Amended Draft Corporate response to: Healthy Lives, Healthy People: Our strategy for public health in England

A - Consultation Questions on Funding and Commissioning

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

Response:
Yes but this will need clear accountability and a shared understanding of responsibility for delivery. CYC welcome the clarity around separate and reinforced scrutiny of health and wellbeing across the whole system.
CYC believes that the Health and Wellbeing Board should contain substantial representation from local councillors to ensure that there is appropriate democratic accountability for any such Boards. The GP Commissioning Boards should have clear links to the HWB in terms of the development of Annual Plans and the monitoring of performance. There should not be an opportunity for other sectors in the Health Service to undermine the policies and decisions of the HWB.
The Health and Wellbeing Board will need to consider these external influences to maximise health gain.

Question 2: How can local authorities best be encouraged and supported to commission on an any willing provider/ competitive tender basis? How can securing a wide range of providers best be achieved?

Response:
Local Authorities already have systems in place to challenge service delivery on best value. Councils' Financial Regulations encourage and require competition, where there is a market available. Councils will need to be able to ensure sufficient capacity within existing commissioning and procurement teams, and as part of this to maximise the opportunities for joint commissioning.
There needs to be a care to ensure that the prices offered are genuinely based on actual cost and not as loss-leaders to undercut NHS tariffs and to ensure that healthcare providers compete on the basis of measurable quality of care. There should be support, nationally or regionally, for local authorities to make sound judgements about the quality of provision, and in training for procurement officers to work in new fields of purchasing with which they may be unfamiliar.
Careful consideration needs to be made in terms of operating with the voluntary sector which needs support at this critical financial time, but which with encouragement can deliver a wide range of high quality services at efficient costs.
The silos between different parts of the NHS, Local Authorities, and private and voluntary providers need to be broken down as each has an impact on the others. There can be unintended consequences where a minor saving in one area can have a disproportionate impact in another area and in the worst case stops a service from happening. There needs to be wider consideration at a commissioning level of the knock on effects of decisions, and clear

monitoring by those who are in an empowered position to act, to prevent simple cost shunting to offload costs onto another part of the chain.
A framework for evaluating and benchmarking current providers of services would be useful, to help commissioners work with current and potential providers.
Market development is already an emerging area of good practice in other commissioning areas within the local authority, and it should be possible to draw on this work. Regional and sub regional working will also help to encourage new providers understand the opportunities that exist, based on local Joint Health and Wellbeing Strategies.

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 done?

Response:
Local authorities will wish to influence the commissioning of services through the main GP contract and will need to be able to develop local enhanced services as appropriate. This will require a relationship through Public Health England to the NHS Commissioning Board.

Responsibilities

Question 6: Do you agree Public Health England and local authorities should be responsible for funding functions and services in the areas listed in Table A?

Question 7: Do you consider the proposed primary routes for commissioning of public health funded activity (column 3) to be the best way to:
– ensure the best possible outcomes for the population as a whole; and
– reduce avoidable inequalities in health between population groups and communities?

Response to Q6 and Q7:
CYC supports the approach to transfer as much responsibility as possible to local authorities where there are clear links with the existing remits of local authorities (housing, leisure, education, social services) and would question why some areas remain with Public Health England, such as children's public health for the under 5s. There would need to be a strategic analysis of those functions that would most effectively transfer to a more local element of the NHS.
Reviews of the inequalities of health needs to take serious consideration of income, quality of housing, opportunities for active leisure, and exposure to environmental determinants of health. These need to be readily updated, and could be linked with Health Observatories in terms of measuring the effective outcomes of any future arrangements. Any changes has to be to the benefit of the health of a community.

Funding to local authorities

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

Question 10: Which approaches to developing an allocation formula should we ask ACRA to consider?

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

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

Response to Q9-Q12:
It is critical that local authorities receive appropriate funding to meet the public health duties transferred in April 2013. This should cover all of the areas set out as local authority responsibilities (lead and support), not just those determined as mandatory. CYC would expect that existing spend on these areas would be transferred in the first instance.
CYC receives in grant much less per head than the vast majority of councils, and therefore it would be unreasonable to perpetuate this disadvantage which has also been reflected in the per capita provision for the PCT which has undermined its ability to perform since its inception. There should be proper recognition of the demands on services, especially with an aging population who require more support than most.
The allocation formula should not be based on historic patterns of spend as these are not necessarily an accurate indication of need and may in fact be counter productive. Instead a combination of population health needs (including age and deprivation) and potential to benefit would seem appropriate.
The pace-of-change between the current spend and a target allocation should be as rapid as possible with the intention of each local authority receiving its target allocation within 3 years.

Health Premium

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?

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

Question 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?

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

Response to Q13- Q16:

CYC welcomes the use of public health outcomes to measure current and future success. If the outcomes are used to influence funding it is important that they are timely, accurate and robust over time. They need to be specific to the area in question ie there is a direct relationship between action and outcome and should not skew activity to those areas where the measurement of the outcome is easiest (eg measuring overall smoking prevalence rather than smoking cessation activity).

It will also be important to use outcomes in a proportionate way, considering the impact (size of affected population and resulting change), the balance (across different parts of the community) and the relative challenge (eg an incremental change may get harder the better the baseline).

B - <u>Draft Response to Consultation – Public Health Outcomes Framework</u>

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?

