As Members will appreciate the three documents referred to in the report are important and have a lot of questions. Some key points are drafted below in relation to Healthy Lives, Healthy People under some of the questions posed, which the committee can consider, as well as add any other views it wishes to have reflected.

Consultation questions - Healthy Lives, Healthy People
(with initial suggested responses in italics)

a. **Role of GPs and GP practices in public health:** Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

*GP commissioners will need to equip themselves to understand through clear linkage with the JSNA which services are best suited to achieve improved public health outcomes and this must underpin their commissioning decisions. It is vital that all commissioned services eg acute services and maternity include a requirement to deliver health improvement interventions as part of routine care. This could include brief interventions for alcohol and smoking and referral to appropriate support for lifestyle change. GP commissioners must ensure that services are specified to include this and that performance is monitored.*

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

*There is a great deal of public health evidence and intelligence currently available the key issue is ensuring that it is used. This can be achieved by ensuring that all commissioners are supported by public health specialists and that this support is integrated into local structures and processes eg GP consortia rather than being provided from afar.*

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?

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

*There is a growing evidence base of preventive intelligence in Children’s services [and in DoE] to which PH evidence nationally could usefully provide a read across*

e. **Regulation of public health professionals:** We would welcome views on Dr Gabriel Scally’s report. If we were to pursue voluntary registration, which
organisation would be best suited to provide a system of voluntary regulation for public health specialists?

In addition to the White paper a supplementary document *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health* has specified an additional 16 questions which follow:

**Q1** Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

*More critical than just bringing them together is the need for clarity about the resources that will be available and the expectations around them. Important to be clear about the governance arrangements for HWB boards but they could be a useful place to consider funding.*

**Q2:** What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

*Through inclusive local commissioning arrangements with local providers and through a willingness of the sector to operate in partnerships to offer themselves forward as possible providers able to deliver [and be open to being monitored] health outcomes*

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

*It is imperative that public health specialists are an integral part of the GP Consortia structures and processes in order to ensure that public health advice informs decisions. Similar input will be needed by the NHS Commissioning Board.*

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

*Most of the services listed are population based screening or vaccination programmes. Any commissioning arrangement must reflect the need to be able to identify the target population and ensure that services are provided. The registered list basis of general practice makes them well suited to providing this service. Flexibility in commissioning arrangements would be needed where specific groups need a different approach to ensure uptake of services.*

**Q5** Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?
Q6: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

The list includes services and activity that impact directly on public health. However it includes interventions that are not currently generally NHS funded but are local authority funded eg improving the built environment to increase physical activity, seasonal mortality interventions and intensive family interventions. If the grant is derived from current NHS expenditure on public health but has to cover a much wider remit then it will be inadequate unless it also includes funding from current local authority funding streams.

Whilst it may be appropriate for the public health budget to fund these areas there is a risk that commissioning may not be co-ordinated. For example the Human Papillomavirus (HPV) programme would in part be commissioned via the NHS Commissioning Board and in part by the Local Authority. Where services are commissioned from GPs by the LA eg Health Checks this will result in them having to deal with separate commissioners and a less co-ordinated and efficient approach for commissioners.

Q7: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
   a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and b) reduce avoidable inequalities in health between population groups and communities?
   If not, what would work better?

There isn’t any evidence to suggest that this approach will be better than any other at improving outcomes and reducing inequalities. However where commissioning decisions are made more locally then there is greater ability to identify and understand inequalities and work with communities to address them.

Where any area of activity has more than one funding route then responsibilities must be clear. Some of the descriptions are vague so there is plenty of scope for dispute between commissioners.

Q8: Which services should be mandatory for local authorities to provide or commission?
Service provision should be largely determined locally but we would support mandatory provision of sexual health services.

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

There should be a clear description of the mandatory services and other areas that should be funded through the grant. The grant should not be used to fund current local authority responsibilities. Expenditure should be prioritised through a process led by the Director of Public Health to ensure
that it is in line with the strategic priorities in the JSNA and Health and Wellbeing Strategy, based on evidence of effectiveness and value for money.

**Q10:** Which approaches to developing an allocation formula should we ask the Advisory Committee on Resource Allocation (ACRA) to consider?

We support the use of population health measures and that these could be used to develop a number of components to the grant. This will allow the diverse nature of local populations to be reflected in the allocation.

**Q11:** Which approach should we take to pace-of-change?

This should depend on the distance from target across authorities. It can be difficult to accommodate rapid funding changes in either direction so this should be avoided.

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

**Q13:** Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium? Addressing health inequalities requires a whole system approach. In the short term secondary prevention initiatives will have the quickest impact on mortality rates – these are not within remit of local authorities. The interventions that are within the local authority remit achieve impact on mortality in the longer term. Measures that reflect other impacts in the short term should be included within the premium eg smoking rates in areas of greater deprivation.

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

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

Only if the elements chosen were significantly within the influence of the local authority.

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

To ensure it is sensitive enough to reflect the varied local needs and that proposed incentives are not impossibly challenging so as to act as a disincentive.

The proposed **Public Health Outcomes Framework** has additional questions to respond to:
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?

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

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?

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

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

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

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?

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

Q9 How can we improve indicators we have proposed here?

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).

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

This is a sensible approach in that both sectors contribute to influencing these outcomes.

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