By:	Graham Gibbens Cabinet Member for Adult Social Care and Public Health
To:	Corporate Policy Overview and Scrutiny Committee 31st March 2011
Subject:	KCC response to the consultations on the public health white paper, Healthy Lives, Healthy People and the associated documents on funding and outcomes.
Classification:	Unrestricted
For:	Information

Summary

1. (1) The Public Health White Paper - Healthy Lives, Healthy People – Our strategy for public health in England and associated documents - Consultation on the funding and commissioning routes for public health, and Proposals for a Public Health Outcomes Framework - have been issued for consultation by the Department of Health for responses by 31st March 2011.

(2) This report brings together the draft of a KCC response to all three consultations that has been considered and amended by CMT and Cabinet and is now before Corporate PO&SC.

Introduction

2. (1) The changes proposed in Healthy Lives, Healthy People are the most far reaching reforms of public health since 1974. They happen at the same time, and are linked to, the reforms to the NHS and adult social care now contained in the Health and Social Care Bill currently before parliament. The new structures are due to come into effect in April 2013, although shadow arrangements are expected to be in place much earlier. Commissioning responsibilities for public health activity will now be split between the new national organisation separate from the NHS, Public Health England (PHE), the local authority, and the NHS Commissioning Board:

Activities to be commissioned through PHE:

- Current functions of the Health Protection Agency
- National nutrition programmes (with some local LA activity)
- Emergency preparedness (supported by LAs)

- Health intelligence and information (jointly with LAs)

Activities to be commissioned through Local Authorities (including some that KCC already has full or partial responsibility for which are italicised):

- *Sexual health services (apart from contraceptive services)*
- School immunisation programmes
- Local initiatives to reduce seasonal mortality excess deaths
- *Local initiatives such as falls prevention services*
- *Mental health promotion, mental illness and suicide prevention*
- *Local activity to promote physical activity*
- *Local programmes to prevent/address obesity*
- *Drug & alcohol misuse services, prevention and treatment*
- Tobacco control
- NHS Health Check Programme (assessment & lifestyle intervention only)
- *Local initiatives to promote health in the workplace*
- Reducing and preventing birth defects (jointly with PHE)
- Campaigns and services to promote prevention & early presentation of cancer and long-term conditions
- Dental public health (supported by PHE for coordination of surveys)
- *Specialist domestic violence services*
- *Support for families with multiple problems*
- *Health intelligence and information (jointly with PHE)*

It is proposed that LAs are mandated to provide or commission a limited number of these services but it has not yet been determined which these should be.

Activities to be commissioned through the NHS Commissioning Board:

- Contraceptive services (via GP contract)
- Vaccine programmes for children
- Flu & pneumococcal vaccines for older people (including via GP contract)
- Targeted neonatal immunisations
- Screening (quality assurance and monitoring by PHE; cervical screening in GP contract)
- Health visiting services
- Healthy Child Programme for school age children (commissioned as part of health visiting services for under 5's)
- Public health care for those in prison or custody

(2) The proposals are extremely significant for local authorities both in terms of new functions and the funding streams that apply to them. The location of public health functions within local authorities is a very welcome development but we must be careful to ensure that the allocation of funding and the ways in which progress will be measured are fair to upper tier authorities in general and Kent in particular.

(3) Work is in hand to ascertain all the resources and funding streams for public health activity currently located within the PCTs. So far over £17m has been identified as being spent on health promotion activities across Kent. These include stop smoking services, healthy

weight services, health trainers, sexual health services, healthy schools, alcohol services etc.

(4) A report concerning the staffing and other transitional issues associated with the transfer of public health functions to KCC by the Director of Public Health is attached as an appendix to this report.

Consultation process

3. (1) This report concerns the KCC response to the consultation. Other organisations involved in public health have made their views and observations known and these have been considered and incorporated where relevant. However this does not replace the responses of any other organisations involved in public health in Kent.

(2) In order to compile the KCC response a cross-directorate working group was established and chaired by the Head of Public Health Policy. This has included active representation from all current KCC directorates and the Kent Forum team.

(3) A well attended consultation event was held with colleagues from district councils the NHS and KCC to discuss the main themes and issues contained in the papers.

(3) The deadline for submission to the Department of Health is 31st March. Usual procedure could include consideration by full cabinet but as there is no cabinet meeting in March KCC sign off is proposed to be by cabinet member following cabinet briefing on 21st March.

(4) Further consultations on specific public health topics will continue to be issued by the DH during the coming year.

Headline issues for Kent in the consultation papers

4. (1) This report does not summarise the main provisions of the consultation papers as for the White Paper this can be found in the initial report to CMT on 7th December 2010. Summaries of the other two documents are contained within this report. However there are some overarching headline issues related to each document that have informed the draft responses.

Healthy Lives, Healthy People

(2) For the white paper itself we welcome changes to PH system and location of PH function within the local authority which we have been advocating for some years. The transfer of a ring-fenced budget is also welcome. PHE being established as a separate entity outside the NHS is a positive move. Introduction of local accountability through involvement of elected members is important. However most details

and key issues are contained in associated consultations on funding and outcomes.

Consultation on the Funding and Commissioning Routes for Public Health

(3) The critical issue is how will the national formula for the main allocation of budget be decided? Kent's experience of nationally applied formulae is that they are often disadvantageous to Kent because of geography and population issues. Similarly how the proposed "Health Premium" is constructed will be critical if Kent is to benefit from it. In particular the population level at which both the basic formula and the health premium are calculated and applied will determine the financial consequences for Kent.

Proposals for a Public Health Outcomes Framework

(4) The population issues that inform the commissioning and funding responses are also critical in deciding which outcomes should be measured. This is also an important consideration in the application of the Health Premium. For an upper tier authority the ability to measure progress at a local level with a variety of indicators that properly reflect local issues and priorities is important. The ability to collect relevant indicators in year, in order to show progress to influence the application of the Health Premium is also an issue in many public health activities.

(5) In considering which outcomes we would support we have applied some basic principles: Does the measure have a direct relationship to the general health and wellbeing of the population? Can its measurement be both accurate and timely? Is it a measure that can be applied to a range of population groups?

SUMMARY OF PUBLIC HEALTH COMMISSIONING AND FUNDING PAPER

1. Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health

1) This consultation document complements the Public Health White Paper, seeking views on the functions and commissioning mechanisms for public health, the public health ring-fenced budget and proposed new health premium.

2. The Public Health System

1) Whilst central government will be directly accountable for protecting and improving public health through the new Public Health England. Wherever possible, functions will be devolved to local level. The key elements of the new system are:

- Public Health England (PHE) will be established, combining health protection and improvement functions.
- Responsibility for local health improvement will transfer from the NHS to Local Authorities
- Local Authorities (LAs) will employ Directors of Public Health and will be responsible for preventative services and some health protection functions.
- Health & Wellbeing Boards will be established in upper tier/unitary authorities, bringing together GP Commissioning Consortia, public health and social care, and Healthwatch to promote partnership and coordinate decisions about commissioning.

