Appendix A

White paper consultation – Draft response

The proposal for public health improvement to become the responsibility of local authorities is welcomed, however, it is felt that there needs to be some clarity around the process for transferring existing PCT public health staff to local authorities; whether they are to simply be TUPEd across, or whether local authorities will be expected to go through a process of recruitment.

There are also concerns that the remaining PCT workforce will be made redundant from the PCT, then potentially going to work for other organisations such as the GP commissioning consortia, to help manage that function, which would result in a huge amount of public money being wasted through redundancy costs and re-establishment of posts within another organisation, be that the GP consortia or the local authority. This is a major concern and in light of current reductions in resources, a potentially ineffective use of public money, as well as potentially detrimental to the workforce and the level of expertise which has been developed within PCTs, which will be a valuable resource to local authorities and GP commissioning.

In relation to the commissioning of public health services, we believe that local areas should have as much responsibility as possible to ensure locally driven services are commissioned to meet the needs of people within local authority areas. It would also therefore be essential that the public health budget reflects this responsibility locally and allows local authorities to deliver what is needed, without placing added burden on them through lack of resources.

Strengthening the role of GPs in relation to public health promotion is welcomed, however the duty placed on GPs to be actively engaged in the Health and Wellbeing Board needs to be clear and there should be powers in place to ensure GPs do engage with the Board as well as the local authority, and a clear reporting route if this is not the case.

All statutory members of the Health and Wellbeing Board should also have a duty to actively input into the JSNA and Health and Wellbeing Strategy and not just simply have to give regard to them when developing commissioning plans in relation to public health, but to ensure the strategy informs development of all subsequent plans and strategies, by all statutory partners.

The voluntary regulation of public health professionals is agreed in principle, in that it ensures a coherent, single regulation for any members of the public health workforce who are not currently regulated and the recognition of the broad range of public health staff is welcomed. However, there are concerns around the regulation of alternative therapists and it is hoped that putting in place this system will ensure that those using alternative therapies are not able to be voluntary regulated to the same standard as other public health professionals.

Funding and Commissioning

Question	(Draft) Response
1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?	To an extent. The difficulty with ring fenced budgets (e.g. community care) is that they are targeted and this can limit the flexibility with which spending can be allocated. The Health and Wellbeing Board will give an opportunity to look at ring fenced budgets in the context of the wider community strategy which will enable a more strategic approach to developing preventative measures which will in turn mean that we can focus on maximising budgets.
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 wellbeing services and minimise barriers to such involvement?	• Publish a clear plan (Health and Wellbeing Strategy) that indicates the direction of travel (based on need identified in JSNA , other health inequalities and the vision for Rotherham) • Evaluate current procurement / contracting procedures to ensure that they do not disadvantage small providers, voluntary sector etc through being too bureaucratic or procedure driven so that we develop a wider range of providers • Review the Compact to ensure that the voluntary and faith sectors maximise their competitiveness by maximising retention of money in the local economy, developing those not in employment, defining social value added and supporting local inequalities targets • Effective communication between Assessment staff and commissioners, to support the micro-commissioning or person centred commissioning of services is also vital • Grant fund on an outcomes basis to promote prevention
3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?	A robust and regularly updated JSNA. Expectation on the Director of Public Health to deliver information and advice that can be acted on in relation to commissioning of services.

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?	While identification and commissioning of specific treatments can be done by GP's as can preventative interventions such as screening and vaccination programmes, many public health problems have social routes. Area Assemblies along with strategic developments across housing, education and economic development will have just as important an impact as direct provision from the NHS. Local Strategic Partnership and Adult Boards would be best placed to take this overview of strategic commissioning and Market Management.
5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?	The economic outlook and particularly employment situation has become less secure since the document was originally written. An increase in long term unemployment and a slow recovery in employment rates will have major implications for long term health and financial dependency levels for many years to come.
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 (pg 16)?	Yes. Although, there needs to be adequate resource provided to local authorities through the public health budget to deliver the range of services for public health. This needs to be based on previous spend within the existing PCT as well as taking into account future pressures on services and ill health. Consideration also needs to be given to options for using the public health budget towards match funding with other budgets and ensuring the flexibilities for pooled budgets are used effectively.
7. 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?	We believe that as much public health commissioning responsibility as possible should be delivered locally and not through the National Commissioning Board. It is unclear why the Children's health (0-5) has a different commissioning route to the Children's health (5-18).
8. Which services should be mandatory for local authorities to provide or commission?	Health Protection and Resilience. Tackling the wider determinants of health: In particular encouraging neighbourhood renewal and economic wellbeing are important

