Agenda item:

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Cabinet
Date:	28 March 2011
Title:	Update on NHS Reforms and Plans for the new Health and Wellbeing Board
Reference:	2541
Report From:	Director of Adult Services and Joint Director of Public Health

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1. Summary

1.1. This report updates Cabinet on the developing NHS reform programme and how it impacts on the County Council. It also covers the outcome of the *Liberating the NHS* White Paper consultation process and sets out proposals to put in place a transitional Health and Wellbeing Board. It updates Cabinet on arrangements for Local HealthWatch and future health scrutiny powers in local authorities. It informs Cabinet of the County Council's collaborative work with NHS Hampshire (the PCT) to manage the transition to GP commissioning and the transfer of public health responsibilities to local government. Suggested draft responses to the consultations linked to the Public Health White Paper, *Healthy Lives, Healthy People* are attached as an appendix for Cabinet's consideration prior to the closing date of 31 March 2011.

1.2. This report will also be considered by the Board of NHS Hampshire.

2. Contextual information

2.1. In September 2010, Cabinet received a report outlining the implications of the NHS White Paper, *Liberating the NHS*, and setting out a proposed County Council response to the White Paper consultation. Cabinet agreed the consultation response and also approved recommendations that:

a) work should commence to put in place arrangements for a new Health and Wellbeing Board building on the existing Health and Wellbeing Partnership Board;
b) that Hampshire County Council should work in partnership with Hampshire Primary Care Trust (PCT) to manage the transition; and

c) that the County Council would seek to work with GPs to support their emerging new commissioning responsibilities.

Cabinet requested a progress report early in 2011.

2.2. In December 2010, Government published *Liberating the NHS: Legislative framework and next steps* (its response to the Health White Paper). This was followed in January 2011 by the Government's Health and Social Care Bill.

2.3. The policy drive behind the NHS reform programme presents a number of challenges and opportunities for both local government and the NHS. The proposals are intended to deliver a more local and personalised system for health, promoting a real integration with social care, better value for money and better outcomes. The principle of 'no decision about me without me' and the link to the Government's localism approach mean that there is an enhanced role for local government and the democratic process, alongside the NHS in health delivery.

3. Outcome of the *Liberating the NHS* White Paper consultation process

3.1. The Leader of the County Council wrote to the Secretary of State for Health on 9 September 2010 setting out the County Council's views on the White Paper proposals and a formal consultation submission was also made. Encouragingly, many of the County Council's concerns with the proposals have been reflected in the Government's response.

3.2. In summary, the main modifications to the original proposals are that the Government will:

a) Strengthen Health and Wellbeing Boards in local authorities, making them statutory, with a new responsibility to develop a 'joint health and wellbeing strategy' spanning the NHS, social care, public health and potentially other local services.
b) Start an earlier phased approach to the introduction of GP commissioning, with a programme of GP consortia pathfinders (there are two in Hampshire: one in Basingstoke and one in South East Hampshire).
c) Introduce an early implementer programme for Health and Wellbeing Boards to accelerate progress.
d) Increase transparency in commissioning by requiring all GP consortia to have a published constitution and making consortia more accountable to the public through various measures.
e) Retain and strengthen separate local authority health scrutiny functions (not merging them into Health and Wellbeing Boards).
f) Phase the timetable for the requirement on local authorities to commission NHS complaints advocacy, and allow flexibility for this service to be commissioned from other organisations as well as local HealthWatch.

4. Health and Wellbeing Board

4.1. As set out in the Command Paper *Liberating the NHS: Legislative framework and next steps* and confirmed in the Health and Social Care Bill, all upper-tier

authorities are required to establish a statutory Health and Wellbeing Board, as a committee of the local authority appointed under section 102 of the Local Government Act 1972. The Health and Social Care Bill sets out the minimum statutory membership for the Board.

4.2. The core purpose of the Board will be to lead on improving the strategic coordination of commissioning across NHS, social care, and related children's and public health services. The Board will increase the local democratic legitimacy of NHS commissioning decisions and bring together the key NHS, public health and social care leaders in Hampshire to work in partnership.