3. Funding and Commissioning Flows

1) Using a new ring-fenced public health budget, PHE will fund public health through:
   - Allocating funding to LAs (under s31 of the Local Government Act), which will be separate from the funding of existing health protection and public health functions they provide (e.g. housing, leisure and social care primary prevention).
   - Commissioning services via the NHS Commissioning Board (e.g. screening programmes), either directly or by GP Consortia, where 'activity is best commissioned as part of pathway of health care' or already part of primary care contracts.
   - Directly commissioning or providing services (e.g. campaigns & Health Protection Agency functions).

2) Some services will be commissioned at sub-national level, which could be through PHE or LAs e.g. services for victims of sexual violence. The broad funding flows are set out diagrammatically in s2.3 of the consultation.

4. Activities Funded & Proposed Commissioning Route

1) In defining which activities will be funded by the public health budget, the definition given by the Faculty of Public Health is used, account has also been taken of potential impact on health inequalities and decisions have been made on the premise that where ever possible, 'activity should be commissioned by local authorities according to locally identified needs and priorities'. The 'unique advantage' LAs have 'in terms of tackling the wider determinants of health' is acknowledged, in light of their wider functions and their knowledge of the needs of 'vulnerable groups' which will enable them to inform commissioning decisions.

2) Proposed activities and primary commissioning routes are set out against associated NHS-funded activities, so illustrating the boundary of the public health role and NHS activity, whilst acknowledging the interdependency and the fact that public health 'advice will need to be part of designing whole pathways of care'. All but 5 activities have associated activity funded by the NHS. Views are sought on all but a small number of activities and funding route proposals which will be determined through the Health & Social Care Bill. The paper gives further detail of the summary of activities and commissioning routes set out below:

Activities to be commissioned through PHE:

- Current functions of the Health Protection Agency
- National nutrition programmes (with some local LA activity)
- Emergency preparedness (supported by LAs)
- Health intelligence and information (jointly with LAs)
-

Activities to be commissioned through Local Authorities:

- Sexual health services (apart from contraceptive services)
- School immunisation programmes
- Local initiatives to reduce seasonal mortality excess deaths
- Local initiatives such as falls prevention services
- Mental health promotion, mental illness and suicide prevention
- Local activity to promote physical activity
- Local programmes to prevent/address obesity
- Drug & alcohol misuse services, prevention and treatment
- Tobacco control
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- Local initiatives to promote health in the workplace
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- Dental public health (supported by PHE for coordination of surveys)
- Specialist domestic violence services

- Support for families with multiple problems
- Health intelligence and information (jointly with PHE)

It is proposed that LAs are mandated to provide or commission a limited number of these services but it has not yet been determined which these should be.

Activities to be commissioned through the NHS Commissioning Board:

- Contraceptive services (via GP contract)
- Vaccine programmes for children
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- Targeted neonatal immunisations
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- Health visiting services
- Healthy Child Programme for school age children (commissioned as part of health visiting services for under 5's)
- Public health care for those in prison or custody

3) In addition, it is noted that to 'increase the incentives for GP practices to improve the health of their patients' it is proposed that 15% of the current value of the Quality & Outcomes Framework should be devoted to public health and primary care indicators. This will be 'cash-neutral' with new indicators replacing existing less effective ones.

5. Public Health Budget & Accountability

1) The Secretary of State (SoS) for Health remains accountable for health and social care resources, policy, legislation and progress against national outcomes, with PHE accountable to the SoS. Where services are commissioned by the NHS Commissioning Board on PHE behalf, clear lines of accountability will be established.

2) The overall budget for public health has not yet been determined. In determining ring-fenced budgets for LAs, health inequalities will be taken into account through weighting. The approach to determining the allocations formulae will be based on consideration of 'utilisation', 'cost-effectiveness', 'population health measures'.

3) Data on performance against the Public Health Outcomes Framework will be published by PHE, whilst Health & Wellbeing Boards will provide forums to enable co-ordination of commissioning, underpinned by 'a new health improvement duty' on LAs.

6. Public Health Premium

1) To 'incentivise action to reduce health inequalities' a new 'health premium' will be introduced. Payments will be determined by 'progress made in improving the health of the local population and reducing health inequalities', with greater premiums for progress in disadvantaged areas, 'recognising that they face the greatest challenges'. It will be a sliding scale, dependent on the 'size and extent of a local authority's progress and relative to the authorities position in terms of relative health outcomes'.

2) Early consideration of the commissioning and funding paper raises a number of issues for KCC. The calculation of the Health Premium needs to be at an appropriate geographical level (see briefing on the outcomes framework paper).

3) The amount of funding in the "ring-fenced" allocation has yet to be determined. The general assumption is that it will be c.4% of current PCT budgets (set at 09/10 levels to avoid issues of recent disinvestment in relevant activities). However this figure will include the PHE "top slice" for the activities for which they will retain responsibility, commissioning from the NHS and the Health Premium. The exact figure could be substantially less than previously anticipated.

   The consultations, including all questions and how to respond can be found at:
   http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122916

   The deadline for responses to the consultation is: 31st March 2011.

SUMMARY OF PUBLIC HEALTH OUTCOMES PAPER

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

1) The Outcomes Framework aims to reflect the collective responsibility of communities, local authorities, their partners and Government in improving and protecting health and wellbeing.

2) The aim is to focus on transparent health outcomes with 'top-down targets' being 'replaced by a new public health outcomes framework'. This is intended to increase accountability with an 'end to central control' and giving 'local government the freedom, responsibility and financing to innovate and develop their own ways of improving public health'. It should also promote the basic principle of the white paper

   "To improve and protect the nation's health and to improve the health of the poorest, fastest."

3) The outcomes framework should reflect the contributions made at national and local level, and across public services. It should promote joint working. It is not a top down framework to drive targets and performance management –it will set out the outcomes for public health across public services and at all levels of responsibility.

4) The framework should:

   - use indicators which are meaningful to people and communities;
   - focus on major causes and impacts of health inequality, disease, and premature mortality;
   - take account of statutory duties including equalities legislation
   - adopt a life course approach, and
   - as far as possible be based on evidence and data.

2. Purpose of the Outcome Framework

1) The Outcome framework has 3 purposes:
   - To set out government's goals for improving and protecting the nation's health and wellbeing, and for narrowing health inequalities through improving the health of the poorest, fastest;
   - To provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and
   - To provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

3. Indicators

1) A subset of indicators, agreed by the Department of Health, Public Health England and local government partners, will measure progress especially regarding health inequalities. Improving health inequalities in the area will attract a Health Premium payment in addition to the basic ring-fenced grant given to local authorities, designed incentivise councils.

