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Sefton Council
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Date: 15 March 2011
Our Ref:
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Dear Councillor

CABINET MEMBER - HEALTH AND SOCIAL CARE - WEDNESDAY 16TH MARCH, 2011

I refer to the agenda for the above meeting and now enclose the following report(s) which were unavailable when the agenda was printed.

Agenda No.	**Item**
9.	**Sefton's Joint Strategic Response To The Public Health White Paper Healthy Lives, Healthy People** (Pages 3 - 24) Joint report of the Chief Executive, Sefton Council and the Acting Chief Executive – NHS Sefton to follow

Yours sincerely,

M. CARNEY

Chief Executive

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REPORT TO:	Cabinet Member - Health and Social Care
DATE:	16th March 2011
SUBJECT:	Joint Strategic Response: Public Health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England*
WARDS AFFECTED:	All
REPORT OF:	Hannah Chellaswamy; Acting Director of Public Health (NHS Sefton & Sefton Council) and Thematic Chair - Healthier Communities and Older People partnership
CONTACT OFFICER:	Cathy Warlow; Thematic Manager - Healthier Communities and Older People partnership
EXEMPT/ CONFIDENTIAL:	No

PURPOSE/SUMMARY:

To provide the Cabinet Member with the joint strategic response summary by Sefton Council and NHS Sefton on the published White Paper on Public Health – *Healthy Lives, Healthy People and the two supporting papers.*

To request that the Cabinet Member signs off the joint strategic response summary and agrees for the response to be submitted into the Consultation process that closes on **31st March 2011.**

REASON WHY DECISION REQUIRED:

To meet the national deadline of 31st March 2011.

RECOMMENDATION(S):

That the Cabinet Member notes and approves the contents of the paper.

KEY DECISION:	No
FORWARD PLAN:	N/A
IMPLEMENTATION DATE:	N/A

ALTERNATIVE OPTIONS:

IMPLICATIONS:

Budget/Policy Framework: None

Financial: None

CAPITAL EXPENDITURE	**2009 2010 £**	**2010/ 2011 £**	**2011/ 2012 £**	**2012/ 2013 £**
Gross Increase in Capital Expenditure				
Funded by:				
Sefton Capital Resources				
Specific Capital Resources				
REVENUE IMPLICATIONS				
Gross Increase in Revenue Expenditure				
Funded by:				
Sefton funded Resources				
Funded from External Resources				
Does the External Funding have an expiry date? Y/N		When?		
How will the service be funded post expiry?				

Legal:

Risk Assessment: None

Asset Management: None

CONSULTATION UNDERTAKEN/VIEWS

CORPORATE OBJECTIVE MONITORING:

Corporate Objective		Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community		✓	
2	Creating Safe Communities		✓	
3	Jobs and Prosperity		✓	
4	Improving Health and Well-Being	✓		
5	Environmental Sustainability		✓	
6	Creating Inclusive Communities		✓	
7	Improving the Quality of Council Services and Strengthening local Democracy		✓	
8	Children and Young People		✓	

LIST OF BACKGROUND PAPERS RELIED UPON IN THE PREPARATION OF THIS REPORT

Department of Health (2010) *Equity and Excellence; Liberating the NHS*

Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*

Department of Health (2010) *Our Health and Wellbeing Today*

Strategy for Public Health in England

Background

Sefton Council and NHS Sefton have agreed to submit a joint strategic response to the *Healthy Lives, Healthy People White paper*. This White Paper outlines government's commitment to protecting the population from serious health threats; helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest

This White Paper responds to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* report and adopts its life course framework for tackling the wider determinants of health.

Summary

As part of the consultation and engagement process, briefing papers and presentations have been submitted to the Health and Social Care Cabinet meetings, to Overview and Scrutiny – Health and Social Care and to Overview and Scrutiny Management Board.

A draft joint strategic response that highlights key themes and provides responses to the consultation questions has now been produced.

A session was held on 14th March 2011 with elected members facilitated by the Overview and Scrutiny to provide an opportunity for wider discussion on the Public Health White Paper.

