



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

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<b>For Recipient's Use</b>	

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

**Prepared by the Public Health Development Unit, Department of Health**

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## Executive summary

1. The White Paper *Healthy Lives, Healthy People*<sup>1</sup>, described a new era for public health, with a higher priority and dedicated resources. There will be ring-fenced public health funding from within the overall NHS budget. Local authorities will have a new role in improving the health and wellbeing of their population as part of a new system with localism at its heart and devolved responsibilities, freedoms and funding. The majority of the public health budget will be spent on local services, either via local authorities through a ring-fenced grant or via the NHS. The Department of Health will incentivise action to reduce health inequalities by introducing a new health premium. The purpose of this consultation document is to describe in more detail the proposed key public health functions and responsibilities across the public health system and to set out the proposed commissioning and funding arrangements for delivery of public health services. This consultation document also asks questions about how we should implement some of these proposals.
2. This consultation document is an opportunity to collect the views of public health professionals, NHS commissioners, local authorities, service providers, particularly the voluntary and independent sector, and all other interested parties.

### *How to respond*

3. The questions for consultation are listed in chapter 6 of this document, which provides more detail about the consultation process. This consultation will close on 31 March 2011. You can contribute to the consultation by providing written comments, using the template on page 37 to:

By email: [publichealthengland@dh.gsi.gov.uk](mailto:publichealthengland@dh.gsi.gov.uk)

Online: <http://consultations.dh.gov.uk/healthy-people/funding-and-commissioning>

By post: Public Health Consultation  
Department of Health, Room G16  
Wellington House  
133-155 Waterloo Road  
London SE1 8UG

4. Some of the detail in this document is subject not only to the outcomes of this consultation, but also – particularly those requiring legislation – to Parliamentary approval.
5. The proposals in this consultation document apply to England, but we will work closely with the Devolved Administrations on areas of shared interest.

# 1. The public health system

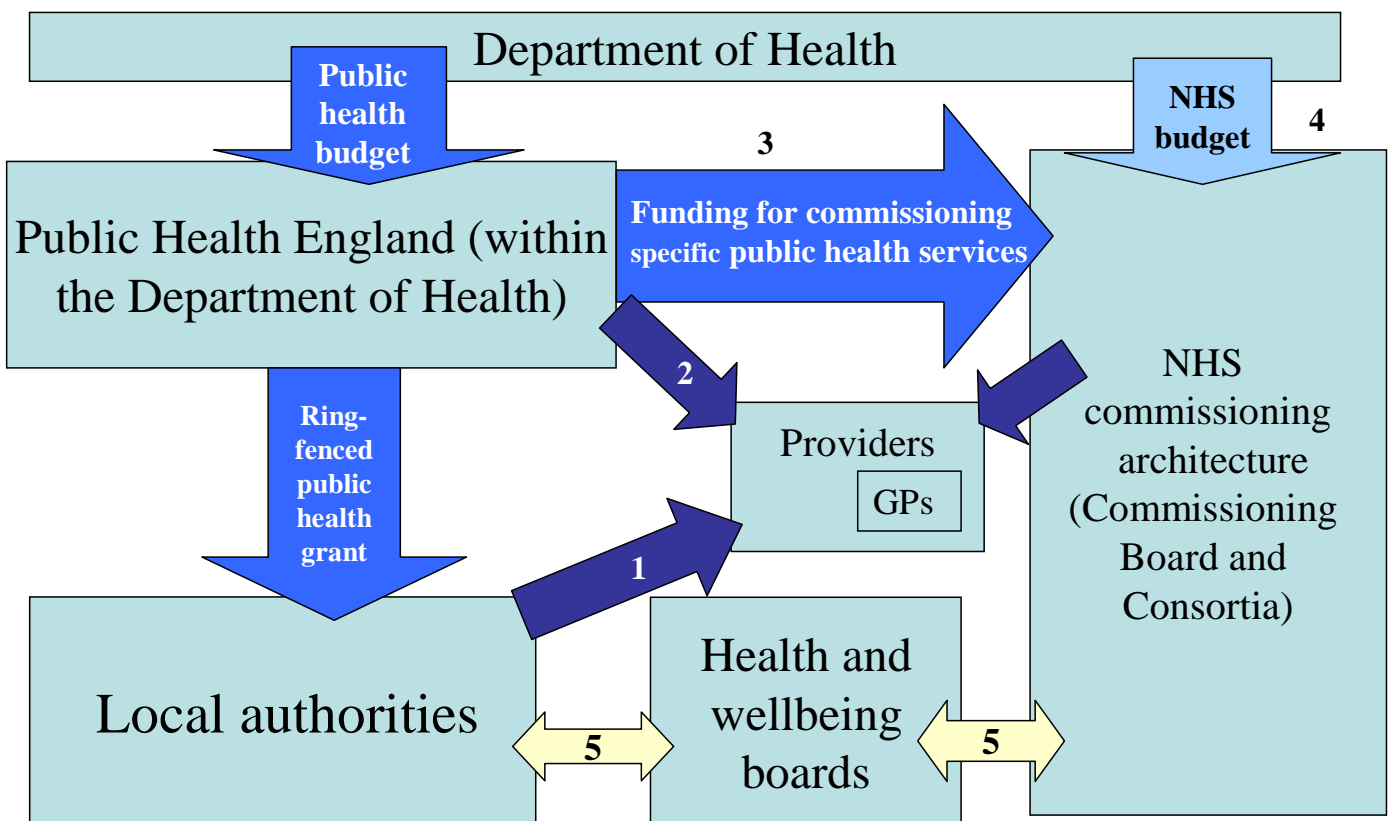
- 1.1 The White Paper, *Healthy Lives, Healthy People* described the future role of Public Health England as part of a new health and social care system, outlining its remit at a high level. Public Health England will be a professional and efficient service with a clear mission to achieve improvements in public health outcomes: and provide effective protection from public health threats. Public Health England will lead health protection, and harness the efforts of the whole government, the NHS and Big Society to improve the public's health. The primary aim of the changes set out in *Healthy Lives, Healthy People* is to help people live longer, healthier and more fulfilling lives, and improve the health of the poorest fastest.
- 1.2 Previously Primary Care Trusts (PCTs) were responsible for commissioning local health services, including for public health. PCTs will be abolished and replaced by a new NHS commissioning architecture, locally led by GP consortia, and nationally by a new independent NHS Commissioning Board as set out in *Equity and Excellence: Liberating the NHS*<sup>ii</sup>.
- 1.3 *Healthy Lives, Healthy People* set out that central government will be directly accountable for effectively protecting and improving the health of the population. It also set out a core principle that functions should be devolved to the local level wherever possible. This means that local authorities will take on primary responsibility for health improvement. They will also, where practical and appropriate, exercise some health protection functions and take on responsibility for some specific preventative services. This document assumes that Directors of Public Health (DsPH), employed by local authorities but jointly appointed by Public Health England, will play the leading role in discharging local authorities' public health functions.
- 1.4 As set out in the response to the NHS White Paper, *Liberating the NHS: Legislative framework and next steps*, published on 14 December, subject to Parliamentary approval, the Health and Social Care Bill will require the establishment of a health and wellbeing board in every upper tier local authority. Health and wellbeing boards will bring together the key NHS, public health and social care leaders in each local authority area to work in partnership.
- 1.5 Each of these bodies will need to demonstrate their compliance with the letter and the spirit of the Equality Act 2010 in the discharge of these duties, and will be expected to undertake their functions in a way that is most likely to reduce inequalities in health.
- 1.6 In this consultation document, we set out further details of the future functions of Public Health England, and how they will be exercised, and ask questions about how we should implement some of these proposals.