2) The framework is organised as a set of indicators aligned to each of 5 domains.

   Domain 1 contains overarching indicators for all domains:

   - Healthy life expectancy.
   - Differences in life expectancy and healthy life expectancy between communities.

   These are key indicators for measuring the overall health of the population but suffer from the problem that they take a long time to show accurate results and trends. In order to track progress in shorter timescales other indicators will be necessary.

   The other 4 domains reflect important aspects of health and wellbeing and numerous examples of indicators are given which the consultation process is intended to whittle down to a manageable number.

   Domain 2: Health protection and resilience: protect the population's health from major emergencies and remain resilient to harm.

   Example indicator: Population vaccination coverage (for each of the national vaccination programmes across the life course).

   Domain 3: Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing.

   Example indicator: People killed and seriously injured on England's roads.

   Domain 4: Health Improvement: Helping people to live healthy lifestyles and make healthy choices.

   Example indicator: Prevalence of healthy weight in 4-5 and 10-11 year olds.

   Domain 5: Prevention of ill health: reducing the number of people living with preventable ill health.

   Example indicator: Breastfeeding initiation and prevalence at 6-8 weeks after birth.

Domain 5: Healthy life expectancy and preventable mortality: preventing people from dying prematurely.

Example indicator: Suicide rate.

It is intended that all indicators performance should be publically available.

All the examples are available in the document on the DH consultation website:
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

3) The outcomes are also intended to align with those for the NHS and adult social care, also recently issued for consultation.

   Early examination of the consultation paper suggests there are several important issues for KCC and other upper tier authorities:

   The geographical level at which the outcomes are measured will be critical. For Kent, which has some large areas of deprivation but also many more isolated, smaller pockets within districts, improvements in heath inequality need to be measured at a very local level.

   It is also important that the indicators do not generate a new data collection industry and can be aligned with those we will adopt for other purposes such as those for the Kent Forum. Indicators also need to be measurable and relevant.

   The proposed indicators contain a mixed bag of those that seem to make a lot of sense, some that reflect serious issues but are not in themselves necessarily good measures of general health and wellbeing, some that could be very useful if listed in a different domain, and some that do not appear to be indicators at all.

Conclusion

5. (1) This consultation exercise enables KCC to help influence the biggest change to public health provision in nearly 40 years. The decisions made on how these changes are implemented and the funding and performance issues associated with them will have profound effects on local authorities for many years to come.

(2) Corporate Policy Overview and Scrutiny Committee is asked to note the draft consultation response.

Appendices

- Response to Healthy Lives, Healthy People
- Response to Proposals for a Public Health Outcomes Framework (Introduction and questions 1 – 12)
- Response to Consultation on the Funding and Commissioning Routes for Public Health (Introduction and questions 1 – 16)
- Proposal for the Public Health Transition to Kent County Council – Report by DPH

Background papers – CMT report on Healthy Lives, Healthy People 7th December 2010

Meradin Peachey

Director of Public Health

21st March 2011

KCC CONSULTATION RESPONSE

Introduction to response to Public Health White Paper – Healthy Lives, Healthy People.

Kent County Council welcomes the White Paper's emphasis on the extensive contribution local government can make to the health of the population through its functions and it is right that the chief responsibility for public health should return to local authorities. We also welcome the opportunity to respond to the consultation on *Healthy Lives, Healthy People* and its associated documents as they herald very significant change and opportunities for local government.

In addition to responding to the specific questions posed in the White Paper there are a number of more general points we would wish to make.

Structure

The thrust of the White Paper and a number of its proposals were widely rehearsed and were also announced in the NHS White Paper "Liberating the NHS". However how the new public health system can be made to work will depend largely on the arrangements for funding and commissioning and the relevance of the outcomes selected. These will be addressed more fully in the relevant responses to the funding and commissioning and outcomes papers that have been issued since the White Paper itself.

The creation of Public Health England is a positive development and it's formal separation from the NHS is welcome. There remains a need for greater clarity of the relationship between public health, the NHS and GP consortia.

The extension of the role of the DPH is also positive as long as the post is properly located within the top tier management of the organisation.

We support the "non-silo" approach at both a national and local level – Public Health is everybody's business

Finance

Ring-fencing of the public health budget has many advantages but it must not be allowed to detract from local ability to determine priorities and funding. It is also important that the budget is not assumed to be committed to the continuance of existing services.

Dependent upon the measures adopted we broadly welcome the Health Premium but the relationship between premium payments and the base budget needs to ensure that does not lead to distortions whereby areas that need resources the most are disadvantaged by premium payments to more "successful" authorities.

Generally the expressed need for simplicity in the funding formula, premium payments and outcomes must be maintained.

It is important for local government to have the full resources to implement its responsibilities for public health. It needs to be recognised the significant responsibilities that DsPH currently have in health protection for the quality assurance of screening programmes, ensuring high uptake rates in all communities of screening programmes all immunisation programmes, commissioning, quality and ensuring high uptake rates in all communities. These functions are carried out by staff in our local public health teams and it is important that all these responsibilities are transferred to local government with the teams.

We support the transfer of health improvement resources to local government and the responsibility for commissioning these. We would like to see commissioning resources to be included within the ring fenced budgets.

Philosophy and approach

Health Inequalities are the most serious public health issue (even in what is often considered to be a relatively wealthy area such as Kent) and we welcome the emphasis placed upon addressing them. We are therefore pleased that the White Paper builds on the Marmot report and we have considered its proposals in the context of Marmot. However we note that the White Paper is silent on the Marmot recommendation "Ensuring a healthy standard of living for all".

We agree with the approach proposed in the White Paper as described by the 4 R's – responsive, resourced, rigorous and resilient. The emphasis on "nudge" rather than "nag" or "nanny" is a positive one and the ladder of interventions provides a useful framework.

We must also be sensitive to the need to balance use of current evidence with the need to build up evidence on the success (or otherwise) of the new approaches – nudge, social cohesion etc. in order to promote innovation.

The wisdom of Responsibility Deals remains controversial and KCC would wish to remain neutral on this point until there are indications as to their effectiveness or not. We would prefer them to be considered as experimental and be properly evaluated before any long-term commitment to them is made.

In response to the wider proposals set out in the Public Health White Paper we would propose that all training and education providers should ensure that the new approaches and emphasis in the Public Health White Paper and in the Marmot review - behaviour change, "nudge", building social cohesion and capital, supporting resilience – are reflected in the provision of all relevant programmes. This will include a range of training and education that is not specifically identified as a public health programme e.g. social work qualifications. The emphasis in the Health and Social Care Bill on localism and putting citizens in control should also feature strongly in training programmes.

KCC RESPONSE TO THE SPECIFIC QUESTIONS POSED IN HEALTHY LIVES, HEALTHY PEOPLE

Question a.
Are there additional ways in which we can ensure that GPs and GP practices will continue to play a role in areas for which PH England will take responsibility?