Following this session comments have been collated into this attached draft final response for submission to the Cabinet Member – Health and Social Care on the 16th March for agreement to be submitted into the National Consultation process

Sefton's Joint Strategic Response to the Public Health White Paper

Healthy Lives, Healthy People

Background

Healthy Lives, Healthy People builds on the NHS White Paper *Equity and Excellence: Liberating the NHS*, published in July 2010. The White Paper for Public Health outlines government's commitment to protecting the population from serious health threats, helping people live longer, healthier and more fulfilling lives and improving the health of the poorest, fastest.

It responds to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* report and adopts its life course framework for tackling the wider determinants of health.

The White Paper sets out a timetable for transition. Subject to Parliamentary approval of the Health and Social Care Bill, a new integrated public health service 'Public Health England' will be set up as part of the Department of Health, and will take on full responsibilities from 2012. There will be a new statutory duty for local authorities to promote and improve health of the population. Some of the public health function will transfer from Primary Care Trusts to local government, with ring-fenced funding allocated to local government from April 2013. The Director of Public Health will be employed by the local authority, jointly appointed with Public Health England.The Director of Public Health will be the principal advisor on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population. The Director of Public Health is accountable for health protection and will need to have access to resources of Public Health England to discharge this responsibility effectively. The Director of Public Health will also advise and support GP consortia on the population aspects of NHS services. There will be a new 'health premium' to reward progress made locally against elements of the new proposed public health outcomes framework. Local statutory Health and Wellbeing Boards will bring together the key NHS, public health and social care leaders in each local authority area to work in partnership. Health and Wellbeing Boards will develop joint health and wellbeing strategies, based upon assessment of need outlined in the Joint Strategic Needs Assessment.

Context

Sefton is a metropolitan borough of Merseyside. The borough consists of a coastal strip of land on the Irish Sea, extending from Bootle in the south, which is part of the Liverpool Urban Area, to the seaside town of Southport in the north. The district is bounded by Liverpool to the south, Knowsley to the south-east, and West Lancashire to the north-east.

Currently, Sefton's population is projected to be 272,100. Over the last decade (2000 -2010), Sefton has seen fewer families with young children and more young adults, including international workers. Over the next decade

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(2010 -2020), Sefton is projected to have fewer residents aged 15-24 years and 40-49 years and more residents aged 65+ years.

At present, Sefton has a working age population of approximately 162,124 people of which approximately 4.8% claim Job Seekers Allowance and 8.9% claim Incapacity Benefit, with large variations between wards.

Sefton has a total of 190 Lower Super Output Areas across the borough, 49 of these are in the 20% most deprived nationally and 19 are in the 20% least deprived nationally, this suggests that parts of the borough experiences above average levels of deprivation whilst others experience relative affluence. As a result of Sefton experiences high levels of health inequalities across the borough with as much as 9.6 years difference in life expectancy between wards a few miles apart.

Within Sefton there is an excellent history of partnership work between the Council, the NHS and the Local Voluntary Community Faith Sector and we welcome the prospect of developing this work further as a result of the new proposed system of health care.

Sefton MBC and NHS Sefton welcome the opportunity to respond to the consultation on the Public Health White Paper *Healthy Lives, Healthy People* and the two supporting consultations on a Public Health Outcomes Framework and Funding and Commissioning Routes for Public Health.

Sefton's response to *Healthy Lives, Healthy People*

Key themes

- *Public health returning to local authority*

Sefton Council and NHS Sefton welcome the proposal for public health responsibilities to return local government. Our health and wellbeing is influenced by a wide range of factors. Embedding public health within other areas of local government's work (such as housing, employment, the environment, transport, planning, children's services and social care) will help improve the health of all our residents. However, like many other local authorities Sefton is facing significant financial challenges over the next three years and we need to ensure resources coming with public health are sufficient to run an effective public health function.

- *Role of the Director of Public Health*

Sefton Council and NHS Sefton support the role of the Director of Public Health as principal adviser on all health matters, to the local authority, its elected members and officers. Building upon the existing success of the joint Director of Public Health appointment between Sefton Council and NHS Sefton, the future Director of Public Health will have direct influence over the wider determinants of health, helping to better assess local needs, promote more joining up of services and support joint commissioning.