## 2. Funding and commissioning flows

- 2.1 Public health services will be funded by a new public health budget, separate from the budget managed through the NHS Commissioning Board for healthcare, to ensure that investment in public health is ring-fenced. As outlined in the White Paper, in exercising its functions, Public Health England will fund public health activity through three principal routes: through allocating funding to local authorities; commissioning services via the NHS Commissioning Board; or commissioning or providing services itself.
- 2.2 This section describes the broad funding flows in the new system, sets out the options in terms of commissioning routes for key public health services, and proposes what activity will be public health funded and who should commission it.

### *The Broad Funding Flows*

- 2.3 The diagram below sets out at a high level the flows of the public health budget from the Department of Health across the system.



## Key

- 1: Paragraphs 2.8-2.11 describe how public health funded services could be commissioned or provided by local authorities at local level.
- 2: Paragraph 2.12 describes how public health funded services could be commissioned or provided by Public Health England at a national level.
- 3: Paragraphs 2.14-2.15 describes how public health funded services could be commissioned via the NHS.
- 4: Paragraph 2.16-2.17 describes how the NHS will continue to fund and commission some public health services.
- 5: These arrows represent the role of health and wellbeing boards in supporting integrated commissioning across the system. Paragraphs 2.7 and 2.9 describes the role of health and wellbeing boards in more detail.

- 2.4 Decisions as to how services would be best commissioned will determine how much funding flows through different parts of the system. The majority of the public health budget will be spent on local services, either commissioned via the NHS Commissioning Board (who may choose to pass the responsibility down to GP consortia) acting on behalf of Public Health England, or led by local authorities through a ring-fenced grant. This ring-fenced grant will be made under section 31 of the Local Government Act 2003. The operation of, and accountability for, this grant is discussed in more detail below in the section on accountability.

## *How the public health ring-fenced grant will work with other local authority functions*

- 2.5 It should be noted that the above funding flows diagram is not exhaustive, and only details the public health grant that local authorities receive from the Department of Health, not other funding that local authorities receive. Local authorities already carry out a range of health protection functions and have many wider responsibilities that bear on public health such as leisure, housing, education and social care. For the purposes of funding, the Department is treating these existing functions as separate from the public health ring-fence, as they are already funded through the existing funding settlement: for example, local authorities health protection activity is funded as part of existing local authority funding for health protection. Local authorities will of course be free to integrate management of these functions with their new public health responsibilities, should they wish.
- 2.6 Social care primary prevention is one area in which local authorities already support preventative activity. This includes community-directed primary prevention and support, which comprises a wide range of services to promote social interaction, wellbeing and peer support - for example, exercise and balance classes, foot care services and befriending<sup>iii</sup>. It also includes equipment and minor adaptations services, which assist older people to remain living safely and independently in their own homes by providing aids such as grab rails or walking frames. In recognition of the pressures on the social care system in a



challenging local government Spending Review settlement, the Government has allocated an additional £2 billion per annum by 2014/15 to support the delivery of social care. Of this, an additional £1 billion per annum by 2014/15 will be made available from within the health system to support social care services, such as evidence based primary prevention services.