4.3. Although the Board will not assume its full statutory responsibilities until 2013, there is an expectation that local authorities will put in place transitional arrangements during 2011 and that Boards will be operational from 2012. It is therefore proposed that a Transitional Health and Wellbeing Board be established from April 2011, with its first meeting taking place in June 2011. A joint development plan would be put in place to support the work of the Board.

4.4. It will be essential for the transitional Board to be established in a way that ensures it is able to provide leadership and make a real contribution to integration of commissioning in Hampshire. Until the legislation is enacted there will be a need for the Board to reflect both County Council and PCT governance and constitutional arrangements.

4.5. On 27 January 2011, the Department of Health wrote to all Leaders and Chief Executives of upper tier authorities to invite them to join a network of early implementers for Health and Wellbeing Boards. Hampshire has submitted an expression of interest in being an early implementer, as this would provide an opportunity to share learning with other authorities and work through some of the challenges in parallel with other areas.

4.6. It is important to ensure that the Board is able to represent and influence all elements of health and wellbeing provision and potential spend in developing a Health and Wellbeing Strategy that will reflect the needs of the people of Hampshire.

4.7. Hampshire's existing Health and Wellbeing Partnership Board, which includes all of the district and borough councils, has worked successfully and it is important to build on this partnership approach at a local level alongside the emerging GP consortia across Hampshire.

4.8. Membership will need to be reviewed prior to the formal transfer of duties on 1 April 2013. It is anticipated that the PCT representatives will be replaced by a representative of the NHS Commissioning Board during this time period. Further details about the purpose and objectives of the Board are set out in Appendix C.

5. Local HealthWatch

5.1. The White Paper proposed to evolve existing Local Involvement Networks (LINks) into a new organisation called HealthWatch, which would operate both at a national level and have a local organisational form. Local HealthWatch will ensure that the views of patients, carers and the public are

represented to commissioners and provide local intelligence to their national body, HealthWatch England. Local authorities will also be required to commission advocacy, advice and information services to support people if they have a complaint and to help people make choices about services. Local HealthWatch may be commissioned to provide this support, which has to be in place for 2013/14, but other appropriate local organisations can also be considered.

5.2. The funding for Hampshire's existing LINk will continue through the transition into Local HealthWatch in 2012/13, albeit at a reduced rate in line with the outcome of the Government's Comprehensive Spending Review and Local Government Settlement. Local authorities will then have unring-fenced funding for HealthWatch built into their existing allocations, including additional funding for NHS complaints advocacy and providing advice and information for people making choices.

5.3. Hampshire's existing LINk contract with the host organisation HAP UK comes to an end in March 2011. Arrangements are in hand to manage the transition process prior to the launch of Local HealthWatch.

6. Health Overview and Scrutiny

6.1. Following significant opposition from many consultees (including Hampshire County Council), the Government has amended its original proposals and local authorities' health overview and scrutiny (HOSC) functions will not now be subsumed within Health and Wellbeing Boards. The legislation now gives local authorities a new freedom and flexibility to discharge its health scrutiny powers in the way it deems most suitable. To enable this flexibility, the Health and Social Care Bill confers the health overview and scrutiny functions directly on the local authority itself.

6.2. The Bill retains the existing rights of the HOSC in relation to consultation by the NHS as well as referral to the Secretary of State for Health and access to information. The current accountability of health services to the HOSC is extended to include 'any NHS funded service': this will include GP Commissioning Consortia and the private sector.

7. Changes in health commissioning

7.1. The NHS Operating Framework for 2011/12 was published in December 2010. This gives guidance for Primary Care Trusts on the organisational and commissioning arrangements that need to be put in place in the lead-up to responsibility for NHS commissioning being transferred to GP consortia. The consortia will have shadow budgets in 2012/13 and full budgets in 2013/14.

7.2. In order to realise efficiencies and manage the transition to GP commissioning effectively, PCTs will be reorganised into clusters by June 2011, led by a single Executive Team, which will oversee work up to April 2013. The function of each cluster in relation to local government (as set out in guidance released by the Department of Health on 31 January) will be to:

a) Oversee continuity of effective local joint working and engagement with patients, communities and marginalised groups

b) Oversee the development of local Health and Wellbeing Boards

c) Work with local public health and local authorities on development and use of Joint Strategic Needs Assessments

d) Ensure resilience of emergency planning structures

e) Work with the Department of Health on creation of local elements of the new public health service

f) Work with the Department of Health and local partners on effective development of HealthWatch.

