Coventry City Council

9.3.1

Public report
Cabinet Report

Cabinet 15 March 2011
Council 22 March 2011

Name of Cabinet Member:
Cabinet Member (Community Services) – Councillor O'Boyle

Director approving the report:
Director of Community Services

Ward(s) affected:
All

Title:
Healthy lives, healthy people: our strategy for public health in England – consultation response to proposals for a public health outcomes framework and the funding and commissioning routes for public health.

Is this a key decision?
No

Executive summary:

This report details the City Council's response to two public consultation documents; 'Healthy lives, healthy people: Transparency in Outcomes' and 'Healthy lives, healthy people: consultation on the funding and commissioning routes for public health', published respectively on 20 and 21 December 2010. The documents have been published in parallel with the Public Health White Paper and expand on and present more detail on the proposals.

The proposed outcomes framework has been designed to present the strategic outcomes for public health at national and local levels. The framework is designed to align with the NHS and proposed adult social care outcome frameworks. The consultation seeks views on the overall structure and scope of the framework and the range of outcome indicators themselves. The consultation on the proposed funding and commissioning routes for public health details which organisations will be responsible for commissioning aspects of public health activity. As outlined in the White Paper, a range of responsibilities are transferred to the local authority, to be funded from a ring-fenced public health budget allocation.

Flexibility to prioritise local needs will be a key factor in ensuring the successful implementation of a public health outcomes framework. The funding and commissioning proposals contain new and challenging remits for local authorities which will require a coordinated approach by all local partners, facilitated by the proposed health and wellbeing boards.

Recommendations:

1. Cabinet is requested to consider the consultation response and forward any comments to Council.

2. Council is requested to consider the consultation response and comments from Cabinet and approve the response.

List of Appendices included:

Consultation response

Other useful background papers:

Healthy lives, healthy people: our strategy for public health in England (Department of Health) 2010. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf

Healthy lives, healthy people: a consultation on the funding and commissioning routes for public health (Department of Health) 2010. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123001.pdf

Healthy lives, healthy people: transparency in outcomes –proposals for a public health outcomes framework (Department of Health) 2010. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122966.pdf

Review of the regulation of public health professionals (Dr Gabriel Scally, Regional Director of Public Health) 2010. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122237.pdf

Has it or will it be considered by scrutiny?

No.

Has it, or will it be considered by any other council committee, advisory panel or other body?

No.

Will this report go to Council?

Yes.

Report title:
Healthy lives, healthy people: our strategy for public health in England – consultation response to proposals for a public health outcomes framework and the funding and commissioning routes for public health.

1. Context (or background)

1.1 The Government is seeking views on the proposals contained in the consultation documents 'Healthy lives, healthy people: Transparency in Outcomes' and 'Healthy lives, healthy people: consultation on the funding and commissioning routes for public health. The proposals made within the documents are published in parallel with the consultation on the Public Health White Paper, which was responded to by the Council at Cabinet on the 8th February 2011. The White Paper presented a new approach for public health, with public health functions, in conjunction with a ring-fenced public health grant, proposed to transfer to local authorities from Primary Care Trusts from April 2013 and the creation of Public Health England – a new public health service, based in the Department of Health.

1.2 The two consultation documents seek views on a proposed outcomes framework for public health, which will be used to measure success, and on the detailed implementation of some of the proposals contained in the White Paper, particularly the proposed key public health functions and responsibilities and proposed commissioning and funding arrangements for the delivery of public health services.

2. Options considered and recommended proposal

2.1 The consultation document, 'Healthy lives, healthy people: transparency in outcomes' sets out proposals for a public health outcomes framework. It aims to define how success in public health will be measured, both nationally and locally, and promote joint working where local organisations share common goals. As such, the framework is intended to align with the NHS Outcomes Framework and the proposed Outcomes Framework for Adult Social Care. The framework is based on the Government's high level vision for public health: 'to improve and protect the nation's health and to improve the health of the poorest, fastest.'

2.2 The proposed framework has been developed in consultation with a range of bodies and organisations, including the Local Government Association and the Faculty of Public Health. It is intended that the final set of outcome measures will be 'co-produced' alongside local government and public health colleagues to ensure that measures are workable and applicable as soon as they are introduced. In an effort to embed a sense of collective responsibility amongst communities, local authorities and its partners in improving and protecting health, the proposed framework has used indicators which are meaningful to people and communities and focused on the major causes and impacts of health inequality, disease and premature mortality. The outcomes framework will be used alongside the Joint Strategic Needs Assessment by Health and Wellbeing Boards to determine local priorities.

2.3 The Council considers that the outcome framework needs to be sufficiently flexible to allow local priorities and challenges to be addressed. The driver of the framework should be agreed local priority and not the indicators themselves. It is also important that the framework does not duplicate existing local partnership and performance management arrangements. It is necessary to recognise that it is not always possible or appropriate to measure performance in the short term by trying to force long term outcome measurement into an inappropriate timescale, therefore proxy measures will need to be applied for meaningful measurement of progress.

2.4 Taking a similar approach to the NHS outcomes framework and proposed adult social care framework, it is proposed that the public health outcomes data is publically available at national, and where possible, local authority levels, and will be published in one place by Public Health England. It is also made clear that the framework is not a performance management tool and a commitment to reducing data burdens on local government is made.

2.5 The Council would welcome a smaller set of indicators in order to reduce data burdens. In order to do this, central government will need to select a set of outcomes and associated indicators nationally, but at a local level, local authorities should have the freedom to choose local priorities and select indicators accordingly.