- 2.7 The Government's response to the NHS White Paper consultations, *Liberating the NHS: legislative framework and next steps*<sup>iv</sup> set out further detail about the proposed health and wellbeing boards which will provide a mechanism for bringing together discussions about investment in cross-cutting services, such as social care primary prevention. Health and wellbeing boards will include elected representatives, local HealthWatch and key local commissioners for health and social care, including GP consortia and DsPH, adult social care and children's services. "Early implementer"<sup>v</sup> health and wellbeing boards may also be able to provide feedback on how partnership working for the investment in, and delivery of, cross-cutting services can be supported at a local level to deliver effective outcomes.

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

### *Public health funded services commissioned or provided by local authorities at a local level*

- 2.8 Localism will be at the heart of this new system, with devolved responsibilities, freedoms and funding, subject to parliamentary approval of the forthcoming Health and Social Care Bill. Local authorities will have a new statutory duty to take steps to improve the health of their population in addition to other related statutory functions. In the exercise of his functions, the Secretary of State may also agree with local authorities that they lead on other responsibilities, including for health protection. A ring-fenced grant will be paid to local authorities in order to fund the activity carried out in the exercise of those functions. The Department of Health expects that the majority of services will be commissioned, given the opportunities this would bring to engage local communities more widely in the provision of public health, and to deliver best value and best results. It is also expected that local people will have access to information about commissioning decisions, how public health money has been spent and the outcomes that have been achieved.
- 2.9 To ensure joined-up commissioning at a local level, local authorities and GP consortia will each have an equal and explicit obligation to prepare the joint strategic needs assessment (JSNA), and to do so through the health and wellbeing board. To build on the JSNA, and to ensure that collaboration is the norm, all health and wellbeing boards should have to develop a high-level "joint health and wellbeing strategy" that spans the NHS, social care, public health and could potentially consider wider health determinants such as housing, or education. The strategy should provide the overarching framework within which commissioning plans for the NHS, social care, public health and other services the health

and wellbeing board agrees are relevant are developed. At present JSNA obligations extend only to its production, not its application, to remedy this, the forthcoming Health and Social Care Bill will place a duty on commissioners to have regard to the JSNA and the joint health and wellbeing strategy when exercising their functions.

2.10 These freedoms and the new ring-fenced budget open up opportunities for local government to take innovative approaches to public health involving new partners. The Department of Health expects that local authorities will want to contract for services with a wide range of providers and incentivise and reward those organisations for improving health and wellbeing outcomes and tackling inequalities, to deliver best value for their population. The Department will work to ensure that voluntary, community and social enterprise (VCSE) sector organisations are supported to play a full part in providing health and wellbeing services. There is a significant opportunity to involve organisations across all sectors not just in terms of commissioning, but also, for example through sharing expertise, and wider initiatives such as the Big Society Bank. As part of building capable and confident communities, areas may wish to consider using grant funding in local communities to support preventive community-focused activities, such as volunteering peer support, befriending and social networks<sup>vi</sup>.

2.11 The Department of Health would encourage and expect that local authorities, where possible and appropriate, should be commissioning on an any willing provider/ competitive tender basis. We would particularly welcome views from local authorities and providers, including from the voluntary and independent sector about how this can best be achieved.

**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?**

### *Public health funded services commissioned or provided at a national level*

2.12 In line with the overall remit of Public Health England, some services will need to be commissioned and/or provided at a national level. Public Health England will directly fund and commission some services, such as any national campaigns; directly provide some services, for example the functions currently carried out by the Health Protection Agency; and directly provide some activity which will be exercised locally, for example via the local networks of Public Health England Health Protection Units.

### *Sub-national or supra-local commissioning arrangements*

2.13 For some services, commissioning may be best carried out at a sub-national or supra-local level. This would apply to services that are specialised in nature, such as services for

victims of sexual violence and for vulnerable groups. These services may need to secure specialist expertise and facilities. These services also need to be strategically commissioned where there is a need at either a local or supra-local level. Although there will be no formal structural provision for sub-national commissioning, where it is appropriate either sub-national commissioning arrangements would be established as part of Public Health England, or local authorities could choose to adopt supra-local arrangements for commissioning certain activities for which they are responsible. For example a particular local authority might commission such a service, leading on behalf of others with arrangements to fund activity accordingly.

### *Public health funded services commissioned via the NHS*

- 2.14 It will be appropriate in some cases for Public Health England to ask the NHS to take responsibility for commissioning public health interventions or services funded from the public health budget. This will include population interventions, such as screening programmes, that are best delivered as part of a wider pathway of care and which would be commissioned on behalf of Public Health England. This will be mediated via a relationship between Public Health England and the NHS Commissioning Board. Public Health England will also have input to the Secretary of State's annual mandate for the NHS Commissioning Board and any supplementary agreement that is considered appropriate. It may also advise or agree with the NHS Commissioning Board to include a public health element or activity as part of the exercise of its NHS functions using the same mechanism.
- 2.15 Where the NHS takes responsibility for commissioning public health interventions, the NHS commissioning architecture will determine how it does so appropriately. The assumption will be that such services will usually be commissioned by GP consortia in collaboration, where appropriate, with each other or with other bodies. The main exception to this will be some public health elements of primary care services that will be funded by Public Health England but commissioned by the NHS Commissioning Board (in exercise of its own functions). For instance, the GP contract currently includes provision of childhood immunisation and cervical screening tests. These elements will be funded by Public Health England, which will therefore want to influence how the services are commissioned.