Employed by local government, jointly appointed with Public Health England, the Director of Public Health will have direct accountability to both the local authority and the Secretary of State, through the new public health service. In light of this Sefton would like to gain a better understanding of how this dual accountability will operate. Currently, the Director of Public Health acts as an independent voice for population health and an influential leader. In balancing accountabilities across the Secretary of State, local council and the public health service there is concern as to whether or not these distinctive features of the role will be in conflict..

- *Life course approach*

Sefton Council and NHS Sefton welcome the life course approach to promoting health and reducing health inequalities that has been adopted in the new strategy. It is encouraging to see specific reference to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* report and the particular emphasis on 'giving every child the best start in life. Adopting this life course framework and Marmot's recommendations, particularly the concept of proportionate universalism, will help realise Government's commitment of improving the health of the poorest, fastest.

- *Prevention agenda*

Sefton Council and NHS Sefton are encouraged by the commitment to the prevention agenda and welcome the opportunity to build on good health and prevent people from living with ill-health. The use of the term health and wellbeing acknowledges the need to focus on the wider determinants of health as well as lifestyle factors. In our view Sefton Council is well placed to explore opportunities to embed ill-health prevention (such as within planning or housing), to make a real difference for local populations. Furthermore, Sefton embraces the shift in focus from what people are doing (e.g. drinking and smoking) to why they are doing it (e.g. lack of control, self esteem, self determination) and are encouraged by the opportunity to further utilise social marketing tools to better understand behaviour change and intervene more effectively to tackle the root causes and conditions of health; nudging people in the right direction

- *Health & Wellbeing Board*

Sefton Council and NHS Sefton are pleased that the Health and Social Care Bill confirms that local authorities will have a duty to establish Health & Wellbeing Boards, which will have a statutory footing. Sefton also approve that the Health and Wellbeing Boards will be the lead on improving the strategic coordination of commissioning across NHS, social care, children's services, public health services and other relevant services. We feel that this will play a crucial part in the future development of health and wellbeing in the borough.

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As we stated in the background / context section there is an excellent history of partnership working in Sefton across all sectors and therefore we value that the Bill states that the Health & Wellbeing Board should "encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner" and "encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board". However, we have concerns that the wording "encourage" does not go far enough to ensure partnership work is developed or give any accountability.

- *HealthWatch*

We appreciate in principle the development of the Local HealthWatch which will build on the Local Involvement Networks (LInKs) that already exist. We welcome that the Local HealthWatch will be the local consumer champion across health and social care particularly for vulnerable members of the community who may not be able to express their own views or exercise choice when it comes to health or care. We also embrace the scrutiny role that Local Authorities will have to ensure that the focus of the Local Health Watch activities is representative of the local community.

We seek further clarity about how the Local HealthWatch will be able to report concerns about the quality of local health and social care services to Health Watch England independently of their Local Authority and how this will result in a better service for the community as a whole.

As the Local authorities will fund the work of the Local HealthWatch and will contract support to help them carry out their work, we endorse the fact that they will be able to intervene and if necessary re-tender the contract for the support work of Local HealthWatch in the event of under-performance.

We seek further information on the legal duty that will be placed on Local Authorities to ensure that the activities and support for the Local HealthWatch are effective and value for money.

- *Ring-fenced public health budget(s)*

NHS Sefton agrees with the proposal to introduce ring fenced budgets in the spirit of the localism agenda. In order to ensure establishment of a new local public health service that is fit for purpose, ring fenced budgets will ensure sufficient funding is available however, as developments progress and priorities change, Sefton sees that this will become a matter that needs determining locally

Sefton MBC acknowledges NHS Sefton views on this mater, however disagrees with the need for any ring fenced budget and would welcome its removal. This would allow us to develop and deliver a truly local public health service that meets the needs of the community by delivering services which address the wider determinants.

