CABINET
5TH APRIL 2011

ITEM NO. .....

HEALTHY LIVES, HEALTHY PEOPLE RESPONSE TO THE CONSULTATION

Responsible Cabinet Member – Councillor Steve Harker, Health and Leisure Portfolio

Responsible Director – Murray Rose, Director of People

SUMMARY REPORT

Purpose of the Report

1. To endorse a response to the White Paper drafted by the Health and Wellbeing Scrutiny Committee.

Summary

2. This Committee, at its meeting held on 24th August, 2010, agreed to establish a standing Task and Finish Review, comprising of all its Members to undertake detailed scrutiny of the White Paper to formulate a response.

3. On 30th November 2010 the Government launched a consultation on the Public Health White Paper: Healthy Lives, Healthy People: Our strategy for Public Health in England.

4. The Director of Public Health arranged a Members Training/briefing session on the Public Health White Paper for all Members of Council on 8th March 2011 to discuss the consultation.

5. Nine Members attended this session and the discussion has informed the Task and Finish Review Groups findings.

6. The Group met with Ken Ross, Public Health Specialist NHS County Durham and Darlington to assist in responding to the consultation questions.

Recommendation

7. It is recommended that Cabinet endorse the response to the White Paper detailed at paragraph 11 below and it be forwarded to the Department of Health.

Reasons

8. The recommendations are supported by the following reasons :-

   To enable this Council to respond to the White Paper.

Paul Wildsmith,
Director of Resources

Background Papers

Department of Health: Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health.
Department of Health: Healthy Lives, Healthy People: Transparency on Outcomes
Department of Health: healthy Lives, Healthy People: Our Strategy for Public Health in England.

Abbie Metcalfe: Extension 2365

S17 Crime and Disorder	This report has no implications for Crime and Disorder.
Health and Well Being	This report has implications to address Health and Well Being for the residents of Darlington.
Sustainability	There are no direct implications to Sustainability which this report needs to address.
Diversity	There are no direct implications to Diversity which this report needs to address.
Wards Affected	There is no direct impact on any individual Ward.
Groups Affected	This report impacts on Darlington residents as a whole.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	For the purpose of the 'call-in' procedure this does not represent an urgent matter.
One Darlington: Perfectly Placed	This links to the Theme 3 "Healthy Darlington". Specifically addressing health inequalities to narrow the gaps in health and well-being and life expectancy.
Efficiency	There are no efficiency identified as part of this work.

MAIN REPORT

Information and Analysis

9. On 30th November 2010 the Government launched a consultation on the Public Health White Paper: Healthy Lives, Healthy People: Our Strategy for Public Health in England.

10. The White paper is accompanied by two further consultations: Consultation on the funding and commissioning routes for public health and Transparency in outcomes, proposals for a public health outcomes framework. Executive Summaries are attached as **Appendix 1**.

11. Members of the Health and Well Being Scrutiny Committee have agreed at its meeting on 22nd March 2011 to submit to the Department of Health the following response:-

Members of the Health and Well Being Scrutiny Committee wish to submit their thoughts and comments to the Public Health White Paper consultation documents as follows:-

Consultation questions - Healthy Lives, Healthy People:

Q1. 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?
• Accountability - Elected Members will be able to hold GPs to account, under the Health Scrutiny powers. • Accessibility - GPs will be more accessible to Scrutiny Committees, through better engagement and closer working. • Greater interaction - It is hoped that there will be greater interaction between GPs and involvement in the Scrutiny process. • Role of Scrutiny – It is hoped that GPs will make themselves available for Scrutiny and welcome the critical challenge that scrutiny can provide. It is hoped that GPs recognise the importance of the role of Scrutiny, whilst acknowledging that awareness of scrutiny functions will need to be promoted with GPs.
Q2. Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?
Deferred this response for the Director of Public Health and other local public health professionals to provide feedback on this matter via their own response.
Q3. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioral science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?
Deferred this response for the Director of Public Health and other local public health

professionals to provide feedback on this matter via their own response.
Q4. Public health evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?
Deferred this response for the Director of Public Health and other local public health professionals to provide feedback on this matter via their own response.
Q5. 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?
• Support for the regulation of public health professionals becoming statutory. • Regular updates – The register should be regularly updated and evidenced. This would enable public health professionals to be more accountable.

Consultation Questions – Outcomes Framework:

Q1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?
• Welcome the overlap between public health, NHS and Adult Social Care and do not anticipate that it will act as a barrier. • Inclusion of the elected member role. • Careful selection of indicators are required. • Flexibility and local determination of indicators is crucial • Indicators should be incentivised to enable indicators to be chosen that are achievable and show measured improvements. • A sound evidence base should be used to determine indicators and they should also reflect local priorities.
Q2. Do you feel these are the right criteria to use in determining indicators for public health?
• Yes – Welcome the proposed indicator domains of health protection and resilience, tackling the wider determinants of health, health improvement, prevention of ill health and healthy life expectancy and preventable mortality; each domain reflects each outcome framework.
Q3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?
• Welcome the outcomes frameworks do not sit alone. • Flexibilities must be taken into account across all sections, and the commonalities between the three are shared. • Through working together and good communications contributions to reduce health inequalities can be achieved. • The indicators should be selected locally and the health premiums need to be taken into account, although, targets should be not chosen because of the potential rewards that can

be gained, there needs to be a balance between rewards and improvements.