### *NHS funded and commissioned services*

- 2.16 In other cases, public health work is - and should continue to be - an integral part of the services provided in primary care, and will continue to be funded from within the overall resources used by the NHS Commissioning Board to commission these services. This includes public health activity carried out by GP practices as part of the essential services they provide for all patients, preventative services provided by dentists under their NHS contracts, and services provided under the community pharmacy contractual framework

(CPCF). The CPCF includes provision of prescription-linked healthy lifestyle advice and participation in public health campaigns, which will both need to involve close liaison with the relevant public health experts.

2.17 Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients. This will be underpinned locally by ensuring DsPH are able to advise the GP consortia on public health issues (for example through health and wellbeing boards or through the provision of intelligence and data on population health issues) and nationally via the relationship between the Secretary of State/ Public Health England and the NHS Commissioning Board. We would particularly welcome views from NHS commissioners and from public health professionals as to how best we may ensure that NHS commissioning is underpinned by the necessary public health advice.

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

### *Ensuring flexibility on commissioning services*

2.18 If any particular commissioning arrangement is providing an inadequate service, Public Health England will be able to change the funding and commissioning route, subject to contractual and other constraints. Individual commissioners will manage contracts with providers to achieve the best possible outcomes.

2.19 GP practices are currently the preferred provider for a range of public health services under the GP contract, such as childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. These arrangements will continue and will be funded from the public health budget. However, there may be a case for Public Health England and local authorities in the future to have greater flexibility to choose how such services are commissioned, as circumstances change or if services can be better delivered another way.

***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?***

### 3. Defining commissioning responsibilities

3.1 Table A on page 16 details the activities that will be funded by the public health budget in the second column. In order to establish why something should be considered to be public health, we used the definition of public health, as set out in *Healthy Lives, Healthy People*.

What is public health?

The Faculty of Public Health defines public health as: The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society.

There are three domains of public health, health improvement (including people's lifestyles as well as inequalities in health and the wider social influences of health), health protection (including infectious diseases, environmental hazards and emergency preparedness) and health services (including service planning, efficiency and audit and evaluation).<sup>vii</sup>

3.2 In considering what activity should be funded from the public health budget we have also taken account of:

- the likely potential to impact on different equality groups and to reduce health inequalities;
- close linkages to other public health responsibilities; or
- whether there were pragmatic reasons for inclusion or exclusion, for example maintaining integrated commissioning of services.

We have undertaken an initial equality impact assessment<sup>viii</sup> for the White Paper and will be updating this after the consultation. We would welcome views from interested parties in relation to the likely potential of our policies to impact on different equality groups and to reduce health inequalities.

**Q5 Consultation question: 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?**

3.3 The third column in Table A sets out the proposed primary commissioning route for public health funded services. Proposals about who the primary commissioner should be were based on the following principles:

- a) The default position is that, wherever possible, public health activity should be commissioned by local authorities according to locally identified needs and priorities;

- b) If the service in question needs to be commissioned at scale, or if it is health protection best done at national level, then it should be commissioned or delivered by Public Health England at a national level; and
- c) If the activity in question is best commissioned as part of a pathway of health care (therefore, the level of integration with other health services is more significant), or if the activity in question currently forms part of existing contractual NHS primary care commissioning arrangements, then Public Health England should fund that public health activity and commission it via the NHS Commissioning Board.
- 3.4 The primary commissioning routes for public health funded services shown do not necessarily rule out activity in other parts of the system; DsPH in local authorities will have a wide-ranging freedom to determine how they wish to work to improve public health. In addition, where appropriate there will be some national level activity in areas for which local authorities are primarily responsible.
- 3.5 The column showing associated NHS-funded activities illustrates the boundary of the public health role. Thus, although programmes to prevent and reduce obesity are public health interventions, bariatric surgery as a treatment intervention should remain with the NHS, and funded by the NHS. Of course, public health advice will need to be part of designing whole pathways of care, from obesity-prevention programmes to bariatric surgery.
- 3.6 Local authorities are well placed to integrate their new responsibility for public health activity with their wider functions. This puts them at a unique advantage in terms of tackling the wider determinants of health and improving wellbeing, and using their understanding of the local population to consider vulnerable groups when commissioning services in order to improve health outcomes for the most disadvantaged. In other cases there are advantages to continuing NHS service provision in terms of maintaining existing primary care arrangements and specialist clinical treatment (treatment of infectious disease for example). These different and complementary strengths have also influenced our proposals about who should commission different services.
- 3.7 The Department of Health is consulting on the entirety of Table A with some exceptions that are provided for in legislation. In relation to some areas, the Department has already decided its preferred funding route/primary commissioner and this will be set out in the Health & Social Care Bill and debated by Parliament. The Department is not specifically consulting on those areas.
- 3.8 The Department intends to describe some of the areas set out in the second column of Table A as public health in the forthcoming Health and Social Care Bill, and subject to Parliamentary approval, they will be funded from the public health budget. As such, we will not be consulting on the funding route for:
- all screening;
  - radiation, chemical and environmental hazards;

- immunisation against infectious disease; and
- the current functions of the Health Protection Agency.

3.9 In addition, the Department intends to propose in the forthcoming Health and Social Care Bill that local authorities should be the lead commissioner for certain activities as set out below which will therefore be funded by the public health budget:

- weighing and measuring of children (a component of work to tackle childhood obesity);
- dental public health;
- fluoridation;
- medical inspection of school children;

For everything else we are consulting on the activity which should be funded by the public health budget in each area (and the inclusion of the area per se) and therefore the boundary with the NHS.