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- *Public health outcomes*

Sefton Council and NHS Sefton recognise the use of outcomes, as opposed to process targets, as a positive development. The implementation of a new strategic outcomes framework for public health at national and local levels is supported and Sefton welcomes the opportunity to input into their development. Sefton Council and NHS Sefton acknowledge the five key domains– health protection and resilience, tackling the wider determinants of health, health improvement, prevention of ill health and healthy life expectancy and preventable mortality; however, it is felt that there are too many outcomes included. Further clarity is needed to determine whether by adopting the localism agenda all outcomes within the proposed national framework would be measured or would there be an element of local determination and how does this link to the new proposed health premium?

- *Public health commissioning routes*

Sefton Council and Sefton NHS acknowledge the commissioning routes outlined in the White Paper; however we feel that the proposed delivery model looks overly complex and disjointed. This is because the White Paper proposes that Public Health England will be responsible for funding and ensuring the provision of a number of services including health protection, sexual health, immunisation, obesity, health checks, child health promotion and some elements of the GP contract via three principal routes: funding local authorities; the NHS Commissioning Board and direct provision. Therefore there is the possibility that commissioning may become fragmented or result in the duplication of services as each of the three will commission different aspects of the same thing. For example services earmarked for commissioning by the Board include health visiting, the Healthy Child Programme for under fives, and the Family Nurse Partnership. With the Local Authority responsible for school nurses and over 5's Healthy Child programme. We feel that the under 5s prevention spend should be kept as local as possible to get synergies with wider children's services by commissioning all these services through the Local Authority. Similarly some aspects of sexual health will be commissioned centrally and some by the Council. Therefore we would welcome more clarity around areas of responsibility for each of the commissioning routes.

The new commissioning process will create supply opportunities for local companies and we will need to help companies become 'fit to bid' to maximise the 'Sefton pound' within the local community.

- *Training and development*

Sefton Council and NHS Sefton appreciate that the workforce strategy for public health is currently being developed and is to be published later in 2011. Within the impending workforce strategy Sefton is optimistic that training and continuing professional development will feature for all public health staff including for those working to consultant level,

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public health is everyone's business
building public health capacity for the future
to ensure that people reach the standards for the profession

- need the national training scheme – consultant level
- ensuring continuing professional development for currently trained staff
- training for the wider public health workforce across different sectors

need to work together across the sectors, particularly in times of reduced resources for example the compact training and development network – brief intervention training

the Council and the NHS organisations will remain substantial employers in Sefton and should continue to exercise a positive influence as a health promoting workplace, mitigating social and spatial inequalities by its recruitment and workforce development policies.

Consultation Questions

Healthy Lives, Healthy People: **Our strategy for public health in England**

A. **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?

Sefton MBC welcomes the roles and responsibilities outlined in the Department of Health Healthy Lives, Healthy people: Our strategy for public health in England. GPs have a vital role in ensuring that people are offered choice and control with regard to their health. However, it is unclear what role the Local Authority (LA) will play in the development of the GP consortia despite being the strategic lead for public health from 2013.

The relationship between the GPs, Local Authority and Health & Wellbeing Board (HWBB) will be vital in ensuring improved health outcomes for local people and reducing health inequalities in the borough. GPs and emerging GP consortia will require help to develop the skills, competencies and expertise required to deliver effective service development and clinical leadership. GPs will need to build capacity, be committed to improved public health and work cooperatively on health and well-being priorities highlighted in the JSNA, if local commissioning is going to be fit for purpose.

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

We welcome more emphasis on public health research and the opportunities to explore champions for public health in the community.

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

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

As a LA we will discharge responsibility for the management of available public health intelligence to HWBB. It is important that this evidence is made available at a local / neighbourhood level to enable local politicians to decide on service delivery in their area.

It is essential that the available evidence for tackling health inequalities is robust and can be evidenced in terms of case studies which can be replicated. The importance of using the evidence base not just 'good practice' needs to be recognised. It is important that these case studies are fully understood, not just what was done but also the social and cultural conditions which made them successful. Public health research needs consistent and continued investment and needs to be responsive to local needs. It is important to ensure the commissioners of the research include costings of interventions and health economic approaches.