2.6 Overall, the Council considers that there is too little detail about the role of children's services within the proposals. The document recognises the overlaps across the NHS, adult social care and public health, and makes a commitment to ensuring that their outcome frameworks will be coordinated. However, children's social care is significantly missing from the approach. To deliver a 'whole systems approach' much more consideration needs to be given to the role and impact of children's services in delivering improved public health and wider outcomes.

2.7 A separate consultation document, 'Healthy lives, healthy people: consultation on the funding and commissioning routes for public health' adds to the detail outlined in the White Paper, the proposed key public health functions and responsibilities across the public health system, and sets out the proposed commissioning and funding arrangements for the delivery of public health services.

2.8 Nationally, public health services will be funded by a new public health budget, separate from the budget managed through the NHS Commissioning Board for healthcare, ensuring that investment in public health is ring-fenced. Public Health England will fund public health activity through three principal routes: through allocating funding to local authorities; commissioning services via the NHS Commissioning Board; or commissioning or providing services itself.

2.9 The proposals present localism as being at the centre of the new system. The Department of Health expects the majority of services local authorities are responsible for to be commissioned, rather than directly provided, in order to engage local communities more widely and to deliver value for money. It is proposed that some specialised services, such as services for victims of sexual violence and for vulnerable groups, would be commissioned most effectively at levels above individual local authority level. However, the Council would choose to utilise the flexibility offered within the proposals and adopt the most appropriate local arrangements for the commissioning of the activities for which the authority is responsible for, addressing local population needs directly.

2.10 It is proposed that Public Health England may ask the NHS, through the NHS Commissioning Board, to take responsibility for commissioning a range of public health services or interventions from the public health budget. This will include population interventions such as screening programmes. Some public health services will remain funded and commissioned by the NHS and will remain an integral part of the primary care. For example, the public health activity currently carried out by GP practices as part of the essential services they provide for all patients; preventative services provided by dentists under their NHS contracts; and services provided under the community pharmacy contractual framework.

2.11 Table C in the Appendix of this report details the proposed primary commissioning route for public health funded services. Already set out in the Health and Social Care Bill, local authorities will be the lead commissioners for the weighing and measuring of children; dental public health; fluoridation and the medical inspection of school children. This activity will be funded from the public health budget. The range of other proposed funding and commissioning routes are open to consultation. Primary commissioning routes proposed do not necessarily rule out activity in other parts of the system and it is intended that Directors of Public Health in local authorities will have wide-ranging freedom to determine how they wish to work to improve public health.

2.12 It is proposed that local authorities will be responsible for commissioning, from the public health budget, immunisation programmes primarily delivered through schools; comprehensive open-access sexual health services and termination of pregnancy services; contraceptive services for patients who do not wish to go to their GP or who have more complex needs; smoking cessation services and other local tobacco control activities, including the commissioning or provision of prevention activities, enforcement and local communications; alcohol and drug treatment, harm reduction and prevention services for the local population; mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities.

2.13 Public Health England and local authorities will have a key role in dental public health with Public Health England leading on the coordination of oral health surveys while local authorities will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes. Dental services will be commissioned by the NHS Commissioning Board. The Council welcomes the opportunity to influence and shape the dental public health agenda.

2.14 It is proposed that Public Health England will be responsible for emergency preparedness and response relating to public health emergencies. It is expected that most incidents will be managed locally, with the public health response being led by the Director of Public Health and Public Health England Health Protection Units.

2.15 The proposals state that the primary accountability for local government will be to their local populations. This will occur through a variety of functions, including the publishing of data on performance; via the scrutiny of the Health and Wellbeing Board; and through a new statutory duty placed on authorities to improve health. Councils will be accountable to Public Health England through the proper use of the ring-fenced grant, including ensuring value for money. As outlined in the White Paper, the proposals include no centrally imposed targets and no performance management of local authorities by the centre.

2.16 The White Paper announced that Directors of Public Health will be jointly appointed by the relevant local authority as well as Public Health England. Further detail explains that while local authorities will have the power to dismiss Directors of Public Health for serious failings across the full spectrum of their responsibilities, the Secretary of State for Health will have the power to dismiss them for serious failings in discharge of their health protection functions. Alongside this, there will be lines of professional accountability from Directors of Public Health to the Chief Medical Officer.

2.17 In respect of funding allocations, it is proposed that from April 2013, Public Health England will allocate ring-fenced budgets, weighted for inequalities, to upper-tier and unitary authorities in local government for improving the health and wellbeing of local populations. There will be scope to pool budgets locally in order to support public health work. Shadow allocations for local authorities will be made in 2012/13 in order to provide an opportunity to plan before live allocations the following year. During the transitional years of 2011/12 and

2012/13 the NHS will continue to lead on improvements in public health, ensuring that public health services are in the strongest position when responsibilities are devolved to local authorities.

2.18 Three approaches are being considered to establish the formula that will determine funding allocations. Coventry experiences specific challenges around a range of lifestyle-affected health outcomes and has higher than expected mortality rates for a number of diseases. The 'population health measures' approach is preferred by the City Council. This method is based on measures of health outcomes, such as Standardised Mortality Ratios, or Disability-Free Life Expectancy. Using this approach, allocations would be higher to areas with poorer health, taking into account health inequalities. Actual allocations will move towards the specified target allocations over a period of time in order to minimise the risk of destabilising existing service provision as authorities manage any decrease or increase on existing budget levels.