The involvement of GP's in developing and supporting Public Health is critical. Not only will they control budgets that can make a big difference to PH but it is essential that all elements of the health system become more integrated to be most effective at an individual and population level.

The availability of robust evidence based cost benefit analysis of prevention and public health interventions, with a particular emphasis on how it can support and reduce the necessity for primary and acute care, will be vital. PHE should lead on developing this analysis so that local health and wellbeing boards can use it to inform their JSNA and health and wellbeing strategies.
Involving GP's in the evidence base and data collection – using their local knowledge of the population they serve whilst recognising they mostly see part of it in particular circumstances may help engage them in a positive way.

How GPs can be incentivised to take on a greater role in public health interventions needs more thought. We welcome the idea of quality premium for GPs and would like to see public health outcomes feature prominently in them. Clear leadership from PHE, the NHS Commissioning Board and NICE about the contribution GP's are expected to make to PH would be very useful. In terms of GP outcomes both QUIPP and QOF should be configured to give incentives for positive public health outcomes.

There may some incentivisation for GPs on reducing the time they spend with the "worried well" by better public health information and messaging.

Another important aspect will be the integration of the outcomes frameworks for PH, the NHS and Adult Social Care which should operate as shared accountability measures. We strongly support the creation of the Joint Health and Wellbeing Strategy which will underpin the integration of Public Health and GP commissioning plans.

The role of the GP has predominantly been a medical one although GPs are well positioned and are often the first line of contact with patients whose social circumstances are likely to affect their health. There are many excellent examples of GPs taking a very active role in public health but some GPs may still see their role as treating the ill who present themselves at surgery. The target group for public health services needs to be expanded to include those who defer from attending the GP surgery, as they may be the very people who require early intervention or prevention. Whilst integration of commissioning plans and agreement to work towards the ambitions set out in the Health and Wellbeing Strategy will help GPs to take a more active interest in Public Health, PHE should consider how they can support and incentivise GPs to

take on a more preventative and population based approach. A considered and manageable approach to raising PH awareness, providing advice and identifying commissioning priorities for GPs to help them take on a greater PH role is needed. Ideally, support would be provided for GPs that is delivered in a structured and whole-systems approach. PCTs are currently working very closely with GPs; Local Authorities and other agencies need to be able to tie in with these development plans to ensure that the more integrated approach to health, public health and social care is developed. GPs need to be aware of other commissioning functions performed by the Local Authority within the community to maximise opportunities for referral and avoid duplication.

GP's may need some help in moving more to the social model of intervention to address health inequalities as Michael Marmot's report requires. GP engagement in the wider determinants discussion will be promoted by their inclusion on Health and Wellbeing Boards, their contribution to JSNAs and the Joint Health and Wellbeing Strategies and the integration of commissioning plans. In Kent we are working towards tying in Health and Wellbeing Boards to our local strategic partnership now rebadged as the Kent Forum. The Kent Forum is focussed on delivering outcomes on reduced resources and re-emphasising the leadership role of democratically elected Members. Central to the partnership arrangements is a core focus on the three Ambitions identified as central to the aims of the County, they are:

i) To Grow the Economy
ii) To Tackle Disadvantage and
iii) To Put Citizens In Control.

Tackling disadvantage and putting citizens in control are key to delivering the NHS and Public Health reforms. Public Health England should encourage, support and incentivise Local Authorities, GP Consortia and other key stakeholders to ensure that the public health agenda is central to the ambitions of the organisations

Screening programmes, immunisation and vaccination programmes and other services delivered by GP's will continue to be crucial and need to be maintained. The role of GPs and Local Authorities in delivering and supporting these programmes needs greater consideration

Shadowing arrangements across England could give us the opportunity to test how best to provide professional PH support to GPs – through PH staff working for GP Consortia or GP practices, through co-location, through development and use of PH referral pathways etc. PHE could usefully set up pathfinder arrangements that would evaluate these models and share good practice.

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

With emerging technologies and an appetite from the public for good quality information, there is an opportunity to be more transparent and open with the data and information that we hold. There is a need to balance the amount of information, to prevent information overload, with the quality of information to ensure consistency.

The availability, accessibility and utility of public health information and intelligence needs to be delivered at a National Level [Public Health England] and at a more local level. The National approach should enable comparisons and benchmarking and offer some level of quality assurance, whilst at a local level the information and intelligence can be more directive with greater interpretation and insight at a local level.

The Kent and Medway Public Health Observatory provides a very good example of how local information can be brought together and made available to all relevant organisations and the public. In response to the PH Outcomes Framework consultation response, we have made a case for the use of local indicators to support locally identified needs; support and funding for local observatories to support the localism agenda would be very welcome.

Also in the PH Outcomes we have asked for national guidance to be produced to clarify the expectations around information sharing across organisations. In Kent we have been developing our own model to promote information sharing that includes an Information Sharing Agreement which recognises the need for agencies to share personal information when appropriate to ensure services are effectively delivered. The Agreement provides a generic standard (including 'Golden Rules'), that must be applied when sharing information between parties. It is accompanied by Standard Operating Procedures that provide more detail on when and how information can be shared to support specific areas of service, for example crime and disorder. The Information Sharing Agreement will promote best practice in sharing information, provide clarity for staff on their responsibilities and allow organisations to share data more quickly and simply.

Organisations which have been invited to become signatories to the agreement include Kent County Council, District Councils, Police, Fire, Probation, South East Coast Strategic Health Authority, Eastern & Coastal Kent PCT, West Kent PCT, Medway PCT, NHS Trusts in Kent and Kent & Medway NHS & Social Care Partnership Trust. GP consortia will be invited to become signatories providing an important opportunity to enhance the availability and accessibility of public health information and intelligence.

This links to the "Open Kent" project which aims to facilitate the sharing and transparency of data across partner organisations. Data can be uploaded, downloaded and visualised in a number of presentation formats, such as

maps, charts and tables. For use by professionals and the public to disseminate and share data**.**

Tools that would organisations develop a more cohesive approach to websites would be very useful. In Kent we have developed Active Kent, which provides health advice to the public as well as practitioners. This is a web portal as well as being a promotional campaign which has helped to galvanise advocates of health in all sectors. If this approach was widely adopted it could create a consistent approach to information dissemination. .

There are a number of different solutions required at a national and local level to deliver efficient and effective public health information and intelligence which incorporates both clinical, service, demographic and wider determinates of ill health and social care. We would recommend establishing a set of core principles for the transparency and openness of public health information and technology, making use of best practices and exemplar organisations where accessibility to information has been successful. We would encourage investment in new technology, software and methodologies to ensure that the information and intelligence is relevant and up to date.