Marmot (2010) describes a social gradient in health – the lower a person's social position, the worse his or her health. Evidence should be focused on reducing the gradient in health as a person's health inequalities result from social inequalities. Action on health inequalities requires work across all the social determinants of health therefore evidence should be collected across all of these domains. Additionally focusing solely on the most disadvantaged will not reduce health inequalities sufficiently and evidence should be collected across the whole borough at a local level. Having the evidence at a local level is critically important for local politicians to be able to challenge service providers. Additionally it is important that the data is at a neighbourhood level rather than borough level to ensure local variations are not masked.

There needs to be clear data / intelligence sharing protocols established to remove resistance about sharing data as this is currently a barrier. A "can do share" philosophy within data protection boundaries needs to be established going forward to ensure all partners have access to all of the facts when designing, delivering and monitoring services and their subsequent results on the health of the population.

Public feedback, consultation and monitoring are crucial to the development of a successful public health service going forward and methods of collating feedback should be built into the Commissioning Framework process. Additionally robust equality monitoring of users and services will help establish gaps in provision.

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Finally service providers must be commitment to change services to reflect the needs of the local area based on locally available data and intelligence.

E. **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?

The regulation of public health professionals is important as it provides the LA, partners and its wider community protection by ensuring competent public health professionals are registered and that high standards of practice are maintained. Having a register ensures that standards are set which can be monitored. It also means that a register of professionals is publicly available and that there are methods of dealing with registered specialists who fail to meet the necessary standards. To ensure that the LA, partners and the wider public are able to understand and have confidence in the registration process 1 combined register of public health professionals would be advantageous, rather than the current system of multiple registers depending on specialism, level of qualification or experience which may cause confusion.
The management of a voluntary register of public health professionals with robust standards and criteria may be best achieved by a National organisation rather than local independent organisations. There is a need for consistency across the UK to ensure that a postcode lottery of standards does not occur. This will also benefit LA when professionals move from one organisation to another across the country as the registration will be held in one central place.
We believe that the regulatory framework should be mandatory and managed at national level much in the same manner as social worker registration

As a LA, with the responsibility for public health and as the employer of public health professionals, Sefton MBC would not want to be responsible for the voluntary regulation of public health professionals, there needs to be a distinction between employers and regulators.

Healthy Lives, Healthy People: **consultation on the funding and commissioning routes for public health**

Question 1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

Ring fenced budgets should offer maximum flexibility in the spirit of the Localism agenda to allow partners to work together, to share budgets and commissioning to deliver effective and efficient services to meet the need of the local population.

One of the purposes of the HWBB is to improve the strategic coordination of commissioning of services across the LA area to improve public health and reduce health inequalities. The Board will bring together elected representative and the key NHS, public health, social leaders and patient representatives to work in partnership. This will ensure services are joined up around the needs of

people using them, and that resources are invested in the best way to improve outcomes for local communities. The board will be able to choose to do their work at whatever level "makes sense locally" focussing on the needs of specific neighbourhoods. The Board will provide a key forum for public accountability of NHS, public health, social care and adults and other commissioned services that are agreed relate to health and wellbeing. The Board will be able to look at the totality of resources available to support local people's health and wellbeing, across the budgets the NHS, LA and other partners, allowing them to make more use of the flexibilities already available to them – such as pooling budgets or having lead commissioning arrangements.

The HWBB will form part of the family of the Local Strategic Partnership (LSP) and will be able to look at the totality of resources in their local area for health and wellbeing. The HWBB will be able to consider how to prioritise health improvement and prevention alongside other health needs such as management of long term conditions. The aim is to improve health outcomes based on the Joint Strategic Needs Assessment (JSNA), a new Joint Health and Wellbeing Strategy (JHWS) and other wider evidence of the needs of the local people. This is important to ensure that the prioritisation of services to be delivered through ring fenced budgets and other resources balances the overarching universal need of the community, with identified health needs of individual communities and the specific Health and Social Care (H&SC) needs of groups within the community. It will be important that the allocations of such funding and other budgets offer maximum value for money (VFM) down to a neighbourhood level. The national formula for allocation of funding needs to reflect adequately the levels of deprivation within Sefton and take into account the demographics including the high elderly population in the north of the Borough.