2.19 The proposed 'health premium' to incentivise action to reduce health inequalities was introduced in the White Paper. It is explained in this document that the health premium will apply to the part of the public health budget which is for health improvement. The proposals state that the premium will be simple and will be developed with key partners, representatives of local government and public health experts. Again, the intention is to design the health premium so that disadvantaged areas will see a greater premium if they make progress, recognising that they face the greatest challenges. Three proposed approaches for the development of the formula are under consideration. The Council considers the 'population health measures' approach to be the most appropriate of the three, as it takes in to consideration measures of health outcomes and would mean higher allocations to areas with poorer health and wider health inequalities. It is important that the formula is robust and comprehensive enough so that local priorities and decision making are not distorted by the potential to receive the health premium and is based on progress made and not unrelated deterioration or improvement in the population's health.

3. Results of consultation undertaken

3.1 The consultation response is from the City Council and therefore wider consultation has not been undertaken.

4. Timetable for implementing this decision

4.1 Responses to the proposals under consultation are required by 31 March 2011. Following the consultation period, the Government expect to publish the Outcomes Framework in summer 2011, and for it to be in operation from April 2012. The timetable for implementation includes the establishment of a shadow-form Public Health England operating within the Department of Health during 2011, while working arrangements are set up with local authorities. A public health professional workforce strategy will be published in autumn 2011. Public Health England will take on full responsibilities from April 2012 when shadow public health ring-fenced allocations to local government will be published. These funds will be allocated to local authorities in April 2013.

5. Comments from Director of Finance and Legal Services

5.1 Financial implications

The financial implications from the changes proposed, whilst not yet defined in value are significant. Current spend on services likely to fall under the responsibility of Public Health England are estimated to be in excess of £4bn nationally. Public Health England will

allocate ring fenced budgets, weighted for inequalities to upper-tier and unitary authorities, as well as a new "health premium" funded from within the overall public health budget targeted at health improvement.

There will be shadow allocations for the budget in 2012/13 to local authorities to enable planning prior to allocations going live in 2013/14.

The Advisory Committee on Resource Allocation (ACRA) will be developing the detailed approach to how the resources will be allocated which is expected to be based on one of three approaches, utilisation - using modelling of statistical relationships of health activity and need across the country, cost effectiveness – looking at health gains using information on cost effectiveness of public health interventions and finally population health measures – based on measures of health outcomes.

The final grant allocated would then be prioritised locally to meet local need.

Due to the risk of destabilising existing services, changes from current to the future target allocations may be phased over time.

5.2 Legal implications

The plans considered within the consultation are subject to the successful passage of the Health and Social Care Bill which was introduced into Parliament on the 19th January 2011.

Legal implications around employment issues, including any transfer of staff, will need to be considered in full as more information is published.

6. Other implications

6.1 How will this contribute to achievement of the council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / LAA (or Coventry SCS)?

The plans to embed public health within the Local Authority will support the aims of the Sustainable Communities Strategy of helping Coventry citizens live longer and healthier lives, by improving early years and child health, improving employment prospects and housing quality and reducing health inequalities across the city.

6.2 How is risk being managed?

The Council recognises that it is imperative that there is an orderly transition to new ways of working. In order to minimise any instability the Council will work with both existing and developing partnerships to ensure the needs of local people are met. In ensuring continuity of service and the development of the required future functions within the area of public health it is likely that a number of existing NHS staff will transfer to the local authority within the TUPE framework. This process will need to be adequately supported with the appropriate HR expertise, as well as a joint understanding of responsibility and accountability for the employment liabilities that will come with transferred staff. This will be addressed through detailed project planning and formal agreements between the relevant organisations.

6.3 What is the impact on the organisation?

The impact on the Council is significant as the proposals bring the Public Health budget and local health improvement responsibilities back into local government. The Council supports this proposal and welcomes the opportunity to empower individuals to make positive health choices for themselves and their families. As such, the Council views health improvement as a key function of the local authority.

6.4 Equalities / EIA

An Equalities Impact Assessment is included within the Government's proposals.

6.5 Implications for (or impact on) the environment

N/A

6.6 Implications for partner organisations?

The proposals represent a significant shift in existing public health structures and service delivery. The result will have major implications for partner organisations and for organisations across the city.

Report author(s):

Name and job title:

Simon Brake, Assistant Director, Policy & Performance
Marie Bench, Policy Analyst, Policy & Performance

Directorate:

Community Services

Tel and email contact:

Simon Brake on (024 7683) 1652 or simon.brake@coventry.gov.uk

Enquiries should be directed to the above person.

Contributor/approver name	Title	Directorate or organisation	Date doc sent out	Date response received or approved
Contributors:				
Jenni Venn	Assistant Director, Corporate Policy and Research	Chief Executive's Directorate	07.02.11	11.02.11
Geoff Makin	Environmental Health Manager	Community Services	07.02.11	14.02.11
Neil Eaton	Private Sector Housing Manager	Community Services	07.02.11	11.02.11

Names of approvers: (officers and members)				
Finance: Ewan Dewar	Directorate Finance Manager	Finance & legal	08.02.11	18.02.11
Legal: Julie Newman	Solicitor	Finance & legal	07.02.11	08.02.11
Director: Brian Walsh	Director	Community Services	18.02.11	18.02.11
Members: Councillor O'Boyle	Cabinet Member	Community Services	18.02.11	22.02.11

This report is published on the council's website:
www.coventry.gov.uk/cmis

Appendix:

Healthy Lives, Healthy People

Consultation Questions and Responses

Transparency in outcomes – proposals for a Public Health Outcomes Framework

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

The outcomes framework needs sufficient flexibility to allow for local priorities and challenges and be priority driven rather than indicator-led. It must not be used by Public Health England to direct local authority activity, but should be used as a framework of measures which reflects the very wide 'toolkit' of interventions available to local authorities to meet local need. The framework should not duplicate existing local partnership and performance management arrangements.