7.3. Hampshire PCT will be clustered with the PCTs of Southampton, Portsmouth and the Isle of Wight. The Chief Executive of the single Executive Team for this cluster is shortly to be appointed. Early indications are that PCT clusters might become the local presence of the National NHS Commissioning Board from 2013.

7.4. During 2011/12 and 2012/13, PCTs will receive specific allocations to support social care. They will be expected to transfer this funding to local authorities for spending on social care services to benefit health and to improve health and social care outcomes. As part of the NHS QIPP (Quality Innovation, Productivity and Prevention) plan and Hampshire County Council budget setting senior officers from Hampshire PCT and Adult Services are working together to agree appropriate areas for social care investment and expected outcomes, and joint work to achieve these.

7.5. The County Council and PCT are also collaborating on plans to improve the effectiveness of adults' community health and social care commissioning across the two organisations prior to GP Consortia taking over many aspects of NHS commissioning from 2013. Although health and social care commissioning are addressing different aspects of a client's needs, there are often significant overlaps where improvement and efficiencies could be realised through a comprehensive and robust joined-up approach.

7.6. The ambition is to create a single joint commissioning team, with staff from Hampshire County Council and the PCT working together to commission community health and social care services for people with a learning disability, and people with substance misuse and mental health needs. The team would also have a strong focus on developing integrated and enhanced models of care and support across community health and social care to support the 'out of hospital' model of care across Hampshire. This would become an offer to the emerging GP Commissioning Consortia as an efficient approach to commissioning community health and social care services.

7.7. Children's commissioning arrangements are currently overseen by a joint commissioning board. There are similar ambitions to develop integrated services in a range of areas including children with disabilities and special educational needs, placements for children with complex needs, therapies and children's mental health services. The joint commissioning board forms

one of the sub-groups beneath the Hampshire Children's Trust Board (www.hants.gov.uk/childrens-trust).

7.8. There may also be further opportunities to look at new models of organising staff and outcomes with our health partners so that we can all benefit from future collaboration and aggregation, reduce our overhead costs and contribute to the objectives of other public sector organisations.

8. Public Health

8.1. The Public Health White Paper, *Healthy Lives, Healthy People*, was published on 30 November 2010. This provides further detail about the plans to establish Public Health England and to transfer significant public health functions to local authorities with a ring-fenced public health budget.

8.2 Faculty of Public Health (a faculty of the Royal College of Physicians) has defined public health as: "The science and art of preventing disease, prolonging life and promoting health through organised efforts of society" (Sir Donald Acheson, 1988).

There are three domains of public health:

- health improvement (including people's lifestyles as well as inequalities in health and the wider social influences on health);
- health protection (including infectious diseases, environmental hazards and emergency preparedness);
- health and social care service improvement (including evidence based service planning, efficiency, audit and evaluation).

8.3 Public health considers all aspects of the business of a local authority. The new public health responsibilities for local authorities are described in most detail in terms of the role of their director of public health (DPH) *(Healthy Lives, Healthy People)*. It must be noted that existent statutory public health responsibilities for local authorities remain intact.

a) Subject to the passage of the Health and Social Care Bill, the DPH will be the principal adviser on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population. They will be the strategic leaders for public health and health inequalities in local communities.

b) Directors of Public Health (DsPH) will be responsible for the health improvement functions of upper-tier and unitary authorities and will be required to prepare an annual report on the population's health. To meet these responsibilities, DsPH will need to discharge their functions in a number of ways, ranging from direct responsibility for achieving public health to advising colleagues and partners on public health. They will need to be supported by a team with specific public health and commissioning expertise.

c) The DPH will be responsible for ensuring that the local authority and its key partners have access to the high-quality analysis and evidence needed to inform the Joint Strategic Needs Assessment (JSNA), the Annual Health Report, emergency preparation and response and all public health services for which they are responsible. In tight financial times, it will be incumbent only to identify and support effective interventions that deliver proven benefits and to evaluate innovative approaches.