Question 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?**

Firstly transparent communication and clear commissioning process will be required, allowing the HWBB toconsider whether the commissioning arrangements for social care, public health and the NHS, developed by the local authority and GP consortia respectively, are in line with the Joint Health and Wellbeing Strategy which meet the prioritised needs of our individual residents and the wider communities at large.

We welcome the extension of the duty regarding JSNA and the new Joint Health and Wellbeing Strategy, and envisage that that HWBB will work with all partners to develop a commissioning framework which supports and enables a competitive level playing field within the sector.

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It will be essential that those in the Voluntary, Community and Faith (VCF) and independent sectors are helped to gain the skills to enable them to have the capacity to compete in a market environment and that associated funding is available for this to take place. Allowing them to be able to operate on a level playing field with other providers in the commissioning process.

It will be critical to the development of a successful commissioning process that specific outcomes, including social value, to be achieved are detailed, supplemented by the necessary performance standards, measures and mechanisms to evaluate outcomes and ensure they are met.

It will be important that where providers, fail to meet outcomes, HWBB work with them in a timely manner to ensure the necessary improvement. However, where performance is not sufficiently improved and outcomes are not met, boards should have the mechanisms in place to consider the need to re-commission the service from an alternative provider.

Commissioning should be evaluated on an annual basis taking into account existing evidence, together with feedback from service users, to ensure that the commissioning of services continues to meet the needs of the population, is effective and value for money.

In addition, it will be important that service providers are able to evidence social return (SOR) on investment.

It will also be important to have a proportionate Commissioning Framework for the VCF sector as and that the HWBB recognise that one size does not fit all.

Finally it is important that GPs and subsequent consortia are educated to recognise the importance of the CVF sector in the future delivery of services.

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

Question 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**

The commissioning of the right services to improve public health that will reduce health inequalities in specific local areas whilst providing value for money will require strong partnerships between the Local Authority, GP consortia, HWBB and wider partners which will inevitably take time to form.

It is important that all NHS commissioning, at local and national levels is based on accurate and up to date local intelligence from a wide range of sources, including the JSNA. It will be vital going forward that the commissioning of services is based on the new JHWS to ensure services meet the need identified at a local level.

This commissioning process should be overseen through the HWBB and LSP who will be able to challenge and hold to account GP consortia and Local Authority..

The HWBB will be able to report back to the NHS Commissioning Board, GP Consortia and the local authority leadership local commissioning plans due not reflect the Joint Health and Wellbeing Strategy priorities. Subsequently the LA should be to be empowered to commission services locally by organisations who understand the cultural and social factors affecting people in a community.

Question 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?**

It needs to be fit for purpose as it is overly complex at the moment. It also needs to align with the local challenges and the JSNA.

Question 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?**

There is still work being undertaken nationally to establish the formula for funding local public health services. Until it is clear what level of funding is being proposed for Sefton it is difficult to agree these functions and services listed should be within the public health budget. Some services might be better commissioned locally via the LA such as contraceptive services for young people. Although there is still a need for national campaigns.

Question 7. **Do you consider the proposed primary routes for public health funded activity (third column) to be the best way to: a) ensure the best possible outcomes for the population as a whole, including the most vulnerable b) reduce avoidable inequalities in health between population groups and communities and if not what would work better?**

We feel the funding and commissioning routes matrix is complex and it is unclear how the proposed commissioning arrangements will be co-ordinated across the new systems nationally, regionally and locally.

Question 8. **What services should be mandatory for local authorities to commission?**

We welcome the opportunity to provide and commission some mandatory public health services because we feel that the health of our communities is influenced directly by their immediate environment and social circumstances.

As a LA we feel that we are able to use along with our many partners an inter-sectoral approach at a local level to improve health. By working with partners we have the power to create healthier environments to support behaviour change, for example by promoting and developing leisure facilities and parks, and using planning laws to limit the number of fast food outlets and betting shops. Early Years is a key priority of this government. It is important to develop supporting policy across government departments.

We would welcome the directive to provide or commission the identified mandatory services, including the Healthy Child programme as there is strong evidence base that it will improve health and wellbeing.