	functions for local authorities. The single conversation has gone a long way towards encouraging local authorities to take a holistic view of how the local infrastructure works to contribute to wellbeing. Tackling poverty and worklessness must be at the heart of addressing health inequality and this needs a strategic approach which local authorities are well placed to take.
9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?	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. 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.
10. Which approaches to developing an allocation formula should we ask ACRA to consider?	An area based allocation may not acknowledge the value added to people's lives or opportunities when they migrate from the area under observation to a more affluent one.
11. Which approach should we take to pace-of-change?	Don't rush!
12. Who should be represented in the group developing the formula?	It is important that the group also involves representatives from local government within northern industrial regions to reflect the specific issues faced by those areas.
13. Which factors do we need to consider when considering how to apply premium?	The extent to which we have achieved the targets set out in action plans. These need to take into account the very long term nature of some of the outcome targets where progress may be slow. Slowing the rate of increase of diabetes for example may be a success.
14. How should we design the health premium to ensure that it incentivises reductions in inequalities?	Sustaining long term employment, prevention, screening, vaccination and addressing child poverty will provide the best foundation for reducing inequalities in the long term. It is also relatively easy to identify performance indicators that can monitor progress on these areas. In terms of KSIs it is suggested that the rate of reduction in disadvantaged areas compared to the borough as a whole should be used. Alternatively, or in addition, the rate of reduction in the different categories of vulnerable road user groups could be

	compared to the overall rate of reduction.
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?	Yes, this would encourage better performance however, it might worsen progress on key outcomes that prove more difficult to achieve.
16. What are the key issues the group developing the formula will need to consider?	Should look at local demographic profiles (super output areas) to identify how far behind an area is against the benchmark and the issues that are a priority for remedial action. A funding formula could then be built around this.

Outcomes Framework

Question	**(Draft) Response**
1. 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?	• Consistent approach taken across all three Outcome Frameworks • Flexibility in how outcomes can be achieved • Reduction in bureaucracy • Staff engagement and Partnership Working • Need clear agreements with partners in health
2. Do you feel these are the right criteria to use in determining indicators for public health? • Are there evidence-based interventions to support this indicator? • Does this indicator reflect a major cause of premature mortality or avoidable death? • By improving on this indicator, can you help reduce inequalities in health? • Will this indicator be meaningful to the broader public health workforce and wider public? • Is this indicator likely to have a negative/adverse impact on defined groups? • 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	Generally yes however some of the indicators are more objective and easy to measure than others. Information regarding the incidence of premature death can be based on defined criteria and can be easily measured and compared to other areas. The main causes of premature death have also been identified. Helping people recover from episodes of ill health can also be measured and judged on the extent to which and the time taken for them to regain independence. Again inequalities in these areas are easily identified and thus it should in theory be possible to identify remedial action. The other three domains are more subjective and harder to measure. Measuring people's satisfaction can be time consuming and may not always pick everything up. Quality of life indicators are also hard to define. At worst the indicator would have no effect on health inequalities