d) The DPH will play a key role in the proposed new functions of local authorities in promoting integrated working; contribute to the development of the local JSNA and the joint health and wellbeing strategy; be an advocate for the public's health within the community and produce an authoritative independent annual report on the health of their local population.

e) To be the most effective leaders possible of public health in their areas, DsPH will have a number of critical tasks, as set out below:

- promoting health and wellbeing within local government;
- providing and using evidence relating to health and wellbeing;
- advising and supporting GP consortia on the population aspects of NHS services;
- developing an approach to improving health and wellbeing locally, including promoting equality and tackling health inequalities; working closely with Public Health England health protection units (HPUs) to provide health protection as directed by the Secretary of State for Health; and
- collaborating with local partners on improving health and wellbeing.

8.4 As the Director of Public Health is already a joint appointment of the County Council and the PCT, it is proposed that arrangements to relocate her and her staff to the County Council should happen sooner than is required by legislation. This will allow collaborative working on the public health agenda to be accelerated and closely linked into the developing plans for the Transitional Health and Wellbeing Board and work with the emerging GP commissioning consortia.

Public Health consultations

8.5 Linked to the Public Health White Paper, the Department of Health has published two more detailed consultation documents: *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* and *Transparency in Outcomes*, which explores the proposed public health outcomes framework.

8.6 *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health* focuses on key public health functions and responsibilities across the public health system and implementation of the following required changes:

a) Commissioning mechanisms for public health in relation to Public Health England, top tier local authorities and the NHS Commissioning Board

b) What activities should be funded from the public health and ring-fenced budget. How money will be allocated to local authorities including the funding formula for the health premium which will reward success in improving outcomes and incentivising action to reduce health inequalities

c) Public health-funded activity and the appropriate allocations of responsibility for public health activity in the new system.

The *Healthy Lives, Healthy People: Transparency in Outcomes* consultation details proposals for a public health outcomes framework. It seeks views on the overall structure and scope of the framework and the range of outcomes and measures within it, including views on those measures that should be incentivised.

8.7 Proposed responses to these two documents are attached at Appendix D, for Cabinet's comments and approval, prior to submission by 31 March 2011.

8.8 The Director of Public Health will be reporting in a separate paper to Cabinet on the detailed plans for the transfer of public health functions to the County Council.

9. Recommendations

9.1. Cabinet is recommended to:

a) Approve the proposed initial membership of the Transitional Health and Wellbeing Board as set out in Appendix C, Section 4 and the development of future governance arrangements.

b) Recognise the importance of Hampshire County Council's role in the developing NHS Reform programme and the actions put in place by the County Council and PCT, endorse the ambition to create a single Adults Joint Commissioning Team and the early transfer of Public Health to be hosted by the County Council during the transition period.

c) Make any comments on the draft responses to the Public Health consultation documents in Appendix D, prior to Cabinet submitting a final response to the Department of Health by 31 March 2011.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Other Significant Links

Links to previous Member decisions:		
Title Hampshire County Council response to the 'Equity and Excellence: Liberating the NHS' White Paper consultation documents	Reference 1998	Date 27 September 2010
Direct links to specific legislation or Government Directives		
Title Health and Social Care Bill 2011		Date 19 January 2011

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

1.1. This report is an update on the Government's planned health reforms, so an equality impact assessment has not been completed. It is worth noting however that the new partnership arrangements that will be put in place as a result of the reforms, and in particular the return of public health functions to local authorities, will bring significant opportunities to share data, intelligence and expertise to target services more effectively to meet the needs of vulnerable groups and deprived areas across the county.

2. Impact on Crime and Disorder:

2.1. Certain elements of the Public Health agenda relate to community safety issues including domestic violence, drugs and alcohol and offender health.

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption?

No impact has been identified.

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No implications have been identified.

APPENDIX C

The Transitional Hampshire Health and Wellbeing Board

1. Introduction

The two White Papers *Equity and Excellence: Liberating the NHS* and *Healthy Lives, Healthy People* introduced the Coalition Government's plans for an enhanced health role for local authorities. This is now being implemented by the Health and Social Care Bill, currently going through Parliament.

Local authorities will assume the major responsibility and local leadership role for improving the health and life-chances of their local populations. Local authorities will lead on public health, with a new ring-fenced budget for this purpose. There is a health premium proposed to reward areas who make the most progress. The Director of Public Health will move from the NHS to local authorities to provide professional leadership for these new responsibilities acting as the main source of health advice to the local authority.