Functions of the Health Protection Agency

LA to work closely with Public Health England Health Protection Unit to provide health protection as directed by the Secretary of State for Health, e.g. providing training and mobilising staff for outbreak control. (***Environmental Protection***)

Immunisation

LA responsible for commissioning immunisation programmes primarily delivered through schools such as HPV and teenage boosters from a range of providers. (***Children's Services***)

Work with partners to coordinate immunisation responses during public health incident.

Sexual Health

LA responsible for commissioning comprehensive open access sexual health services including testing / treatment of STI's.

LA responsible for commissioning fully integrated termination of pregnancy services.

LA fund and commission contraception services for patients who do not wish to go to their GP or who have more complex needs.

Tobacco control, Obesity, Physical Activity, Nutrition

Smoking cessation services and other local tobacco control activities to pass to LA.

Obesity and physical activity programmes including active travel will become the responsibility of the LA. (***Leisure services***)

LA will become responsible for the National child measurement programme. (***Children's Services***)

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Local initiatives relating to nutrition undertaken / commissioned by LA.

LA responsible for workplace health at a local level.

Alcohol

LA responsible for commissioning treatment, harm reduction and prevention services for their local population.

NHS Health Check Programme

LA should commission the NHS health check programme with PHE responsible for design, pilot and roll out. NHS health check (5 year check for 40-74 years) will result in referral to lifestyle interventions commissioned by LA as above.

Early presentation and diagnosis

LA may wish to commission services (e.g. bowel cancer symptom campaign) from their ring fenced budget.

Reducing birth defects

LA responsible for areas such as nutrition, alcohol & smoking.

Dental Public Health

LA will lead on providing local dental public health advice to NHS, as well as commissioning community oral health programmes.

Public Mental Health

LA will take on the responsibility for funding and commissioning mental wellbeing promotion, anti stigma, discrimination and suicide / self harm prevention.

Public Health information and intelligence

LA will require a core of information and evidence capacity to support DsPH.

Communicating with the public will be a priority for the LA, providing people and communities within their areas the knowledge and understanding they need to challenge their local health system.

Children's public health

It is expected that in the long term health visiting (under 5's) should be commissioned locally. (***Children's Services***)

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Early Years is a key priority of this government. The importance of developing policy across DH and DfE and ensuring that the policies of respective departments support each other is very important.

Public health services (5-19 years) including mental health for children will be funded by the public health budget and commissioned by LA. (***Children's Services***)

Community safety, violence prevention and social exclusion

LA will be responsible for working in partnership to tackle issues such as social exclusion.

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

We welcome the suggestion of balance in any condition placed upon the grant to ensure maximum capacity for local decision making. However, it is important to ensure some essential conditions are placed on the grant to set out the process on spending decisions. It will be extremely important that these conditions are clearly set out by the DH to ensure the process is fair, open and transparent and does not result in a post code lottery of service delivery, ensuring consistency across all LAs. However, any conditions should be always kept to a minimum level to give freedom and flexibility to those commissioning services.

Guidance must be issued in a clear and transparent way that the wider community are able to understand, thus allowing the HWBB to manage expectation. Giving locally elected members the information they require to explain to their constituents what the community has the flexibility to influence.

Question 10. **Which approaches to developing an allocation formula should we ask the ACRA to consider?**

Understanding that more deprived areas have bigger challenges.

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

We would welcome a "Population Health Measure". However we feel that this measure should be implemented at a local area and not at a wider borough level. The measure should be applied to local neighbourhoods through the collection of relevant local health data, so that funding is not skewed by borough wide data which may mask different levels of inequality.

Question 12. Who should be represented in the group developing formula?

The organisations who should be represented in developing the formula are LG, Public Health, NHS Commissioning Board, Department for Education, Work and Pensions. However, it will be important to engage with the VCF sector and public at large via Health Link (HealthWatch) to ensure a balanced view in relation to developing the formula.

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

Need to look at trends and reward areas that make a difference in the most deprived communities. This could mean small areas within a local authority. Need to reward incremental change.

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

As per Question 15 below

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

We would welcome access to growth in health improvements budget linked to elements of the PH Outcomes Framework. However feel that it is important to consider the possible wider determinants at play which may prohibit improvement in health outcomes.