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

The key issue in using behavioural science is understanding how we should use the right type of intervention with the right group of people at the right time. Many approaches can be effective and the "Ladder of Interventions" is a useful model. PHE can assist and inform local action by developing case studies and disseminating best practice nationally. It could support a stronger focus on segmentation and social marketing, making more use of the media and utilising the skills of private industry in advertising and public engagement to provide a consistent and strong voice as an authority in health advice.

PHE should also work with NICE to develop recommendations for evidence based interventions on the key public health issues.

Public Health England should support research that all the approaches in the ladder of intervention are evidence based across a range of health behaviours and age groups. Public Health England needs to lead the policy discussion drawing on evidence based work that challenges practice and policy which leads to increased inequality and the poor health outcomes that result from it. Models that link increases in social inequity to increased costs to services and society need to be developed in to establish key principles on which policy decisions and central government and local government level can be made.

PHE should support and help evaluate demonstration projects that use behavioural approaches such as "nudge", that build on social capital and social cohesion or are designed to gain a better understanding of building on personal resilience. In Kent we have had great successes with projects such as Curves and Activmobs that used these approaches to promote greater physical activity, especially for those living in the more deprived communities. We would like a forum in which we can share our successes and also learn from other successful projects.

Public Health England needs to recognise and support the continuation of core harm reduction services which are key to reducing drug related harm. Access to sexual health services and smoking cessation services need to be examined to see how these can be best targeted and cost effectiveness assured.

Public Health England needs to promote inclusive housing support and employment practices and work to open up community settings to those who have until now been stigmatised as a result of their behaviours and poor health, especially mental health. Ultimately this requires that Public Health England provides a scrutiny role across Government Departments which will address the impacts on equality of the policies of other parts of Government

We would also welcome Public Health England engaging with the food industry in order to put pressure on the industry to improve nutritional content in all food, especially value brands.

There are many conflicting and constantly emerging sets of research about healthy eating, alcohol use and physical activity constantly appearing in the media that lead to confusion and disengagement amongst the target population. In particular we would highlight the judgement by the Chief Medical Officer regarding an alcohol free childhood. This has failed to be communicated across the population with confusion still remaining about a significant and clearly evidence based judgement. PHE has a role to clarify and explain the conflicting messages that people are being given so that they can better understand how lifestyle changes can be incorporated into their lives.

Young people who are involved in risk taking behaviours tell us that they have lots of information about drugs, alcohol and sexual health but want to have the opportunity to build their skills to ensure that they can make informed choices. We believe engagement in schools settings is vital. We are concerned that the White Paper will not be able to influence schools delivery of Healthy Schools and PHSE. Public Health England must be able to ensure that young people attain developmental appropriately life and communications skills which helps them put into practice the choices that they make and builds their self efficacy.

We fully support the use of Joint Strategic Needs Assessments to inform the development of all our strategies that have a health emphasis. Guidance should be given to ensure JSNA's include assessment of the assets and strengths of local communities and partners to ensure that programmes can be designed and delivered utilising the most appropriate and cost effective resources available.

We would welcome the support of Public Health England in engaging local partners to take more responsibility for education related to health issues, particularly that related to physical activity, substance misuse and sex and relationships. Without a determined and united approach from all government departments, schools are unlikely to prioritise this. In addition, we would particularly welcome promoting the evidence of health benefits of physical activity to GPs as part of patient care.

There are significant opportunities to harness Kent's partnership working. Kent would welcome the opportunity to develop evidence based case studies or act as a pilot under our focus on 'Tackling Disadvantage'. Such analysis would support Kent's work, identify key evidence for Public Health England and be valuable as a dissemination resource for other Local Authorities.

Analysis of the costs and benefits in altering the spending be helpful, especially those with a focus on switching expenditure from acute care to early intervention and a focus on prevention.

Question d
Public Health Evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

As mentioned in our response to Question b, Kent would like to see PHE develop a tool that would help all partners develop and evaluate public health projects. In particular we would like more support for smaller and demonstration projects that test out the new or more strongly emphasised approaches to public health interventions. Compared to medical models, the use and evaluation of projects that use behavioural sciences and approaches that aim to build on social capital and cohesion are still in their infancy. PHE should support a more programme based approach to small projects; lending expertise around evaluation techniques, use of social segmentation tools to scope projects etc would be very useful. A web portal that provides details of the projects that partners have completed and an honest (perhaps external?) appraisal of what worked and what didn't would help build up the evidence base.

With cuts in the public sector and budget squeezes on voluntary organisations and other stakeholders, we are in danger of losing the evidence base for small very localised projects. Not only might this lead to constant wasting of scarce resources, duplication of effort etc, we will miss the opportunities to share good practice and create a new system that is expected to promote localism.

Question e

If we were to pursue voluntary registration, which organisation would be the best suited to provide a system of voluntary regulation for public heath specialists?

We welcome the publication of the Public Health White Paper and the review of the regulation of public health professionals. We consider that it is essential to operate a professionally independent and independently assured regulatory framework for public health.

However it is disappointing that the review does not explicitly refer to the numerous responses submitted by a range of stakeholders during the review period.

The review's focus on the registration of specialist practitioners could jeopardise the growth and development of the wider public health workforce. A range of practitioners and specialists from a variety of organisations will be required to deliver the public health agenda. That agenda described by the Marmot Review ('Fair Society - Healthy Lives', Strategic review of Health Inequalities in England post 2010) demands shared development pathways that conform to clear shared standards for the wide range of workers involved in the delivery of public health. It is essential that a regulatory process is an essential element of professional development pathways.

It is unlikely that a single register model for medics and non medics will happen. How could the GMC manage the regulation of the wide public health workforce in addition? The UKPHR is well placed to provide this and has provided a robust regulatory process for a multidisciplinary non medical specialist public health workforce since 2003 for those not eligible to register with the GMC. This could continue and could include the voluntary registration of practitioners. Regulating practitioners below consultant level would only strengthen public health. There is a substantial unregulated public health workforce which in fact outnumbers the specialist/consultant workforce. This would ensure that all non medic registration would be in one place. Defined specialist registration should continue. It is likely there will be a greater need for Defined Specialists in the new structures

Currently the UKPHR process leaves much of the responsibility to employers for ensuring competent staff but that is also true of other disciplines e.g. pharmacy. This is a desired approach

Practitioners could be registered under Health Professions Council but that would separate the regulation of the profession into 3 regulatory bodies.

There is a case for the statutory registration of Directors of Public Health, consultants and Defined Specialists. However in practice registration with the UKPHR is currently, whilst not statutory, is mandatory in order to be considered for consultant posts.

Having only one route to registration is not viable. There will always the need for retrospective registration and alternative routes. Training and registration are linked but separate issues.

Both Option 1 and Option 6 are viable but this paper favours Option 1 the status quo with the UKPHR being the regulatory body.