The Health and Social Care Bill places the onus on upper tier and unitary local authorities to establish a Health and Wellbeing Board by April 2013. To achieve this successfully at a time of significant transition, an initial Health and Wellbeing Board needs to be established during 2011. These boards will become statutory committees of the local authority.

2. Purpose

Health and Wellbeing Boards will provide a vehicle for NHS and local authority commissioners to come together on a geographical basis. The legislation is intended to give flexibility for the boards to choose to do their work at whatever level "makes sense locally". They will ensure strategic coordination of commissioning services across NHS, social care, related children's, public health services and other services such as leisure or housing.

The Health and Social Care Bill includes a legal obligation on NHS and Local Authority commissioners to ensure they have in place and have regard to a joint health and wellbeing strategy in exercising their commissioning functions. Thus the work of these boards is about influencing, shaping and driving services through a local authority led, new, dynamic, collaborative leadership.

3. Objectives of the Board

1. To use the establishment of a Shadow Health and Wellbeing Board as a development vehicle for the Substantive Board. This will build on existing successful Hampshire partnership working and assure Hampshire County Council that there is a robust, functional Board in place before April 2013.

2. To join up commissioning through a robust knowledge of need by ensuring the delivery of an enhanced Joint Strategic Needs Assessment (JSNA) by local authority and GP Consortia.
3. To oversee and assure the translation of that JSNA into a joint health and wellbeing strategy (JHWS) to address the identified needs.
4. To be assured that the GP Consortia and local authority base their commissioning plans on the JHWS.
5. To be assured that the GP Consortia execute their commissioning in accordance with their accepted plans.
6. To ensure appropriate use of the totality of resources across all partners' budgets for optimal gain for the local population through lead commissioner or pooled budget mechanisms.
7. To demonstrate increased local democratic legitimacy and to represent the interests of the public.
8. To consider and advise on the duty to encourage integrated working.

4. Membership

The Health and Social Care Bill sets out the minimum statutory membership of the Board and so initial membership of the transitional Board needs to include these core members, some of whom will be transitional members until the full implementation of the health reform proposals. Initially the membership reflects the statutory requirement and includes those individuals that the County Council considers appropriate. Membership is proposed to be:

3 County Council Elected Members
Director of Adult Services
Director of Children's Services
Director of Public Health
A representative of the Local Involvement Network (LINk) – until establishment of Healthwatch
GP consortia leads
Chair of NHS Hampshire – as PCT remains statutory organisation
Hampshire PCT Cluster Chief Executive and another nominated representative prior to establishment of National Commissioning Board
Representation from Health & Wellbeing Partners – to be agreed
Such other persons as the Council considers appropriate
County Treasurer – advisory capacity

Membership will be reviewed prior to the formal transfer of duties on 1 April 2013. It is expected that the PCT representatives will stand down at this time and be replaced by a representative of the NHS Commissioning Board.

5. Development Programme

There is a huge amount of change taking place in the Health sector and the draft legislation is still progressing through Parliament. It is therefore suggested that following the formal establishment of the Board in April, a period of development takes place to allow for progress in the PCT clustering and GP commissioning arrangements, evolution of the current Health and Wellbeing Partnership and discussion with NHS colleagues on terms of reference, so that the Board will be in a position to meet formally in June 2011.

Although the Health and Wellbeing Board will not assume its full statutory responsibilities until 2013, there is an expectation that local authorities working with PCT clusters will put in place transitional arrangements during 2011 and that Boards will be operational from 2012.

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APPENDIX D

DRAFT RESPONSE

Healthy Lives, healthy people: consultation on the funding and commissioning routes for public health.

Hampshire County Council welcomes the opportunity to comment on the consultation on the funding and commissioning routes for public health. GP's and local authorities need to work together to ensure that commissioning meets the needs of local people.

Local authorities are best placed to take a lead role in commissioning a wide range of services such as mental health and learning disability as well as many services for children and young people. Adequate resourcing will be essential to ensure that the new service delivers improved outcomes and a wide range of services do not become 'Cinderella services' under the new system.