Whilst it is important to recognise the impact of non-health related drivers and activity on health inequality this does not mean that they become the responsibility of public health arrangements. Public health forms an important part of a much wider agenda to address poverty and inequality.

A set of criteria has been developed to guide the selection of indicators for consultation.

- ✓ Are there evidence-based interventions to support this indicator?
- ✓ Does this indicator reflect a major cause of premature mortality or avoidable ill health?
- ✓ By improving on this indicator, can you help reduce inequalities in health?
- ✓ Will this indicator be meaningful to the broader public health workforce and to the wider public?
- ✓ Is this indicator likely to have a negative/adverse impact on defined groups? (If yes, can this mitigated against?)
- ✓ Is it possible to set measures, SMART objectives against the indicator to monitor progress in both the short and medium term?
- ✓ Are there existing systems to collect the data required to monitor this indicator; and

- is it available at the appropriate spatial level (e.g. Local Authority)?
- is the time lag for data short, preferably less than one year
- can data be reported quarterly in order to report progress?

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

The criteria seem appropriate. However, it is important to recognise that it is not possible to measure performance in the short term by trying to force long term outcome measurement into an inappropriate timescale.

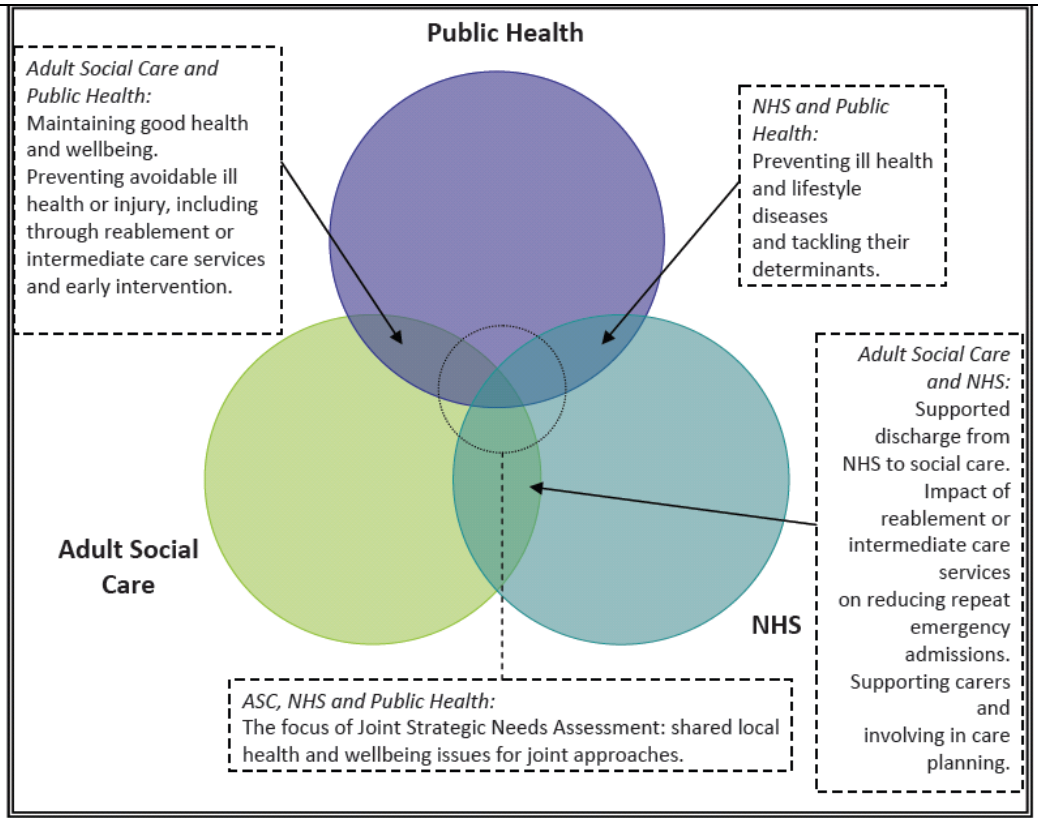
In order to avoid indicator-led decision making, local areas should identify local public health priorities by completing an extensive assessment of local needs. Once identified, indicators should be chosen to enable these priorities to be measured and progress to be checked.

Any indicator chosen as part of the public health outcomes framework should specifically quantify how improvement will impact measurably on public health – otherwise this is merely duplicating performance management being undertaken elsewhere by a range of organisations and partnerships on issues such as tackling employment and crime; meeting housing need; improving child poverty etc.

Q3. How can it be ensured 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?

All need to be aligned through the health and wellbeing board, local partnerships and through the joint strategic needs assessment, including the implementation of audit and oversight functions.

The outcomes framework can be seen to measure 'improvement' or 'reduction in health inequality' but the timescales are key. If the health premium is a yearly allocation, many public health interventions may take a generation or more to have a real impact.



Q4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

The areas of overlap and convergence are greater than the diagram shows. There needs to be a clear set of local priorities and local outcomes shared between the three areas rather than seeing them as separate functions that only overlap at the edges. Children's services are significantly missing from the diagram.

Table A

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Health Protection and Resilience: Protect the population's health from major emergencies and remain resilient to harm	**Tackling the wider determinants of health:** Tackling factors which affect wellbeing and health inequalities	**Health Improvement:** Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities	**Prevention of ill health:** Reducing the number of people living with preventable ill health and reduce health inequalities	**Healthy life expectancy and preventable mortality:** preventing people from dying prematurely and reduce health inequalities

Q5. Do you agree with the overall framework and the domains?

The framework needs to be driven by priorities and not indicator-led. Many of the factors that contribute to health improvement are from functions and activity outside of public health and are delivered through existing partnerships and strategies such as the Sustainable Community Strategy. The proposed public health framework will contribute to, support and maximise the coordination of this activity and provide an opportunity for varying functions to influence priority setting and decision making activity within public health.