Introduction to KCC consultation response on the funding and commissioning routes for public health

It is imperative that there is detail and clarity in the JSNA and Health and Wellbeing strategy so that roles are clearly identified, especially where there may be a variety of commissioning systems throughout the care pathway.

However, members of the public will not be concerned so much about **who** is commissioning, delivering or funding the interventions, but that they are accessible, flexible and commensurate to their needs, including having a joined up approach all along the care pathway. This will make demands on all stakeholders to ensure that there is continuity across services and that consideration is given to prevention at all intervention levels. Commissioners will also need to communicate service changes and improvements to the local population, to demonstrate community co-production in service redesign and incorporate views of the local people in evaluation mechanisms.

The Health Premium could serve well as an incentive to reduce health inequalities, as long as it is applied without prejudice to some of the local authorities where the greatest inequalities exists. Tackling disadvantage and reducing health inequalities are very important priorities but they are not the same thing.

Large local authorities such as Kent (serving 1.4 million population) can face different challenges than smaller authorities as the larger the population, the more likely the variance in range of health outcomes. For example, although the average life expectancy at birth in Kent is higher than the national average, there is a 16.6 year difference between the best and worst wards in Kent. Even in the district with the least difference (Tunbridge Wells) there is a 6.8 years gap between the best and worst wards which is a challenging gap to close.

KCC consultation response to the specific questions on the funding and commissioning routes for public health

Q1 Consultation question: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets

Yes, if this is not done at the Health and Wellbeing Board any alternative would merely replicate the Board in another form.

The ring fenced public health budget needs to be accessible to all partners in the commissioning of effective public health initiatives at a local level. In upper tier authorities such as Kent County Council effective arrangements must be put in place to ensure that public health and wellbeing interventions are commissioned at an appropriate population level and in accordance with local priorities. The role of the Joint Strategic Needs Assessment in identifying local priorities and the Health and Wellbeing Strategy that should articulate how these priorities will be addressed will be crucial.

Q2 Consultation question: 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?

Kent recognizes the value and imperative of the third sector's reach and engagement at community level. The inclusion and representation of the third sector will vary according to the range of local provision provided in their local areas, but their involvement should be included in the JSNA and Health and Wellbeing Strategy, with support to the third sector to provide equal opportunities to bid for contracts. The concept of "any willing provider" should enable voluntary organisations to be included in commissioning plans but it will also be important that smaller providers are able to participate, retaining their independence and without having to resort to forming large trust organisations.

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

The public health advice needs to be robust and based on good evidence and experience. This should include relevant NICE guidance for all partners including the NHS and GP Consortia which should be developed to include more public health and preventative issues.

The JSNA should be created in conjunction with Public Health information, data and analysis to ensure the identified priorities reflect the overall health needs of the population. These priorities should be addressed in the Health and Wellbeing Strategy which should identify the interventions required.

These interventions should relate to a holistic view of people's lives including their needs to be supported in healthy living in the community and not be afraid of being innovative.

Q4 Consultation question: 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?

Public Health England should have the opportunities for greater commissioning flexibility where services can be delivered better through other sources, particularly where local communities identify alternative preferences. The any willing provider principle should apply.

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

The biggest danger in trying to address health inequalities is that of improving health for all but not "improving the health of the poorest, fastest" and thereby increasing the inequalities gap within the overall improvement in the population.

It is important to ensure that there are adequate budgets to effectively support the public health agenda including tackling inequality outcomes. The ring-fenced budget will require support from other mainstream funding to address the wider determinants of health and this will depend on the effectiveness of the joint working arrangements, especially the Health and Wellbeing Board supported by the JSNA and the Health and Wellbeing Strategy.

Q6 Consultation question: 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

Yes, but as above (5), it is important to ensure that there are adequate budgets to effectively support the public health agenda including tackling inequality outcomes. Local Authorities rise to the challenge that public health needs to do more and work differently.

Q7 Consultation question: 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?

Successful Local Authorities are able to engage with their local populations and identify local needs and local issues. They should also be the voice of the local population and the opportunity to work more holistically in public health means that major issues in people's lives can be addressed which will

help define their lifestyle behaviours. These will vary between localities Local Authorities should also be aware of their most vulnerable groups and supra-level pockets of deprivation and inequalities which are sometimes masked at a district population level. By joining up local authority services, resources can be redesigned to provide holistic interventions when and where people need them, particularly throughout their life-course rather than stand alone service interventions.

The proposed routes would appear to provide a basis to deliver in the way intended to reduce avoidable inequalities but this will depend on the effectiveness of the Health and Wellbeing Board to ensure that the JSNA and Health and Wellbeing Strategy enables the public, private and voluntary sectors and the community itself to participate appropriately and effectively.

Q8 Consultation question: Which services should be mandatory for local authorities to provide or commission?

Mandatory service provision has the potential to undermine some of the core principles of the white paper. It has a tendency to create silos of activity around the “must do’s”. It can stifle creativity to deal with the wider determinants of health at a local level by imposing direct service provision rather than promoting commissioning.

Kent is a diverse county made up of many different types of communities with different issues, challenges and strengths. There is no “one size fits all”. Emphasis should be on outcomes rather than giving everyone the same services with local determination of priorities and solutions. A better approach would be to have a suite of mandatory outcome indicators around issues such as tobacco control, alcohol and drug usage, obesity and vaccination rates for children and young people.

The responsibility for screening and vaccination services should be transferred to local authorities to reflect the current involvement of local DPH’s (see also response to Q9).

It is not clear why responsibility for children’s health up to the age of 5 should lie with the NHS Commissioning Board and we would argue that this should also be located within local authorities.

Q9 Consultation question: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health or local authority?

That grant needs to be paid fully at the beginning of the financial year to assist in medium and long term planning.

The grant should be calculated on spend in 09/10 rather than 10/11 to ensure that acute savings imposed this year do not adversely affect the amounts granted.

All public health assets currently located in Primary Care Trusts should be included in the calculation. As well as budgets that support public health activity the commissioning resources should also transfer to local authorities. The resources that deliver the screening and immunisation programmes including staffing should transfer to local authorities along with responsibility for the function.

Indicative shadow budgets need to be issued as soon as possible so that clear commissioning plans can be prepared in the transitional years 2011-2013.

Q10 Consultation question : Which approaches to developing an allocation formula should we ask ACRA to consider?

"Utilisation" in Kent is skewed by problems in parts of the county with the weighted capitation formula and public health spending being cut in order to fund other parts of the health economy. Kent is also a large county, serving 1.3 million residents, with deprivation and inequality existing in patches across the county. Access is also an issue in terms of the wide geographical area covered (much of which is rural) and in terms of behaviour barriers to access. Utilisation would not therefore reflect the actual needs of some of our populations. Any current imbalances in utilisation between areas would become even more ingrained using this measure.