In Hampshire we are working with the local NHS and have established a number of joint commissioning boards, developed joint commissioning strategies and work programmes. There is potential to build on good practice to ensure GP's, community health and social care commissioners work together to plan person centred support.

1	**Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?**
	As the Board is not a commissioning body it is unclear as to the expectation of the Board in relation to the ring-fenced public health and other budgets. There will need to be clear connections made with Children's Trusts who are the focus of decision making for children. It is right for the Board to discuss investment in all cross-cutting services and develop a local view for the investment in and delivery of services to ensure effective outcomes for local people to meet the needs identified through the JSNA and described in the Joint Health & Wellbeing Strategy.
2	**What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?**

	In Hampshire there already exists a network of district level health and wellbeing partnerships. These are multi-agency partnerships which provide a platform for the engagement of the voluntary sector. They provide a focus on local delivery and provide a platform for the sector to engage in health improvement. Each partnership provides a health improvement plan detailing local priorities and the actions that partners will work on together. Local authorities already have a variety of tried and tested ways to engage the voluntary and independent sector in their work. A strategic approach that identifies health improvement as a golden thread throughout the business of the authority will help re-focus the dialogue with providers and suppliers whatever sector they are from. The strategic priorities within the local Compact need to articulate health improvement. Local infrastructure organisations commissioned by local authorities to build capacity will be pivotal in providing support to their local organisations. They will have a significant role in translating the Local Authorities' strategic intentions to the local voluntary sector. Independent providers also have a key role and contract specifications and monitoring will need to be adjusted to clearly define expectations. Inspection bodies also need to be clear about the areas of compliance that have health and wellbeing implications.
3	**How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?**
	The need for NHS Commissioners to take account of the JSNA needs to be further supported by additional intelligence to inform specific commissioning. The ability for GPCC to access the public health commissioning capacity sited in the local authority will be essential and this is being developed with our GPCCs locally. This will need to be supported by access to good quality data. The role of the NHS Commissioning Board and Public Health England as enablers will be pivotal to embedding a public health, evidence based focused approach.
4	**Is there a case for PHE to have greater flexibility in future on commissioning service currently provided through GP contract, and if so how might this be achieved?**
	Yes. It will be essential for Public Health England to have flexibility to

	ensure the service currently under the GP contract can be commissioned in the most effective way. The approach needs to be transparent, proportionate and engage local partners. The approach of working to outcomes rather than numbers of contacts must also be applied to the GP contract and GP business delivery.
5	**Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?**
	It is important that GPs consider all the local population and not just those registered with them as inadvertent discrimination against those less able to advocate for themselves is a possibility, seen in other market based health care systems.
6	**Do you agree that the public health budget should be responsible for funding the remaining functions and services in the area listed in the second column of Table A?**
	The functions and services described provide a list of public health activity. Some areas have very limited description so it is difficult to tell what the areas encompass. It does contain the areas that one would expect.
7	**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?** C) **If not, what would work better?**
	The routes detail a logical approach to commissioning at a national and local level. Nationally coordinated programmes can improve consistency but they need flexibility. Care is needed in terms of national programmes to ensure that the needs of local communities can be taken into account. This will reduce the risk of excluding disadvantaged groups and compounding inequity.
8	**Which services should be mandatory for local authorities to provide or commission?**
	Local Authorities have extensive experience of leading partnership responses and providing services effectively for their local communities. The ability to effectively lead commissioning across organisations requires adequate resources, a clear mandate and levers to ensure all partners engage.