The WHO stated "The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status". They went on to say WHO "why treat people without changing what makes them sick", Marmot refers to these determinants as the "causes of cause".

Within Sefton there are a number of wider determinants affecting the health of different groups within the community including the affects of the recession and high levels of unemployment which affect communities disproportionately across the borough. It is these people who traditionally have the poorest health outcomes and are furthest away from targets set in the framework. Additionally evidence shows that the gap between the health of these and members of the community has widened in recent years despite the efforts to improve it.

It is predicted that there will be a lagged return to 2008 levels of employment by 2017 in Sefton and as highlighted above this will have a significant impact on

the health inequalities within and between communities. Any grant incentive programme needs to take this into account with a symbiotic relationship taken between health inequalities and growth.

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

The formula must be simple and easy to implement and not disadvantage local authorities that have significant entrenched health inequalities. Also please see question 15 above

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Healthy Lives, Healthy People: **Transparency in Outcomes**
Proposals for a Public Health Outcomes Framework

Question 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?**

The development of a JHWS that incorporates the relevant outcomes from the frame work and is based on local intelligence at a neighbourhood level will enable partners to work together on health and wellbeing priorities specific to them and there users. Giving them a common goal at a local area level, that is based on intelligence, feedback / consultation from patients, the wider public and VCF sector.

Additionally the outcome framework should be linked to the publication of the sustainable community strategy through the family group of the LSP.

On a broader level public health outcomes should become more widely incorporated into the agendas of all government departments / agencies and structures to ensure that partnerships evolve at all levels.

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

We welcome the criteria used to determine the indicators to improve public health and reduce health inequalities. We feel that the criteria incorporates a balance which will allow indicates to be both relevant at a local level whilst meeting the legal requirements indicated. We appreciate the use of data

collated and analysed nationally to reduce the burden on LA as well as the use of existing systems to monitor the indicator.

We feel that data produced at a Local Authority spatial level may mask health inequalities across an area which may be better addressed at a lower special level.

It is felt that indicators established using the criteria would result in evidence based interventions that include patient / public feedback and consultation whilst taking into account the legal duties for involvement.

Question 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?

We have a concern that children are not getting a high enough profile in PH service and the relationship between PH and children's social care is not explicitly mentioned.

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

We feel that it is the right approach to align commissioning frameworks for public health, NHS, and adult social care to produce the focus for the JSNA and JHWS from a whole systems approach. We also need to align frameworks to include children so that the life course approach is replicated.

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

Yes we agree with the 5 domains of health as outlined in the consultation

However Marmot describes a 6 domain which involves the "healthy standard of living for all" which is not incorporated into the framework. As a LA we feel that this a domain which requires associated outcomes.

We feel that the domains, subsequent frame work and outcomes should be written in such a way that the wider public can understand them. Additionally they should be written in language that empowers communities to help them self, where they become part of the solution rather than being passive and having things done to them.

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

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We would welcome some indicators on levels of patient and public involvement as well as more clarity on where local indicators fit in to the framework. We feel that there needs to be a balance between national indicators and what is deemed as a priority locally, identified by local neighbourhood level intelligence.

Question 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?

We think this should be locally determined according to locally identified priorities linked to JSNA

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

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

Ensure there is a short data time lag i.e within 12 months of the data age to be meaningful for planning.

Question 10. **Which indicators do you think we should incentivise? (Consultation on this will be through the accompanying consultation on public health finance and systems)**

The early years ones as there is a good evidence base of impact on later prevented spend

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

Good and could make whole partnerships accountable for the outcomes to ensure working together at the same pace.

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

A life course approach emphasises a temporal and social perspective, looking back across an individual's or a cohort's life experiences or across generations for clues to current patterns of health and disease, whilst recognising that both past and present experiences are shaped by the wider social, economic and cultural context.

We feel that the indicators do promote a life course approach as covering all of critical physical and social hazards during gestation, childhood, adolescence, young adulthood and midlife that affect chronic disease risk and health outcomes in later life. However transition from children and young people to adulthood is not well represented currently.

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