3.10 The Department intends to propose in the forthcoming Health and Social Care Bill that the Secretary of State for Health should be the primary commissioner for;

- former functions of the Health Protection Agency;
- standardisation and control of biological medicines;
- radiation, chemical and environmental hazards;
- national immunisation and screening programmes; and
- emergency preparedness (in so far as it is done nationally).

In addition, the Secretary of State has an existing duty to arrange contraceptive services as the primary commissioner through paragraph 8 of Schedule 1 to the NHS Act 2006. Where the forthcoming Health and Social Care Bill would make the Secretary of State for Health primary commissioner, we are not consulting on that per se but on how that is then exercised – commissioning responsibility can be delegated to another commissioner. The rest of the third column is for consultation.

**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?**

**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?**

**Table A – Public health funded activity**

	<b>Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)</b>	<b>Proposed commissioning route/s for this activity (including direct provision in some cases)</b>	<b>Examples of proposed associated activity to be funded by the NHS budget (including from all providers)</b>
Infectious disease	Current functions of the Health Protection Activity in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	Public Health England with supporting role for local authorities	Treatment of infectious disease (see sexual health below) Co-operation with Public Health England on outbreak control and related activity
Sexual Health	Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and prevention	Local authority to commission all sexual health services apart from contraceptive services commissioned by the NHS Commissioning Board (via GP contract)	HIV treatment and promotion of opportunistic testing and treatment
Immunisation against infectious disease	Universal immunisation programmes and targeted neonatal immunisations	Vaccine programmes for children, and flu and pneumococcal vaccines for older people, via NHS Commissioning Board (including via GP contract) Targeted neonatal immunisations via NHS Local authority to commission school programmes such as HPV and teenage booster	Vaccines given for clinical need following referral or opportunistically by GPs
Standardisation and control of biological medicines	Current functions of the HPA in this area	Public Health England	-
Radiation, chemical and environmental hazards, including the public health impact of climate change	Current functions of the HPA in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	Public Health England supported by local authorities	-
Seasonal mortality	Local initiatives to reduce excess deaths	Local authority	-



All screening	Public Health England will design, and provide the quality assurance and monitoring for all screening programmes	NHS Commissioning Board (cervical screening is included in GP contract)	-
Accidental injury prevention	Local initiatives such as falls prevention services	Local authority	-
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Local authority	Treatment for mental ill health
Nutrition	Running national nutrition programmes including Healthy Start Any locally-led initiatives	Public Health England some local authority activity	Nutrition as part of treatment services, dietary advice in a healthcare setting, and brief interventions in primary care
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising the physical activity opportunities offered by the natural environment	Local authority	Provision of brief advice during a primary care consultation e.g. Lets Get Moving
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services	Local authority	NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting, or bariatric surgery
Drug misuse	Drug misuse services, prevention and treatment	Local authority	Brief interventions
Alcohol misuse	Alcohol misuse services, prevention and treatment	Local authority	Alcohol health workers in a variety of healthcare settings
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications	Local authority	Brief interventions in primary care, secondary, dental and maternity care
NHS Health Check Programme	Assessment and lifestyle interventions	Local authority	NHS treatment following NHS Health Check assessments and ongoing risk management
Health at work	Any local initiatives on workplace health	Local authority	NHS occupational health
Reducing and preventing	Population level interventions to reduce	Local authority and Public Health	Interventions in primary care such as

birth defects	and prevent birth defects	England	pre-pregnancy counselling or smoking cessation programmes and secondary care services such as specialist genetic services
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis via awareness of symptoms	Local authority	Integral part of cancer services, outpatient services and primary care. Majority of work to promote early diagnosis in primary care
Dental public health	Epidemiology, and oral health promotion (including fluoridation)	Local authority supported by Public Health England in terms of the co-ordination of surveys	All dental contracts
Emergency preparedness and response and pandemic influenza preparedness	Emergency preparedness including pandemic influenza preparedness and the current functions of the HPA in this area	Public Health England, supported by local authorities	Emergency planning and resilience remains part of core business for the NHS NHS Commissioning Board will have the responsibility for mobilising the NHS in the event of an emergency
Health intelligence and information	Health improvement and protection intelligence and information, including: data collection and management; analysing, evaluating and interpreting data; modelling; and using and communicating data. This includes many existing functions of the Public Health Observatories, Cancer Registries and the Health Protection Agency	Public Health England and local authority	NHS data collection and information reporting systems (for example, Secondary Uses Service)
Children's public health for under 5s	Health Visiting Services including leadership and delivery of the Healthy Child Programme for under 5s, prevention interventions by the multiprofessional team, and the Family Nurse Partnership	NHS Commissioning Board	All treatment services for children (other than those listed above as public health-funded)
Children's public health 5-19	The Healthy Child Programme for school-age children, including school nurses and including health promotion and prevention interventions by the multiprofessional team	Local authority	All treatment services for children (other than those listed above as public health funded, e.g. sexual health services or alcohol misuse)

Community safety and violence prevention and response	Specialist domestic violence services in hospital settings, and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential information sharing activity	Local authority	Non-confidential information sharing
Social exclusion	Support for families with multiple problems, such as intensive family interventions	Local authority	Responsibility for ensuring that socially excluded groups have good access to healthcare
Public health care for those in prison or custody	e.g. All of the above	NHS Commissioning Board	Prison healthcare