Table B

Vision **To improve and protect the nation's health and wellbeing and to improve the health of the poorest, fastest.**
These are over-arching indicators that can be used nationally and locally to give a good snapshot of health inequalities and general health status. They cut across the proposed domains as do health inequalities and are intended to be available for use at a local as well as a national level.
Proposed Indicators
- Healthy life expectancy. - Differences in life expectancy and healthy life expectancy between communities.

Domain 1: **Health Protection and Resilience: Protect the population's health from major emergencies and remain resilient to harm**
The activities to deliver this domain can most appropriately be coordinated nationally by Public Health England, which will have oversight of population health protection and resilience across the country. Local authorities will want to contribute to these outcomes particularly in their role in leading local resilience arrangements, and in providing surveillance information.
Proposed Indicators
- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle. Systems failures identified through testing or through response to real incidents are identified and improvements implemented. - Systems in place to ensure effective and adequate surveillance of health protection risks and hazards. Life years lost from air pollution as measured by fine particulate matter. - Population vaccination coverage (for each of the national vaccination programmes across the life course). - Treatment completion rates for TB. - Public sector organisations with a broad approved sustainable development management plan.

Domain 2:

Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing

Locally, Health and Wellbeing Boards will take a broad approach to health improvement requiring full participation by all partners to focus on improving the wider determinants of health that drive poor health outcomes especially in the most disadvantaged.

The very nature of the indicators proposed require the combined efforts of all public services to focus on the factors that drive health problems amongst the poorest and most disadvantaged in our communities.

Proposed Indicators

- Children in poverty.
- School readiness: foundation stage profile attainment for children starting Key Stage 1.
- Housing overcrowding rates.
- Rates of adolescents not in education, employment or training at 16 and 18 years of age.
- Truancy rate.
- First time entrants to the youth justice system.
- Proportion of people with mental illness and or disability in settled accommodation**
- Proportion of people with mental illness and or disability in employment*, **
- Proportion of people in long-term unemployment.
- Employment of people with long-term conditions.
- Incidents of domestic abuse **
- Statutory homeless households.
- Fuel poverty.
- Access and utilisation of green space.
- Killed and seriously injured casualties on England's roads.
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise.
- Older people's perception of community safety **
- Rates of violent crime, including sexual violence.
- Reduction in proven reoffending.
- Social connectedness
- Cycling participation

* Shared responsibility with the NHS

** Shared responsibility with adult social care

Domain 3:

Health Improvement: Helping people to live healthy lifestyles and make healthy choices

Nationally, there is a clear role for Government in contributing to delivering these indicators, for example through legislation or regulation, and through partnerships with business and industry. Some functions such as some national campaigns, will need to be led at a national level where it is possible to maximise economies of scale and value for money.

However, much of the delivery of these indicators will take place at the local level. Here, health improvement will be the responsibility of local government led by DsPH in partnership with proposed Health and Wellbeing Boards. DSPH will be responsible for investing in health improvement using the ring-fenced public health budget.

Proposed Indicators

- Prevalence of healthy weight in 4-5 and 10-11 year olds.
- Prevalence of healthy weight in adults.
- Smoking prevalence in adults (over18).
- Rate of hospital admissions per 100,000 for alcohol related harm.
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week).
- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds.
- Number leaving drug treatment free of drug(s) dependence.
- Under 18 conception rate.
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth).
- Self reported wellbeing.

Domain 4:

Prevention of ill health: Reducing the number of people living with preventable ill health

Nationally, the role of Government with its partners in business and industry and beyond will be critical.

Across local health and wellbeing partnerships, public health would share responsibility with the NHS, adult social care and children's services to improve outcomes in this domain.

Proposed Indicators

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm.
- Incidence of low-birth weight of term babies.
- Breastfeeding initiation and prevalence at 6-8 weeks after birth.
- Prevalence of recorded diabetes.
- Work sickness absence rate.
- Screening uptake (of national screening programmes).
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24.
- Proportion of persons presenting with HIV at a late stage of infection.
- Child development at 2 – 2.5 years.
- Maternal smoking prevalence (including during pregnancy).
- Smoking rate of people with serious mental illness.
- Emergency readmissions to hospitals within 28 days of discharge *, **
- Health-related quality of life for older people **
- Acute admissions as a result of falls or fall injuries for over 65s **
- Take up of the NHS Health Check programme by those eligible.
- Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed

*Shared responsibility with the NHS

** Shared responsibility with adult social care

Domain 5:

Healthy life expectancy and preventable mortality: Preventing people from dying prematurely

At the local level, improvements in these indicators will be driven by local health and wellbeing partnerships with shared responsibility across the NHS, public health and care services.

Healthy life expectancy is considered as an over-arching outcome under vision and not repeated in this domain. Therefore, the indicators below focus on the causes of premature mortality.

Some delivery will be for other local partners to prevent seasonal mortality for example, or Public Health England locally (currently Health Protection Units) on communicable disease.

National contribution across Government, the NHS Commissioning Board and other national bodies in setting policy or to avoid mortality as a result of major emergencies for example.

Proposed Indicators

- Infant mortality rate *
- Suicide rate.
- Mortality rate from communicable diseases.
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age *
- Mortality rate from cancer in persons less than 75 years of age *
- Mortality rate form Chronic Liver Disease in persons less than 75 years of age *
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age *
- Mortality rate of people with mental illness *
- Excess seasonal mortality

* Shared responsibility with the NHS

Q6. Have any indicators been missed out which you think should be included?