monitor this indicator?	and for the area of premature death and recovery, it has the potential to be a positive influence.
3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?	The outcome framework focuses on NHS provided services while recognising areas of overlap (particularly with Adult Social Care). However much health inequality is due to social deprivation and unhealthy lifestyles in early life. It is therefore important to ensure locally all strategic aims are aligned to ensure the most potential health gain will be wherever possible from those who experience the most inequality. For example, in terms of road safety, the health premium should be linked to the rate of KSI reduction in disadvantaged areas (there is strong evidence that members of poorer communities are more likely to become road accident casualties than their better-off peers) compared with the borough as a whole. For sustainable and healthy travel the premium should be linked to the numbers of children and adults adopting better travel habits.
4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks? • Diagram on pg 14 showing how 3 frameworks sit together	A good quality JSNA is at the centre of the alignment and this is the right approach. The main weakness with the approach is it does not explicitly link in with wider areas of public policy. To promote prevention and early engagement resources not ring fenced to Social Care or health will need to be released. This is crucial to the prevention and early engagement agendas.
5. Do you agree with the overall framework and domains? • *Health protection and resilience* • *Tackling the wider determinants of health* • *Health improvement* • *Prevention of ill health* • *Healthy life expectancy and preventable mortality*	Agree in principle with these 5 domains. **Domain 1** clarity over the role of Adult Protection in relation to the NHS would assist in a whole system approach to quality care for the vulnerable. **Domain 2** in particular Addressing issues such as Child poverty fits in with comments earlier regarding fitting in with wider community plans. **Domains 3, 4 and 5** Have specific and measurable objectives.

6. Have we missed out any indicators that you think we should include?	None that seem obvious.
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?	• D 2.1 Children in Poverty • D 1.4 Population Vaccination • D 1. 6 Public sector organisations with board approved sustainable development management plan • D 2.9 People in long term unemployment • D2.8 Proportion of people with mental illness *and or disability* in employment • D2.10 Employment of people with long-term conditions • D 2.3 Housing overcrowding rates • D2.13 Fuel Poverty • D 2.17 Older Peoples perception of community safety • D 2.16 Environmental noise • D 3.8 Under 18 conception rate • D 3.6 and 4.1 Injuries to people aged 5 to 18 and 1 -5 • D 3.3 Smoking Prevalence • D 4.3 and 4.4 Prevalence of Breast feeding and low birth weight • D 4.7 Screening uptake • D 4.8 Chlamydia diagnosis rates per 100,000 young adults aged 15-24 • D 4.9 Proportion of persons presenting with HIV at a late stage of Infection • D 4.11 Maternal smoking prevalence • D 4.13 Emergency readmission rate to hospital • D 4.15 Acute admission due to falls • D 5.1 Infant mortality • D 5.4 Mortality From cardiovascular diseases of people under the age of 75 • D 5.5 Mortality From cancer of people under the age of 75 • D5.9 Excess seasonal mortality

8. Are there indicators here that you think we should not include?	**Suggested indicators to be taken out:** • D4.14 Health related quality of life for older people (placeholder) could be taken out as it rather subjective. It is unclear what it is asking people to report on – and therefore will this indicator provide any real meaning to anyone (e.g. does it mean, how easily they can have their health needs met, how healthy they are, how well they feel given their state of health?) • D 4.6 Work sickness absence rate is a wide ranging issue and possibly too big for this agenda • D 4.5 Prevalence of recorded diabetes. Not clear why we need to know this • D 310 Self reported wellbeing is too subjective and gain from info gained probably doesn't justify the effort to obtain the information
9. How can we improve indicators we have proposed here?	Set benchmarks on which success will be judged.
10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)	**D2.13** Fuel Poverty (To address this investment is needed in short term. However long term benefits in terms of health and economic wellbeing over a 5 to 10 year period will be significant). **D 2.9** People in long term unemployment (The negative effects of this are immense. It has a negative effect on health, economic regeneration and contributions to savings and pensions. This means higher dependency on means tested services in later life. Investment to encourage employers to create and sustain employment opportunities to see out the current difficult environment will have huge benefits over a 15 to 20 year period. **D 2.3** Housing overcrowding rates. While families are living in overcrowded housing due to affordability issues, many older people are living in larger houses. Incentives to build more suitable accommodation for older people with incentives to move could go a long way to addressing the acute shortage of suitable accommodation for families.

11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?	This seems a sensible proposition. Preventable mortality requires interventions before health problems escalate as well as good quality acute care when crisis point is reached.
12. How well do the indicators promote a life-course approach to public health?	The inclusion of a large number of indicators covering outcomes for children suggests that a whole life approach is being taken.