3.11 The following paragraphs expand on Table A, describing how the Department envisages public health functions should be exercised in each area, including what we believe local authorities should be responsible for. In general, health improvement work will be led by local authorities using funds from ring-fenced public health budgets. Local authorities will determine what activity is best able to improve outcomes and health inequalities in their local area. This could include making local arrangements, based on the priorities identified in the joint health and wellbeing strategy, for others to commission or assist in commissioning certain activity, or to commission services jointly. Those services that we propose local authorities should lead on, will not be commissioned by Public Health England at a national level, or commissioned by the NHS using public health funds. Local work will be complemented by national action by Public Health England where this is appropriate through the use of data collected by local authorities, support to best practice and commissioning, and the provision of any nationally run campaigns.

#### *Functions of the current Health Protection Agency (including infectious disease)*

3.12 Subject to Parliamentary approval, Public Health England will take responsibility for protecting the public's health, including carrying out the functions currently exercised by the Health Protection Agency. Work will take place at all levels to mitigate the public health impact of climate change, reduce excess deaths as a result of seasonal mortality and to protect the public from radiation, chemical and environmental hazards. The prevention and control of infectious disease will be a key function. This will involve surveillance of infections and other indicators of ill health, the provision of public health and reference microbiology, leadership to co-ordinate outbreak investigation and contact tracing, as well as public health advice on infection prevention to the whole health and social care system. At a local level, local authorities will need to work closely with Public Health England Health Protection Units (HPUs) to provide health protection as directed by the Secretary of State for Health. For example, this could include support in outbreak investigation and contact tracing, by providing training and mobilising staff, and in community infection control. The NHS will remain responsible for funding and commissioning infectious disease treatment and related public health activity; for example, all NHS organisations will continue to need to have adequate infection control policies and procedures.

#### *Immunisation*

3.13 Public Health England will be responsible for immunisation as one means of preventing infectious disease. It will be responsible for the national immunisation schedule and setting standards as advised by the Joint Committee on Vaccination and Immunisation and will fund the delivery of immunisation programmes via two routes: local authorities and the NHS Commissioning Board. We propose that local authorities should be responsible for commissioning immunisation programmes primarily delivered through schools, such as the human papillomavirus vaccine (HPV) and the teenage booster (against tetanus, diphtheria and polio) from a range of providers. Local authorities will also work closely with Public Health England, the NHS and local partners to ensure co-

ordination of any immunisation response during a public health incident. Given the existing contractual arrangements in primary care commissioning for other immunisation programmes, we propose that Public Health England transfers funds from the public health budget to the NHS Commissioning Board to allow them to commission the remaining programmes. This will include the childhood, seasonal flu and pneumococcal (for older people) vaccination programmes. The NHS Commissioning Board will be responsible for commissioning a service for the whole population. For programmes where GPs are not preferred providers, or where individual GPs opt out or are decommissioned from providing a service, the NHS Commissioning Board will commission alternative providers as appropriate (for example community pharmacies).

- 3.14 The NHS will continue to commission targeted neonatal Hepatitis B and BCG vaccination provision, funded by Public Health England. Referral and opportunistic vaccination of those at clinical risk, for example intravenous drug users requiring Hepatitis B vaccination, or mothers needing post partum measles mumps and rubella (MMR) vaccination, will also continue to be funded and commissioned by the NHS (including through existing primary care commissioning arrangements).

### *Screening*

- 3.15 Public Health England will be responsible for funding all national screening programmes. The design and quality assurance of screening programmes will be a direct responsibility of Public Health England, as will funding and managing the piloting and rolling out of new programmes and extending current ones. The NHS Commissioning Board will commission established programmes on behalf of Public Health England, as specified and with funding transferred for that purpose.

### *Sexual health*

- 3.16 We propose that local authorities will be responsible for commissioning comprehensive open-access sexual health services using funds from the ring-fenced public health budget. This includes commissioning testing and treatment of sexually transmitted infections (STIs) including opportunistic chlamydia testing; high quality partner notification activity and working with GP practices to encourage opportunistic testing and treatment of STIs in primary care. Public Health England will work with the NHS Commissioning Board to provide more specialised commissioning for human immunodeficiency virus (HIV) treatment and care, where efficiencies can be made from procuring drugs and services at scale. Local authorities will also be responsible for commissioning fully integrated termination of pregnancy services (services that also offer the full range of contraception, STI testing and, where appropriate, treatment). In the case of contraception, Public Health England will fund the commissioning by the NHS Commissioning Board of contraceptive provision through primary care commissioning arrangements, and local authorities will fund and commission contraceptive services (including through community pharmacies) for patients who do not wish to go to their GP or who have more complex needs. This

model also provides opportunities to further integrate provision of STI and contraception services.

### *Tobacco control, obesity, physical activity and nutrition*

3.17 The responsibility for smoking cessation services and other local tobacco control activities will pass to local authorities. The Department of Health proposes that this should include responsibility for commissioning or providing stop smoking services, prevention activities, enforcement and local communications. Obesity and physical activity programmes, including encouraging active travel, will also become the responsibility of local authorities. Local authorities will be responsible for running the National Child Measurement Programme at the local level, with Public Health England co-ordinating the Programme at the national level. Responsibility for commissioning and funding surgery and drug treatment for obesity will sit with the NHS. Any local initiatives relating to nutrition will be commissioned or undertaken by local authorities. However, Public Health England will be responsible for running national nutrition programmes such as Healthy Start as these are best done at a national level, though with some components, such as supporting applications for Healthy Start (which have to be countersigned by registered healthcare professionals) and distributing Healthy Start vitamins, remaining locally delivered. The Department also proposes that local authorities should have responsibility for workplace health at a local level.