The proposed indicators have a significant focus on the healthcare end of the public health spectrum and there needs to be some balance. Government is showing an increased level of interest in 'wellbeing' and the activities of the local authority to improve 'wellbeing' need to be reflected. Indicators should be chosen to reflect local needs and priorities; therefore any additional indicators would need to be identified locally. Local authorities will need to ensure that the composition of the local health and wellbeing board effectively reflects all five domains of the framework and the local population.

In particular:

Domain 1 - Life years lost from air pollution as measured by fine particulate matter. This currently suggests the use of $PM_{2.5}$. Most local authorities at present monitor $PM_{10.}$ Both relate mainly to traffic pollution. Action to reduce traffic pollution has

an impact on both indicators. Monitoring PM_{10} would be easier and just as effective in improving health. This indicator may also be placed in domain 2.

Domain 2 -

The proposed indicators for Domain 2 do not have sufficient regard to the acknowledged role of housing as a key determinant of health. A tenure neutral indicator - "The proportion of vulnerable householders occupying decent accommodation" (meeting decent homes standard) would address this issue.

The measure suggested for unemployment appears too narrow. An additional indicator(s) to measure short-term and medium-term unemployment would give a more accurate understanding of unemployment rates within the population at any one time.

The following indicators are suggested for inclusion:

- Housing unfitness levels using HHSRS (focus on BME groups, measures of deprivation)
- Workplace health/accidents – data available from Health and Safety Executive/local authority/Accident & Emergency
- Livability indicators (green space, litter/graffiti, public attitude to local environment, accessibility of public transport)
- Availability of illicit/counterfeit tobacco

Domain 3 –

The following indicators are suggested for inclusion:

- Alcohol/drugs dependency and/or numbers completing rehabilitation
- Healthy eating/provisions of healthy foods
- Health-related quality of life for older people
- Take up of the NHS Health Check programme by those eligible.

Q7. It is intended that a smaller set of indicators than previously existed will be developed. Which would you rank as the most important?

A smaller set of indicators would be welcomed. However, indicators should be chosen to measure priority outcomes and not selected in isolation. Central government will need to select a set of outcomes and associated indicators nationally, but at a local level local authorities should have the freedom to choose local priorities and select indicators accordingly.

Q8. Are there indicators here that you think should not be included?

In their role, the health and wellbeing board will need to understand the drivers that impact upon the health of the local population. The indicators proposed in domain 2 appear to be a simple list of the factors likely to impact on health. As such, these indicators will just measure the general progress on a range of these issues (progress that is, often, being addressed elsewhere) rather than assessing the specific health benefits of any change.

It is essential that employment rates of particular groups and unemployment rates are

accurately measured to inform priorities and decision making; however, it is not clear if the measures proposed will provide enough detailed and accurate information to do this.

Q9. How can the indicators proposed here be improved?

A small set of outcome measures should be agreed nationally – this will also provide comparative data for local use. Local areas should then identify and select indicators to measure progress on their local priority outcomes. These may include process and proxy measures in the short term so that progress can be measured on the delivery of longer term outcomes.

Q10. Which indicators do you think should be incentivised through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

In addressing inequality, there are a range of measures, which when combined, can give an overall picture of progress in areas of deprivation. A 'basket' of local indicators could therefore be agreed between Public Health England and the health and wellbeing board, director of public health and the local authority. These agreed indicators would demonstrate the overall direction of travel and would give a more comprehensive assessment of progress beyond looking at each indicator in isolation.

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

There are obvious overlaps here and it is sensible that there is some joint activity by the NHS and the local authority. It will be important that the NHS and local authority agree the indicators jointly and plan together to work towards improvement, while being able to assess the contribution and impact of specific activity.

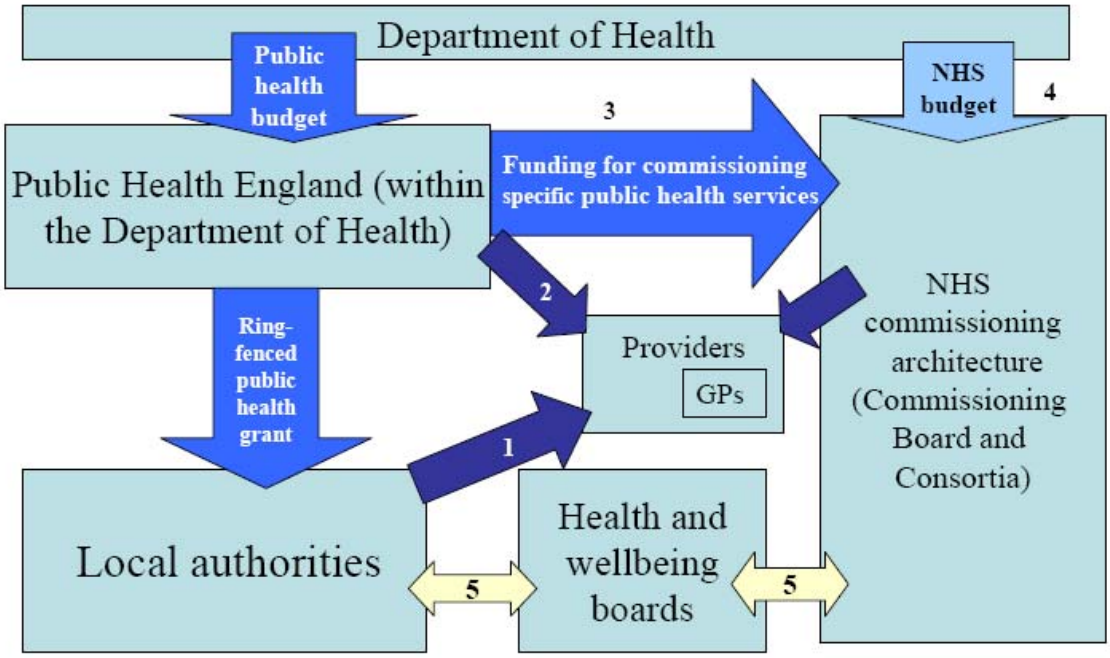
Q12. How well do the indicators promote a life-course approach to public health?