	The areas detailed in Table A of the consultation document provide an appropriate list of proposed commissioning routes and the activities for local authorities. It should be left up to the local authority as to how best they provide the service although they would expect to be commissioning them to national standards and to deliver against outcomes to make a real difference for the local population.
9	**Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?**
	A clear understanding of the expectations and required outcomes needs to be provided. The approach should not involve time consuming reporting. It is essential that there are clear criteria for the grant, a defined process to allocate funding and the required reporting arrangements. A uniform approach to reporting on the outcomes framework should be taken to ensure that progress can be compared across England. A culture of evaluation and determining value for money of interventions will need to be led by Public Health England.
10	**Which approaches to developing an allocation formula should we ask ACRA to consider?**
	It is essential to determine the funding levels that are required to fulfil the stated functions. The grant to local authorities needs to be of an appropriate size. Care should be given when allocating funds so that they do not create inequity by over focusing on areas of deprivation while reducing the ability for other areas to maintain their current position. A sound approach to determining the grant is required that considers a variety of factors. These should include demographics and burden of ill health. The two year period prior to allocating funds needs to be used to work towards an equitable solution to allocating funds. It is recognised that some areas have higher proportions of spend in this area so a cautious approach is needed so as not to destabilise the system.
11	**Which approach should we take to pace-of-change?**
	The change process needs to both have a sense of urgency, but also provide a realistic timeframe. The approach should detail key timescales to reduce unnecessary uncertainty in the system. The two year period gives an adequate time to shift resources.

12	**Who should be represented in the group developing the formula?**
	There should be a variety of people involved from local government, NHS and academia. The involvement of LGA and finance directors in local authorities would be beneficial as they have experience in formula review. The perspectives from both unitary and county councils would also be needed.
13	**Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework on the health premium?**
	Local priority against need. Robust data sets
14	**How should we design the health premium to ensure that it incentivises reductions in inequalities?**
	The areas of focus and challenge will be predetermined according to each JSNA. Each local authority should have the flexibility to present their plans to PHE and negotiate their stretch areas.
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?**
	The merit of such an approach is debatable given that different parts of the country are at very different starting points. The approach to rewarding progress needs to ensure long-term stability to focus on maintaining improvements. Incentives need to be appropriate and not result in perverse actions. A firm evidence base behind the use of incentives as being real levers for enabling improvements needs to be provided to ensure that they are being used appropriately. Alternatively a more long-term approach to funding interventions and holding organisations to account makes for a healthier approach to improving outcomes.
16	**What are the key issues the group developing the formula will need to consider**
	The group will have to consider balancing the need to provide long-term action against short-term gains. They also need to have a firm grasp of demography and area cost pressures.

DRAFT RESPONSE

Healthy Lives, Healthy People: Transparency in Outcomes

Hampshire County Council welcomes the opportunity to comment on proposals on a new strategic outcomes framework for public health at national and local level. The breadth of local government activity has a direct influence on public health outcomes. Local authorities have a lead role in improving, promoting and protecting the health of their local community. It is vital that councils have sufficient financial and human resources, and they are free to deploy them in a way that meets the local need, to support their enhanced public health role. It is important that local government is fully accountable to its local population for its record on improvement and protecting health as well as addressing health inequalities. An effective outcomes framework will assist in demonstrating the impact.

To meet local challenges it is essential that any framework can be weighted against the areas of greatest importance to each local population. Local discretion and freedom is essential to ensure locally determined priorities can be addressed without dissipating actions. Collection, reporting and publishing data take time and money which can result in creating an unintended burden on the council. However we appreciate the need to consider how this can be achieved while maintaining the opportunity to achieve a health premium to recognise successful outcomes.

The NHS, social care and public health outcomes frameworks need to overlap, perhaps more than currently suggested, to ensure consistency and to encourage different sectors to work productively together to improve mental and physical health outcomes and reduce health inequalities throughout a person's life. Impacting on the issues that need to be addressed requires significant time and effort. There is a need for clear lines of accountability to measure progress towards long-term outcomes. This will require an ability to agree and establish a set of indicators that will be collected over a significant period of time. A long-term consistent approach will need to be taken that will not be constantly changed and that can enable benchmarking and comparison across the country.

Joint working will need to flourish to achieve the required outcomes. No one organisation can achieve the required gains alone. Perverse incentives that prevent joined-up approaches need to be eliminated. This will require aligning incentives across the NHS, social care and local government. It will also involve developing a shared language which is not overly medical and is common to all parties. Addressing the wider determinants of health and improving health at work, home and in education involves a wide range of organisations and people. The removal of jargon and the use of plain language to articulate what is to be achieved is necessary. Such an approach is needed to engage a wider range of partners beyond the public sector.