The council supports moves to recognise the wider determinants of health as represented by the proposed measures. The measures present a more holistic view of public health and seeks to show the important role decent, safe homes and neighbourhoods play in a persons' well-being.
Better housing can contribute significantly to improved public health outcomes and be cost effective. Every £1 spent on providing housing support to vulnerable people can save around £2 in reduced health service costs, tenancy failure, crime and residential care. Spending between £2,000 and £20,000 on adaptations that enable and elderly person to remain in their home can save £6,000 per year in care costs. We envisage the recognition of wider determinants to play a useful role in encouraging more joint planning and working towards shared outcomes

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

As a set of criteria these seem appropriate. The challenge will be in interpreting them when setting specific indicators.
Experience of setting outcome indicators suggests that there are a number of risks which need to be considered:

- Apparent improvements (or deteriorations) can in fact be fluctuations in relatively small numbers which are not statistically significant. There may be a knock on cost as sample sizes need to be increased to allow data to be collected at the right spacial level and frequency.
- Systems for data collection need to robust across partnerships
- Time lag can be a significant problem for setting and measuring targets.

Q3: How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

Some fields of activity will impact on individual behaviour over different time frames. Government should be mindful to assess the impact of some indicators over a not too short a period to get a truer picture of the longer term impact on health inequality.

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

The key issue will always be where boundaries are drawn between budgets and this is especially significant as between the three Government Departments whose budgets are involved.
It is also important to recognise other outcomes framework such as that for DfES or DCMS, for example when considering physical activity.

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

We broadly agree with the suggested framework and domains. The areas covered and overlaps between the domains should mean that all important Housing and Public Protection (i.e. environmental health) contributions can be properly included and recognised. Similarly we recognise our physical activity role across domains 3 and 4.

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

We are mindful of the government's intention to minimise the number of indicators required, so with this in mind we suggest there are perhaps too many indicators focused at the healthcare end of the public health scale.
On the other hand, the health protection and health improvement pillars might well be supported by more, appropriate, indicators. We suggest you might consider the following:

Housing Services:

- Domain 2 - Hazards within the home – i.e. Category 1 hazards as measured through the Housing ealth and Safety Rating System (HHSRS).

- Domain 2 - Housing Decency.

Public protection / environmental health:

- Domain 2 - Life years lost from air pollution as measured by nitrogen dioxide. Evidence presented to a recent House of Commons Environmental Audit Committee said that the number of premature deaths per annum could be as high as 50,000, and that for some particularly sensitive individuals exposed to the poorest air quality the reduction in life expectancy could be as high as 9 years. This means that in York up to 158 premature deaths per year may be attributable to air pollution. (House of Commons, Environmental Audit Committee – Air Quality, Fifth report of session 2009-10 Volume 1).

- Perhaps disappointingly, there is nothing about contaminated land. Estimates of historic industrial land use indicate that approximately 2% of land across England and Wales could be contaminated. This is

equivalent to 540 hectares within the City of York Council area. A review of historic maps and records has revealed 3,668 potentially contaminated sites in York. The council has a legal duty to assess all of these sites for contaminated land under Part 2A of the Environmental Protection Act 1990.

- Nor is there anything on clean drinking water. Private water supplies are likely to be more of an issue in rural areas.

- We think there should include a focus on climate change / carbon reduction within the Domain 1, Resilience and protection from harm - given the significant health threats presented by extreme weather events (flooding etc).

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 are several indicators that would be relevant to residents in terms of measuring the local quality of life and the direction of travel.

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

We support the move to a wider range of indicators recognising the wider determinants of public health. It would be a pity to lose this holistic vision.

Q9: How can we improve indicators we have proposed here?

We suggest the method for measuring overcrowding (Ref D2.3) should use the HHSRS not the Bedroom Standard.
We welcome the falls measure for older people in Domain 4 (Ref. 4.15), and wonder if this could be adapted to record falls arising from 1. poor property standards and 2. personal needs of the customer.
The rationale/description for measuring particulate matter (reference D1.3) seems totally impractical and too long term. How will anthropogenic and naturally occurring PM 2.5 be measured? Will this just be a matter of statistics or will local authorities be expected to monitor this pollutant? Few local authorities will have the ability, but we do at our air quality monitoring station at Fishergate, York.
The percentage of the population affected by noise (reference D2.16) maybe more difficult to assess as what is the definition of affected by noise? We are all affected by noise. The question is whether it has a significant adverse impact in terms of amenity, quality of life and most importantly, health. n.b WHO guidelines. Could this be collected via the number of complaints to local authorities (not all are substantiated)? This should be monitored annually, in line with other returns and statistics.
Work sickness absence rate (reference D4.6) - The suggested outcome indicator is the 'work sickness absence rate', collected by the Department of Work and Pensions. Another indicator that could be considered is the data sitting behind notifications made under the Reporting of Injuries, Diseases and

Dangerous Occurrences Regulations 1995. Data is collected centrally for this regulation and is an indicator of the health and safety of the working population.
We are pleased to see 5 x 30 minutes of physical activity for adults included but are concerned that there is no indicator for active young people.

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

We would like to see the falls prevention work, especially within the home, incentivised through the health premium and work around people with mental health and complex needs.
At the very least progress towards meeting health based air quality objectives should be incentivised, possibly via the "health premium".
We would be interested in ensuring that the mortality indicators in domain 5 are tackled by incentivising work in domain 3 (health improvement).
This has the potential for incentivising closer working relations between different parts of the Health Service and Local **Authorities to provide the most effective service provision to residents, local to them and at the most appropriate level. This has tremendous potential for improving quality of life with early intervention being promoted, and for reducing costs. There should be every encouragement for a National Wellness Service not a National Sickness Service.**

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

We support it.

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

Subject to our comments above we think the indicators do promote a lifecourse approach to public health.