The proposed indicators alone cannot promote a life-course approach. The indicators measure progress against priorities and outcomes; a life-course approach could be promoted by setting the indicators out as a time line showing where policy interventions are being measured at different stages.

Consultation on the funding and commissioning routes for public health

Funding and commissioning flows

The diagram below sets out the flows of the public health budget from the Department of Health across the system.



Q1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

The health and wellbeing board is thought to be the right place to bring together the ring-fenced public health and other budgets, however, the health and wellbeing board are not accountable for the budget therefore the various layers of accountability will need to be properly understood and coordinated.

The Department of Health expects that local authorities will want to contract for services with a wide range of providers and incentivise and reward those organisations for improving health and wellbeing outcomes and tackling inequalities, to deliver best value for their population. The Department of Health would encourage and expect that local authorities, where possible and appropriate, should be commissioning on an any willing provider/competitive tender basis.

Q2. What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

In order to ensure a wide range of providers can play a part in the provision of health and wellbeing services the local voluntary sector should be supported by a coordinating

consortia function (e.g. Voluntary Action Coventry). The development of social enterprise type models and mature relationships with the local authorities should minimise barriers to involvement.

Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients. Locally, this will mean that DsPH are able to advise GP consortia on public health issues and influence nationally via their relationship between the Secretary of State, Public Health England and the NHS Commissioning Board.

Q3. How can it be best ensured that NHS commissioning is underpinned by the necessary public health advice?

It can be ensured that NHS Commissioning is underpinned by the necessary public health advice by ensuring that public health integrate with GP Consortia and utilise the health and wellbeing board to influence the joint strategic needs assessment.

GP practices are currently the preferred provider for a range of public health services under the GP contract, such as childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. These arrangements will continue and will be funded from the public health budget. However, there may be a case for Public Health England and local authorities in the future to have greater flexibility to choose how such services are commissioned, as circumstances change or if services can be better delivered another way.

Q4. Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided thought the GP contract, and if so how might this be achieved?

Yes, but only in conjunction with, and by agreement of, local authorities and with consistency across the country, allowing for local needs.

Defining commissioning responsibilities

Q5. Are there any additional positive or negative impacts of the proposals that are not described in the equality impact assessment and that should be taken into account when developing the policy?

Possibly more account of demographics rather than just levels of deprivation.

Table C

Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	Proposed commissioning route/s for this activity (including direct provision in some cases)
- Current functions of the Health Protection Activity in this area, and public health oversight of prevention and control, including co-ordination of outbreak management.	- Public Health England with supporting role for local authorities.
- Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and prevention.	- Local authority to commission all sexual health and termination of pregnancy services apart from contraceptive services commissioned by the NHS Commissioning Board (via GP contract). Local authorities will fund and commission contraceptive services for patients who do not wish to go to their GP or who have more complex needs.
- Universal immunisation programmes and targeted neonatal immunisations.	- Vaccine programmes for children, and flu and pneumococcal vaccines for older people, via NHS Commissioning Board (including via GP contract). Targeted neonatal immunisations via NHS. Local authority to commission school programmes such as HPV and teenage booster. Local authorities will work with local partners, Public Health England and the NHS to coordinate an immunisation response during a public health incident.
- Current functions of the Health Protection Agency (HPA) in the area of standardisation and control of biological medicines.	- Public Health England.
- Current functions of the HPA in the area of radiation, chemical and environmental hazards, including the public health impact of climate change, and public health oversight of prevention and control, including co-ordination of outbreak management.	- Public Health England supported by local authorities.
- Local initiatives to reduce excess deaths.	- Local authority.
- Public Health England will design, and provide the quality assurance and monitoring for all screening programmes.	- NHS Commissioning Board (cervical screening is included in GP contract.
- Accidental injury prevention - local initiatives	- Local authority.

such as falls prevention service.	
- Mental health promotion, mental illness prevention and suicide prevention.	- Local authority.
- Running national nutrition programmes including Healthy Start and any locally-led initiatives.	- Public Health England, some local authority activity.
- Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising the physical activity opportunities offered by the natural environment.	- Local authority.
- Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services.	- Local authority.
- Drug misuse services, prevention and treatment.	- Local authority.
- Alcohol misuse services, prevention and treatment.	- Local authority.
- Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications.	- Local authority.
- NHS Health Check Programme - assessment and lifestyle interventions.	- Local authority with Public Health England responsible for design, piloting and rollout.
- Any local initiatives on workplace health.	- Local authority.
- Population level interventions to reduce and prevent birth defects.	- Local authority and Public Health England.
- Behavioural/lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis via symptoms awareness.	- Local authority.
- Dental public health - Epidemiology and oral health promotion (including fluoridation).	- Local authority supported by Public Health England in terms of the co-ordination of surveys.
- Emergency preparedness including pandemic influenza preparedness and the current functions of the HPA in this area.	- Public Health England, supported by local authorities.
- Health improvement and protection intelligence and information, including: data collection and management; analysing, evaluating and interpreting data; modelling; and using and communicating data. This includes	- Public Health England and local authorities.

many existing functions of the Public Health Observatories, Cancer Registries and the HPA.	
- Health Visiting Services including leadership and delivery of the Healthy Child Programme for under 5s, prevention interventions by the multiprofessional team, and the Family Nurse Partnership.	- NHS Commissioning Board.
- The Healthy Child Programme for school-age children, including school nurses and including health promotion and prevention interventions by the multiprofessional team.	- Local authority.
- Specialist domestic violence services in hospital settings, and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential information sharing activity.	- Local authority.
- Support for families with multiple problems, such as intensive family interventions.	- Local authority.
- Public health care for those in prison or custody (e.g. all of the above).	- NHS Commissioning Board.