Consultation questions

1	**How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?**
	The breadth of public health and the various activities and sectors that have a contribution are vast. For the framework to be accessible and understood by the wide range of sectors it needs to be both relevant and easy to be understood. The wide range of organisations and sectors that will have an impact on improving the public's health need to be able to measure local outcomes at a local level in a way that is meaningful of each other. Care is needed to ensure that the language used to describe the framework can be understood. The framework should not be overcomplicated. Any requirements to monitor and demonstrate progress should not over burden partners. Joined-up thinking from central government will be pivotal to ensuring that all policies are aligned and move towards common overlapping priorities. The alignment of the various outcomes frameworks will be key to demonstrating this.
2	**Do you feel these are the right criteria to use in determining indicators for public health?**
	The criteria are helpful but require clarification. For example Criterion 4 wider public health workforce – to whom does this refer and what is the definition of this group of people? This may be meaningful to our directors of public health but not to everyone involved in delivery. The domains have overlapping actions that will support progress of more than one area. There is a challenge to understand indicators that are cross cutting in nature. There are many co-dependent activities which are mutually supportive across outcomes. It would be unfortunate if a local authority were to be measured and possibly deemed less than successful if it were to succeed in one such area but not achieve so much in another.
3	**How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?**
	Central to the framework and premium must be the equity. The framework and premium must be flexible enough to ensure a focus on groups of disadvantaged people across age groups. This will need to

	be done in terms of population and geography. It also will need to consider the actual population, thus for a very large county such as Hampshire, the overarching data look good, with minimal change year to year which may not attract a premium.
4	**Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?**
	Using outcomes frameworks as non performance management tools is helpful. Alignment across the three frameworks is sensible. However more needs to be done to overlay the elements – namely health improvement, through prevention and addressing the wider determinants of health, health protection, and using an evidence based approach to address these in order for the frameworks to work as part of a whole.
5	**Do you agree with the overall framework and domains?**
	It is helpful that the five domains address five of the six recommendations of the Marmot Review aimed at reducing health inequalities. To ensure transparency and the ability to share information with the public it would be advantageous to revise the high level vision to an outcome such as ‘ Everyone enjoys good health’. The domains seem sensible but would benefit from an explicit reference to and equality as being a cross cutting theme. Safeguarding should be seen in terms of all vulnerable people, not just children. The work already underway for children and vulnerable adults need to be incorporated sufficiently in the framework. A lot of work and good evidence is already available which can be used and built upon. The overlaps in indicators need to be rethought within the context of causes and effects.
6	**Have we missed out any indicators that you think we should include?**
	There is already much evidence in relation to which existing indicators demonstrate improvements in public health. Understanding across government and the data requirements from all government departments is needed. This will help balance the need to focus on both deficits and community assets. There is an opportunity to incorporate climate change under domain 1 within the context of extreme weather.

7	**We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?**
	There is a need to use the work already underway through the Department for Communities and Local Government (DCLG) to ensure the small number of indicators used work and provide the evidence required. The draft single list of central government data requirements for local government Clearer links needs to be drawn between causes and consequences.
8	**Are there indicators here that you think we should not include?**
	It is important to have a suite of indicators that fit with future requirements to collect data across the public sector. The list of indicators is wide ranging and provides a good flavour of what is currently available. Some are very specific and may be too narrow, but the likelihood of this is dependent on local priorities. There also needs to be a serious consideration as to ensuring that any indicators are SMART.
9	**How can we improve indicators we have proposed here?**
	A joined-up government approach is needed. The Department of Health and the DCLG need to work better together to look at the overlapping requirements for data. It is essential that data that is collected is relevant and proportionate. There is a need to have a balance between indicators that are essential and those which can be locally determined.
10	**Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)**
	It is not helpful to define specific indicators that should be incentivised. Each local area will have different priorities. What is important for the people in one area may not be as important in another. The flexibility for each local area to use their Joint Strategic Needs Assessment to justify areas of priority and negotiate their specific areas for improvement would be more appropriate. Therefore the indicators used should be locally determined according to areas where improvements in local health and reduced health inequalities are needed.
11	**What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?**

	If the different outcome frameworks are to be aligned it is inevitable that domains will over lap. The description and use of language is important to promote understanding.
12	**How well do the indicators promote a life-course approach to public health?**
	Given the need to minimise indicators the number presented is sufficient. Local areas may prioritise actions in relation to specific groups, which could be according to age.