- There needs to be further clarity on long term indicators that are achievable for Darlington and whether health premiums can be paid on a phased basis dependent on achievements/improvements made.
- There needs to be a realistic choice of indicators and improvements must be gained, as tackling health inequalities is a long term achievement.
- There has to be realistic recognition of outcomes, while being ambitious in the choice of indicators and there should be no penalties for being ambitious.
- Local indicators need to be chosen by local representatives (including elected members) that are relevant, realistic and achievable.

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

- Yes – Agree that a common framework is essential and welcome the opportunity to the enhance role of Overview and Scrutiny to provide an accountable and transparent framework.
- Concerns were expressed relating to the alignment of children and young people and how it fits into the frameworks.

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

- Members are not enthused by the use of the word 'domain' and do not think it is a helpful term.
- Agree that the framework is logical and welcome the Local Authority's obligation.

Q6. Have we missed out any indicators that you think we should include?

- Indicators which consider environmental issues such as planning and housing considerations.
- Indicators relating to educational attainment, free school meals, could be included.

Q7. 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?

- There is a consensus that a smaller indicator set would be desirable.
- Cross matching public health indicators with the Overview and Scrutiny Committee's Work Programme has shown that the Committee has undertaken work in areas where indicators crop up a few times, in relation to all five domains. It would be difficult at this stage to prioritize indicators.
- However from the Work Programme it is evident that Members have undertaken a vast amount of work in relation to prevention of ill health and reducing the number of people living with preventable ill health.

Q8. Are there indicators here that you think we should not include?

- There are some missing indicators in relation to disabilities and learning disabilities

Q9. How can we improve indicators we have proposed here?
• By grouping together some indicators under specific headings.
Q10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)
• Local determination of indications - the incentive indicators should be locally determined, for example in Darlington a vast amount of work has been undertaken in respect of alcohol. • Indicators that are incentivized should be based on evidence and proven work. • Robust data should inform individual indicators, which may inform the decision on which indicators are chosen. • The Committee's Work Programme will be able to inform Darlington specific indicators.
Q11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
• Support for these proposals, although, concerns are expressed about accountability; who will be accountable and able to be scrutinised.
Q12. How well do the indicators promote a life-course approach to public health?
• The Life-Course approach – starting well, developing well, living well and ageing well should ensure that people will not fall through the 'gaps' and the stages aren't age related.

Consultation Questions - Funding & Commissioning:

Q1. Is the health and wellbeing board the right place to bring together ring fenced public health and other budgets?
• Concerns are expressed about the membership of the Health & Well Being Boards. • There is a need for a board range of expertise amongst its membership to be locally appointed to determine the ring fenced budgets.
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?
• Through local freedoms, barriers will be minimised and allow for joint working and greater joined up of services. • The providers need to be credible and evidence needs to be sought about potential providers, to enable best value for money. • Support needs to be in place to be accountable for best value and best provision of services.

- Support is needed to encourage local providers (with proven track records) to tender for services through an open environment (market) which provides good quality services.
- Support should be given to the providers that already exist to develop and sustain local providers, rather than tender outside the area, at a potential higher cost.
- There is a role for the Overview and Scrutiny Committee to monitor complaints and hold providers into account.

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

- It is crucial to have a good Director of Public Health and team to ensure that commissioning decisions have a public health focus.
- There needs to be public health representation on the GP Commissioning and NHS Commissioning Boards, as well as Health and Well Being Boards.

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

- Yes – Public Health England should be able to impact directly on patients, while being sensitive to local needs.
- The Quality Outcome Frameworks (QOF) should remain, while acknowledging the flux of change.

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

Unable to comment at this time – although, would like to encourage people to take responsibility of their own health care, with an emphasis on encouraging people to understand and recognise their own role in 'their' own health care. This could be developed through schools at an early age.

Q6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

- The current financial constraints that Local Authorities are facing, should be taken into account and the times ahead, allowing Local Authorities to discharge these functions at this time could potentially be difficult.

Q7. Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:

a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and

b) reduce avoidable inequalities

c) in health between population groups and communities?

If not, what would work better?

- Expertise is crucial – Members are insistent that Local Authorities must ensure that there

is expertise for necessary commissioning for health care services.
Q8. Which services should be mandatory for local authorities to provide or commission?
Members found it difficult to comment at this time.
Q9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?
• Conditions should be directly linked to local needs and local outcomes, to ensure that local needs are reflected. • There must be an evidence base of proven providers through the evidence gathering which is crucial.
Q10. Which approaches to developing an allocation formula should we ask ACRA to consider?
• Demographics of the area should be taken into account, which includes the gap of life expectancy between the wards in Darlington; • The mixture of population of Darlington (including the associated needs of the older people living in affluent areas and the access to services for people in areas of deprivation); • Rurality issues; • The differing communities, such as the travelling communities and BME communities; and • Employment opportunities in the town.
Q11. Which approach should we take to pace-of-change?
• The momentum should not be lost, but it was felt that change should be made slowly and gradually, at a measured pace.
Q12. Who should be represented in the group developing the formula?
• Local Authorities, Public health, Academic representatives, Community representatives (who could potentially be an elected Member) should be included in developing the formula.
Q13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?
• Flexibility of local indicators, allowing for change in this period of fluxuation.
Q14. How should we design the health premium to ensure that it incentivises reductions in inequalities?
• Based on indicators once locally determined.

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?
• Health Improvement is an important element of improving health outcomes and therefore there needs to be incentive mechanisms with professional input. For example, the Fire Service could fit smoke alarms to prevent avoidable deaths.
Q16. What are the key issues the group developing the formula will need to consider?
• Local priorities and drivers.