Q6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed above (column one)?

Yes.

Q7. Do you consider the proposed primary routes for commissioning of public health funded activity (the second 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?

It is not clearly understood what the arrangements will be where it is stated that activity will be 'commissioned by Public Health England with a supporting role for local authorities'. The responsibilities and accountabilities will need to be more clearly defined.

The commissioning of termination of pregnancy services by local authorities is a

significant addition to the range of services the local authority will provide. This service has traditionally been delivered through core clinical provision.

It is considered that Health Visiting services should be the responsibility of the local authority and not the NHS Commissioning Board. The local authority should be responsible for the commissioning of the Healthy Child Programme for both under 5s and school-age children to develop a coordinated and consistent approach to services.

It is recognised that although the NHS Commissioning Board is probably the most appropriate commissioner of public health care for those in prison and in custody, this may prove to be a significant challenge when the Board will have varied and sometimes limited experience of commissioning these services for the wider population.

Subject to the approval of Parliament, the forthcoming Health and Social Care Bill will provide that secondary legislation could set out that local authorities should be mandated to provide or commission a particular service. This provision will not specify in significant detail how such services should be provided.

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

It is suggested that local authorities should mandatorily provide or commission lifestyle risk management services, such as drug misuse services, prevention and treatment, alcohol misuse services, prevention and treatment, tobacco control and smoking cessation activity and dental public health.

The public health grant to local authorities will be ring-fenced and will carry some conditions about how it is to be used.

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

It should a condition that expenditure of grant monies should be signed off by the local health and wellbeing board in order to ensure a smooth and coordinated transition of public health responsibilities.

Allocations

It is intended that the independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development of our approach to allocating resources to local authorities, in particular to support the creation of a formula that can be used to calculate each local authority's 'target' allocation. There are three general approaches to

consider when establishing the formula:

- **Utilisation** – based on modelling the statistical relationship between current patterns of public health activity and needs across the country. This is based on the premise that higher or lower expenditure in small areas provides information on relative need;
- **Cost-effectiveness** – based on potential gains in health outcomes across the country using available information about the cost-effectiveness of public health interventions, that is gains in health outcomes relative to spend; and
- **Population health measures** – based on measures of health outcomes, such as Standardised Mortality Ratios, or Disability-Free Life Expectancy. Allocations would be higher to areas with poorer health taking into account health inequalities.

Q10. Which approaches to developing an allocation formula should ACRA be asked to consider?

The population health measures approach is preferred by the Council. Coventry experiences specific challenges around a range of lifestyle-affected health outcomes and has higher than expected mortality rates for a number of diseases. The preferred approach is based on measures of health outcomes, such as Standardised Mortality Ratios, or Disability-Free Life Expectancy.

It may not be possible to set local authorities' actual allocations immediately at target allocation. This would involve cutting allocations in some areas, which would risk destabilising existing services, while other areas may see a rapid increase in available funding that they could not use effectively. Actual allocations would be moved from current spend towards target allocations over a period of time – known as pace-of-change policy for PCT allocations.

Q11. Which approach should be taken to pace-of-change?

The Council supports the approach to move to 'actual' allocations over a period of time, using a tapering mechanism, in order to maintain stability in public health activity. The Council, however, does not agree that any other authority should see a reduction in their funding allocation; current spend on public health activity should be maintained.

Health premium

Building on the baseline allocation, local authorities will receive an incentive payment, or premium, that will depend on the progress made in improving the health of the local population and reducing health inequalities. The premium will be formula based, and developed by key partners.

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

The group responsible for the development of the health premium should contain representation from local authorities, public health, key interest groups and voluntary organisations.

In deciding how to use the Public Health Outcomes Framework alongside the health premium, there will be a need to balance responsiveness to local action with incentivising interventions offering greater long-term benefits.

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

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

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

In addressing inequality, there are a range of measures, which when combined, can give an overall picture of progress in areas of deprivation. A 'basket' of local indicators could therefore be agreed between Public Health England and the health and wellbeing board, director of public health and the local authority and subject to the health premium. These agreed indicators would demonstrate the overall direction of travel and would give a more comprehensive assessment of progress beyond looking at each indicator in isolation. It is legitimate for the Government to want to use funding levels to incentivise good practice, however populations in greatest need ought not to be penalised because a service is under-performing in their locality.

A detailed model will be set out when the baseline and potential scale of the premium are clearly established, and there is agreement about how the Public Health Outcomes Framework will be used. The Department of Health will then bring together a group of key partners. However, a number of the issues to be considered in the detailed design of the premium are already clear. These include:

a) the sensitivity of indicators and outcomes to public health interventions;

b) the possibility of changes in indicators and outcomes for reasons unconnected with public health interventions;

c) the relative focus on the long-term outcomes and progress in the shorter term on those factors that drive these outcomes;

d) the frequency of reporting; and

e) the relative ease of making a difference to an indicator or outcome, and how this varies between areas with different characteristics.

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

The group will need to consider the fairness in the allocation of resources. Evidence, including the Marmot review, suggests it is fair to match resources for public health to the needs of populations, with the greatest resource going to the areas where populations are identified as the greatest need.