### *Alcohol and drug misuse*

3.18 Public Health England and local authorities will play a key role in tackling the harms caused by alcohol and drugs. Local authorities will be responsible for commissioning treatment, harm reduction and prevention services for their local population, providing an opportunity to more comprehensively join up the commissioning of drug and alcohol intervention and recovery services locally. At a national level this will be supported by Public Health England, which will provide evidence of effectiveness, guidance and comparative analyses to support local areas in their task. To ensure this support is immediately available, the core functions of the National Treatment Agency for Substance Misuse (NTA) will transfer to Public Health England.

### *The NHS Health Check Programme*

3.19 The Department of Health proposes that local authorities should commission the NHS Health Check Programme with Public Health England responsible for design, piloting and rollout of any extension of the programme. NHS Health Checks are offered to men and women aged 40 to 74 every five years. Everyone receiving a NHS Health Check receives a personal assessment and individually tailored advice and support to help them manage their risk of heart disease, stroke, diabetes and chronic kidney disease. In many cases this will include referral to, and provision of, lifestyle interventions commissioned and funded by the local authority as part of the programme, such as: smoking cessation, weight management services, physical activity services, or intensive lifestyle interventions (for those found to have pre-diabetes). Some of those receiving a NHS Health Check will

be referred into the NHS for additional testing, follow-up and ongoing risk management, which will be funded and commissioned by the NHS.

### *Early presentation and diagnosis*

3.20 Public Health England will be responsible for designing and funding initiatives to promote earlier presentation and diagnosis, for example the planned national bowel cancer symptom campaign. Local authorities may also choose to commission such initiatives from their local ring-fenced budgets. For many conditions, we know that the earlier people present their symptoms to a healthcare professional, the greater the likelihood of successful treatment and the greater the likelihood of contribution to reducing inequalities in health.

### *Reducing birth defects*

3.21 Public Health England will be responsible for the surveillance of birth defects and anomaly registers. Wider local authority responsibilities, for example in the areas of nutrition, alcohol and smoking, and the wider determinants of health will also contribute to reducing birth defects. The NHS will continue to play an important role in work to reduce birth defects via pre-pregnancy care, genetic counselling and effective screening.

### *Dental public health*

3.22 Public Health England and local authorities will have a key role in dental public health. The Department proposes that Public Health England will lead on the co-ordination of oral health surveys while local authorities will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes. At both levels it will be necessary to liaise closely with the NHS Commissioning Board, which will commission dental services. Contracts for existing (and any new) fluoridation schemes will become the responsibility of Public Health England; consultations on proposals for new schemes will be conducted by local authorities using a majority rule where a scheme covers more than one local authority area.

### *Public mental health*

3.23 Local authorities will take on responsibility for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities. This could include local activities to raise public awareness, provide information, train key professionals and deliver family and parenting interventions. This would cover activity through the life course. Improved mental health and wellbeing has a wide impact across a range of outcomes, including improved physical health and life expectancy; it is also associated with a range of reduced health risk behaviour, including smoking, alcohol and drugs misuse as well as reduced workplace absenteeism. Treatment of mental ill health, including Improving Access to Psychological Therapies (IAPT), will not be a responsibility of Public Health England but will be funded and commissioned by the NHS. Health and wellbeing boards will need to ensure appropriate integration.

### *Emergency preparedness and response*

3.24 Public Health England will be responsible for emergency preparedness and response relating to public health emergencies, and for working together with the NHS to offer support and technical expertise to manage incidents, which impact upon both public health and NHS areas of responsibility. The NHS Commissioning Board will be responsible for mobilising the system in times of emergency and ensuring the resilience and preparedness of the NHS to respond to emergency situations, assuring, for example, that clear arrangements are in place, services are co-ordinated and lead individuals are designated. Working with the NHS, Public Health England will need to plan, prepare and be able to respond in a co-ordinated and effective way. Most incidents will be managed locally, with the public health response being led by the Director of Public Health and Public Health England Health Protection Units. Public Health England and the NHS together will be part of the multi-agency local response, and it will be essential that they plan together and ensure a co-ordinated response.

### *Public health information and intelligence*

3.25 As described in *Healthy Lives, Healthy People*, Public Health England will be responsible for information and intelligence for public health (including surveillance), taking on the existing functions of public health observatories, specialist observatories and cancer registries, alongside relevant current functions of the HPA. Drawing on data already collected by the Health and Social Care Information Centre wherever possible, Public Health England will have a role in collecting and managing data, for example maintaining cancer registries and commissioning surveys from the Health and Social Care Information Centre. Public Health England will therefore need to be able to analyse, evaluate and interpret data, using a wide range of sources to assess needs, set priorities and forecast future requirements, focusing effort on public health and wellbeing outcomes and inequality reduction supporting the specific requirements of local authorities, including their need to determine which interventions are the most cost-effective, and linking these to improved health outcomes. Modelling techniques will be used, for example, to understand the potential impact of particular interventions, and where possible how this differs by different groups and communities, and provide economic assessments of costs and benefits in specific settings. The public health budget will support information functions at national level that will provide the basis for effective DsPH annual reports and Joint Strategic Needs Assessments, for example the Public Health Compendium. Other knowledge functions proposed for consultation in *Healthy Lives, Healthy People* include:

- establishing an accessible and authoritative web-based evidence system for public health professionals, particularly DsPH, as part of the broader range of organisations able to offer health and care service information to a variety of audiences, as set out in the consultation *Liberating the NHS: An Information Revolution*;
- sharing of good practice using the Chief Medical Officer's public health awards which aim to encourage recognition and peer-sharing of successful innovative evidence based approaches, and other mechanisms.