"Cost-effectiveness" is superficially attractive but as mentioned in the paper (4.5), evidence on cost effectiveness of public health interventions is not comprehensive. We need to be mindful that designing some interventions (particularly new ones) sometimes require significant investment at first with longer period pay back benefits. There is a danger that "most cost effective" comes to mean "cheapest" and this is a particular concern especially where there are challenges to reach the most difficult to reach and vulnerable in society rather than the low-hanging fruit and quick wins.

"Population Health Measures" – if they are applied at the right level of population we would agree that this provides the best available measure at the moment.

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

The issue of destabilising existing services through withdrawal of funding is the major issue. Additional "transitional" funding should be made available to cushion the rate of reductions for those that will suffer them, particularly those that have the most need.

It is anticipated that early improvements in reducing health inequalities will attract increased funding through the Health Premium.

KCC is a large organisation and would be able to manage the risk of being able to use "a rapid increase in the available funding" effectively.

Q12 Consultation question : Who should be represented in the group developing the formula?

Department of Health, Public Health England, Local Authorities (all tiers), GP representatives, health economists, public health observatories, economists who have understanding of demographic and social trends and implications, demographers, and members of the team that produced the Marmot Report into health inequalities.

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

Confidence that progress in the measures selected will ultimately show improvements in the overarching indicators eg. years of good health. (The question of what will happen if the "Health Premium" indicators show improvement year on year but this fails to be reflected in the overall measures of life expectancy and years of good health, or vice versa, is an interesting one).

Measures must be meaningful to people and communities.

Focus on major causes and impacts of health inequality, disease, and premature mortality

Measures must take a life course approach from minus 9 months onwards.

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

Consideration needs to be given to the particular characteristics of each area being evaluated. The premium needs to be able to relate to the issues and priorities of local areas at different population levels. If application of the premium fails to reflect the differences experienced by the various levels of disadvantaged populations in local authority areas it will skew funding and the ability to improve health inequalities.

Measuring actual changes in outcomes rather than levels of service provided is essential.

Health Inequality outcomes are very often measured across a long period of time which also masks social and economic changes. The issue of connectivity between the shorter term measures required for the health premium and the longer term outcomes such as all age, all cause mortality (see Q13) is a real one. One suggestion is that there should be a "health premium" that becomes payable over a longer period dependent upon progress in the overarching indicators.

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

Linking growth in health improvement budgets to progress on elements of the outcomes framework, could penalise areas that may find making progress most difficult. This could seriously disadvantage some areas and lead to increasing the health inequalities between areas that benefit form increased funding and those that do not – the opposite of improving the health of the poorest, fastest. This would merely compound any effect that failing to achieve the improvement required for the health premium may have.

The Health Premium alone could provide the necessary incentive, (but also see proposal for a longer term premium in Q 14) but national networking systems (such as Communities for Health) provide a good mechanism for sharing good practice and innovative ideas.

Q16 Consultation question: What are the key issues the group developing the formula will need to consider?

In addition to responses to questions 13-15, the formula requires sophisticated modelling of deprivation and disadvantage at a local level in order not to disadvantage large areas/counties such as Kent where significant local pockets of deprivation may be masked by apparent affluence around them. The size of the Kent population also needs to be considered to understand the relative level of inequalities that exists. For example, in some of the most affluent localities in Kent, Tunbridge Wells for example, there could be a disparity of 17 years life expectancy within that locality. Because this is not acknowledged, most national formulae applied to Kent have an inbuilt unfair bias.

Introduction to KCC's response to the consultation on public health outcomes

An Outcomes Framework that effectively describes progress on helping people live longer, healthier and more fulfilling lives whilst reducing health inequalities is crucial to ensuring we deliver the new approach set out in Healthy Lives, Health People.

We welcome the view that the Public Health Outcomes Framework must not replicate the approach of the previous National Indicator Set but think it is perhaps naive to think that publicly available data won't be used in organisation assessments. If plans go ahead for the health premium to be based on improving outcomes for some indicators, it would be impossible for these indicators not to be used as a tool for performance management. The flaws in the National Indicator Set shouldn't stop us from having an outcomes framework that can be used intelligently by us to assess our own performance and benchmark it against other similar authorities. An outcomes framework that could also be used by audit, CQC etc is not a complete anathema as long as the indicators are fair to all organisations and accurately describe progress in improving the health of the nation.

We would have like to have seen a greater emphasis on work being done with communities to improve social cohesion and build on social capital. The indicator proposed on Social Connectedness based on the "Citizenship Survey" is a welcome step in the right direction but is just one indicator in a list of 65. Similarly we would have liked to have seen indicators that identify and report on use and effectiveness of the "nudge" approach.

The essential truth that health inequalities are primarily a socio economic relationship is not well demonstrated in the proposed framework. For example, one of the most significant indicators of economic stability and better health prospects is good exam results which lead to greater employability. The absence of 5 GCSEs A*-C in the Outcomes Framework misses this important link.

Clarification of the legalities around data sharing between LAs and the NHS, especially with Public Health moving into Local Authorities is urgently needed. We would like to see urgent work on Information Sharing guidelines produced by the DH with help from Public Health England, NHS Commissioning Board and local stakeholders

KCC consultation response to the specific questions on the public health 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?

The framework must concentrate on outcomes for the population and not process or method. Accountability for achieving outcomes must be clearly defined between the NHS, National Public Health Service, Local Authorities

especially in two tier systems and GP consortia (perhaps through their quality outcome payments). This joint accountability must be reflected in shared outcomes between Public Health, Local NHS, Adult Social Care, Child Health. There should be an expectation that all partners are expected to contribute to achieving the desired outcomes.

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

We welcome the criteria given in Principles for Development; we would suggest further criteria need to be developed such as :

1. The level of impact that Local Authorities can have on some causes of poor public health is quite limited and the Outcomes Framework needs to reflect this. For example, global or national recession and resulting high rates of employment will increase stress related illnesses. Whilst Local Authorities clearly have a role in growing their own economy, they rely heavily on national policies and support to do this.
2. There is no mention or measure of access to health services nor quality of health services.
3. The set of indicators must be balanced to reflect a wide range of public health issues and stakeholders ability to impact them. It is important to remember the distinction between correlation and cause.
4. Data must be meaningful and valuable to the organisation that collects it
5. The set of outcomes must be balanced between those which are easily reportable in-year and those that are not. In terms of time lag, it may be useful to review where data seems to take a long time to be published to see if, nationally, this could be speeded up. This may involve new technologies or better prioritising around key data.
6. The cost of collecting data must be proportionate to its value; some data items may be very time-consuming and therefore costly to collect but the importance of the data outweighs this disadvantage.
7. Accountability for production of outcomes must be made clear; Local Authorities must not be asked to be data collection agencies for other organisations.
8. There must be regular review of the outcomes framework and criteria with input from stakeholders. We recommend that an advisory body of Local Authority representatives from both policy and statistical backgrounds and other stakeholders is set up to help ensure that Outcomes Frameworks are developed and reviewed to meet the needs of all organisations and the public.
9. The use of estimated data such as the Health Surveys for England should be discouraged in favour of local surveys following research governance framework standards
10. Data must be measurable at the right population level. This is particularly important to support the localism agenda where we will need to understand data at a very low level.
11. Indicators should not create perverse incentives. For example the need to achieve high numbers for the smoking 4 week quit has encouraged PCTs to concentrate on “low hanging fruit” and leave

tougher and sometimes more urgent cases, such as helping those who smoke during pregnancy.

