to split unintentional and deliberate injuries.
- Missing – an indicator relating to diet, an indicator relating to alcohol treatment, and an indicator relating to alcohol and tobacco use by under 18s

Domain 4:
- Comment – should prevalence of recorded diabetes be in domain 5. Not sure what it has to do with health improvement. More appropriate outcome measures would be around diabetes markers that are affected by lifestyle choices.
- Comment – should breastfeeding not be part of domain 3?
- Comment – should be a reduction in Chlamydia diagnosis, rather than the rate itself.
- Missing – reflect paternal/maternal smoking rates.
- Comment – need to define serious mental illness.

Domain 5:
- Missing – All Age All Cause Mortality <75 years.
- Comment – need better understanding of mortality rate of people with mental illness. Are we talking about premature mortality or suicide rates?
- Missing – HSMR

7. 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?

Ranking will depend upon the priorities for the area and having the right indicators to measure whether the causes of inequalities in a particular area are being effectively dealt with. We do not feel that we should necessarily have to report on all indicators in the outcome framework – but those that are relevant or priority locally.

However the following are probably the most important from a public health perspective:

Domain 1
- Life years lost from air pollution
- Population vaccination coverage
- Treatment completion rates for TB
- Rates/outbreaks linked to care homes
- Completion and consideration of Health Impact Assessment

Domain 2
- Children in poverty
- Other housing indicators

- Proportion of people with mental illness and/or disability in settled accommodation;
- Proportion of people with mental illness and/or disability in employment;
- Reduction in proven reoffending
- School readiness: foundation stage profile attainment for children starting key stage 1
- Rates of adolescents not in education, employment or training at 16 and 18 years of age

Domain 3
- Smoking prevalence
- Rate of A&E attendances for alcohol related harm
- Number leaving drug treatment free of dependence (and longer term follow up)
- Under 18 conception rate
- Prevalence of healthy weight in 4-5 and 10-11 year olds

Domain 4
- Incidence of low birth weight babies
- Breastfeeding
- Work sickness
- Maternal/paternal smoking prevalence
- Smoking rate of people with serious mental illness
- Emergency readmissions
- Acute admissions as a result of falls or fall injuries for over 65s

Domain 5
- Infant mortality rate
- All Age All Cause Mortality <75 years
- Mortality rates – all CVD, Cancer, Chronic Liver, Respiratory
- Excess seasonal mortality

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

See comments above in question 6.

9. How can we improve indicators we have proposed here?

Local areas should have the ability to develop their own indicators, and also milestones. We would suggest that there is a mechanism to, locally, be able to feed good practice for indicators upwards, nationally. This would help to ensure relevance of the outcomes framework.

Need to make sure that focus is on outcome e.g. a reduction in prevalence, rather than recording of something within QoF.

Need to ensure that there is a balance with both short-term and long-term measured indicators – e.g. do not focus on indicators that are just easy to measure.

See comments above in question 6.

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

    Those indicators in domains 3 and 4 and in particular those that are key to reducing inequalities in health and improving health in the local area, and those that are know to make the biggest impact on the health of a population at each stage of life.

    There needs to be local flexibility as to the indicators that should be incentivised and not necessarily government-imposed.

    Incentives could also be used to assist with programmes and initiatives that local areas know will make the greatest difference to the health of their populations rather than being awarded after the event.

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

    Agree – this will pick up on HSMR.

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

    See comments above in question 6.

APPENDICES

Draft report to Cabinet dated 16 March 2010 (and appendices)