Q3 Consultation question: 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?

We are concerned that the Health Premium and a weighted allocation will work against each other. Kent has long had issues with our allocation and we fear the PH allocation and health premium will exacerbate this. Kent is large with a diverse population - we have areas where deprivation is amongst the highest in England and areas where it is the lowest. We have areas of very high deprivation around our coastal areas that are made worse by high levels of immigration of already disadvantaged people. There are enormous challenges in improving the health of a poor and mobile society – a reduction in available budget to tackle this due to losing the health premium will further disadvantage this fragile population.

Kent's location also presents particular challenges – proximity to London raises our costs but as a peninsular authority we have fewer options for buying out-of-county services. London boroughs continue to place their poorest people within our authority especially in the eastern part of the County, driving up our service costs, increasing our population health needs and adding to health inequalities. Will the Allocation and Premium formulae be sophisticated enough to take these types of factors into account?

As a two tier authority, we are not clear what KCC will be held to account for and what districts will take responsibility for; many of the social determinants of health are under the control of District Councils whilst the health improvement workforce and commissioning resources will be with upper tier authorities. Whilst Kent has built up strong partnership working with the Districts, the significant cuts to budgets that will affect the Districts could lead to a reduction in funding in projects such as home improvements and fuel poverty and access to leisure centres and parks. These will have a significant impact on the health of the Kent population though KCC will have only limited powers (or resources) for mitigation.

A key issue for two tier authorities is at which level reductions in health equalities will be measured. The districts in Kent are of comparable size to many unitary authorities. Working on the needs identified in the JSNA and local priorities (and the agendas for choice, democratic accountability and greater public engagement through the new Local HealthWatch are all designed to usher in a more local approach) means that it will make far more sense to assess progress at a District level, though it should be acknowledged that even this level is sometimes too high and risks losing sight of real progress in tackling health inequalities. Where there is a national drive to improve particular aspects of public health, it might make more sense to measure at the county level.

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

We welcome this approach though would like to see more information on shared accountability for specific indicators.

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

The domains seem clumsy in that very similar indicators appear in multiple domains. In particular Domain 5 should be the outcomes of achieving good results in the first 4 domains. Some of the indicators within the domains are a concern – see response to Question 8

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

As mentioned in Q2, there are no measures of accessibility or quality of health services. As part of the GP outcomes, they could be set targets to get a high percentage of the population in their area on their lists, although this data would need regular data quality. Referrals to healthy lifestyle services from GPs would also demonstrate that they are actively involved in public health initiatives. A separate count of healthcare acquired infections would be useful for GP Consortia and the public alike.
A measure of responsible alcohol consumption would be useful and would be a good balance to alcohol-related hospital admissions. Similarly, it would be good to have an indicator that measured drug use as a balance to D3.7 numbers leaving drug treatment free of drugs

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?

V1 Life expectancy
V2 difference in life expectancy

D2.12 Statutory homeless households
D2.13 Fuel poverty
D2.14 Access and utilisation of green space
D2.20 Social Connectedness

D3.1 Healthy weight in 4-5 and 10-11 yr olds
D3.2 Prevalence of healthy weight in adults (assuming robust data)
D3.5 Physical activity for adults

D3.7 Numbers leaving drug treatment free of drugs (or even better, a new indicator for drug use prevalence)
An indicator on responsible alcohol consumption

D3.8 Under 18 conception rate
D4.8 Chlamydia rates

D4.4 Breastfeeding 6-8 wks after birth
D3.3 Smoking prevalence (but based on full local surveys not estimated from HSE)
D4.11 Maternal smoking prevalence

D3.9 Dental caries in 5yr olds

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

A lot of the proposed outcomes, whilst Public Health issues, are not causes of poor health, nor are they deeply impacted by PH work. It is important that the Outcomes Framework reflects where PH can make a reasonable difference.

D1.1 (interagency plans), D1.2 (health protection systems in place) and D1.6 (sustainable development plan) are sensible requirements but have no place in an Outcomes Framework
D1.3 Life years lost from air pollution. Data not robust enough, and accountability not clear.)
D2.21 Cycling participation – ignores other forms of exercise, data to hard to collect and the evidence for it being a good proxy for physical activity is weak, it shouldn't be included in the Outcomes Framework
D2.5, D2.6 Whilst truancy and offending may well impact on health, there is not a strong enough correlation for this indicator to be part of the PH Outcomes Framework.
D2.7, D2.8 Indicators that cover disability rely on a firm and agreed definition for disability that we just don't have so data is unlikely to be robust or comparable
D2.10 Employment of people with long-term conditions – not a significant enough cause of poor health to warrant inclusion in the PH Framework
D2.11 Domestic abuse – high reporting levels can be about good relations between police and population and/or good services available.
D2.21 Cycling
D4.1 unintentional and deliberate injuries to 1-5 yr olds. Again, this is an important indicator but PH should not be held to account for it. May be better placed in Children's Social Services Framework.
D4.12 An important issue and possibly useful for measuring public health failures but if data is only collected every 7 years, we would question its inclusion in the PH Outcomes Framework

Q9 How can we improve indicators we have proposed here?

By applying the criteria you have listed and that we have added to in response to Question 2 and by engaging with Local Authorities in developing and reviewing indicators. Being clearer about national priorities and balancing them against local priorities.

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).

Our preference would be to have a basket of indicators from which Local Authorities could choose the ones that most closely reflect the needs identified in the JSNA and the preferences expressed by local residents (see also comment in response to Question 3). These local indicators would be coupled with the big national priorities and/or overarching indicators such as life expectancy.

V1 and V2, life expectancy and difference in life expectancy (assuming timely data)
D3.1 Healthy weight in 4-5 and 10-11 yr olds
D3.3 Smoking prevalence (but based on full local surveys not estimated from HSE)
An indicator on responsible alcohol consumption
D3.5 Physical activity for adults

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

What is the purpose of a shared domain? Is the data on mortality robust enough to be clear about where the direction of travel is attributable to health improvements or lifestyle improvements? Where would accountability for late presentation to GPs and subsequent preventable mortality lie?

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

More work and emphasis on the social connectedness will better promote a life-course approach. Maybe include an outcome on volunteering once Big Society is more of a reality.