Local authorities will require a core of information and evidence capacity to support DsPH, although large scale analyses will be done once at national level. Communicating with the public will be a priority for local authorities, providing people and communities within their areas with the knowledge and understanding they need to challenge their local public health system.

- 3.26 Where organisations hold or collect data relating to care, the systems used must meet appropriate technical and data standards including those related to safety, security, reliability and resilience. The NHS Commissioning Board will be responsible for centrally developing and maintaining these standards for the NHS. Equivalent standards set by the Department of Health will also be required for social care and for public health services. Where data is collected from the NHS (consortia and providers) for public health purposes, whether by Public Health England or by local authorities or their agents, this will need to conform to those information standards set by the NHS Commissioning Board for the NHS.

### *Children's public health*

- 3.27 We propose that public health services for children under 5 will be a responsibility of Public Health England which will fund the delivery of health visiting services, including the leadership and delivery of the Healthy Child Programme for under 5s (working closely with NHS services such as maternity services and with children's social care); health promotion and prevention interventions by the multiprofessional team and the Family Nurse Partnership. In commissioning these public health services, local areas will need to consider how they join-up with Sure Start Children's Centres to ensure effective links. In the first instance, these services will be commissioned on behalf of Public Health England via the NHS Commissioning Board. In the longer term we expect health visiting to be commissioned locally. The Department will shortly publish an implementation plan which will set out how the Government's commitment to a larger, re-energised health visiting service will be achieved. NHS Partners will need to help to focus on child protection and specifically the early intervention end of support for families through Local Safeguarding Children Boards.
- 3.28 Public health services for children aged 5-19, including public mental health for children, will be funded by the public health budget and commissioned by local authorities. This will include the Healthy Child Programme 5-19; health promotion and prevention interventions by the multiprofessional team and the school nursing service. Local authorities may wish to encourage active travel for children. Local authorities will want to consider the needs of vulnerable groups, for whom they have a responsibility to promote health and welfare, as part of their commissioning arrangements. Consideration is being given to the need for Child Health Information Systems (used for example in immunisation programmes) to be maintained.

### *Community safety, violence prevention and social exclusion*

3.29 Using their ring-fenced public health budget where they decide it is appropriate, local authorities will be responsible for working in partnership to tackle issues such as social exclusion including intensive family interventions, social isolation amongst older people, community safety including road safety awareness and violence prevention and response. This could include supra-local commissioning of services such as Sexual Assault Referral Centres or female genital mutilation (FGM) clinics, where appropriate.

### *Public health for those in prison or custody*

3.30 Where public health services are delivered in prison or for those in custody, these interventions will be funded by Public Health England. However, such interventions will be commissioned by the NHS Commissioning Board on behalf of Public Health England as part of an integrated service. In future we intend that services for offenders in the community and those returning to it from prison will be delivered as part of mainstream health planning and we are not consulting on this point. We will consider further the implications this will have for public health services.

### *Armed Forces public health*

3.31 We are not consulting on the funding and commissioning routes for public health for the Armed Forces as this activity will not be funded from the national public health budget. However, how the Department of Health, the Ministry of Defence and a number of organisations work to achieve the best funding and commissioning solutions to meet the needs of Service personnel, their families, and Veterans will be subject to further discussion.

### *Quality and Outcomes Framework*

3.32 There are public health and primary prevention indicators in the Quality and Outcomes Framework (QOF). In order to increase the incentives for GP practices to improve the health of their patients the Department proposes that a sum at least equivalent to 15% of the current value of the QOF should be devoted to evidence-based public health and primary prevention indicators. Information on achievement by practices will be available publicly, supporting people to choose their GP practice based on performance and enabling communities to hold the local NHS to account.

3.33 The funding for this will be held within the public health budget. It will be funded on a cash-neutral basis by replacing indicators that are less effective with indicators that will have a greater impact on improving patients' health and preventing disease. From 2013, it will become the responsibility of Public Health England, in consultation with the Devolved Administrations, to decide on the level of investment in QOF public health primary prevention indicators, based on priorities for improving people's health and reducing inequalities.

3.34 QOF is currently a UK framework. The Department proposes that Public Health England, having consulted with the Devolved Administrations, should work with NICE to review and develop the primary prevention indicators to include in the QOF. We will discuss how the arrangements will work with stakeholders, including NICE, the BMA and the Devolved Administrations. We are committed to maintaining an independent and transparent process for consulting on and recommending indicators for the QOF. Final decisions on which public health indicators to include in the QOF and their financial value will be made by UK Health Ministers following GP contract negotiations.

### *A requirement to provide certain services?*

3.35 The Department of Health wants to ensure that local authorities are accountable to their local communities, and that they are able to determine how best to improve public health and reduce inequalities in health in their local area. However, some services for which local authorities will take responsibility will need to be provided in a universal fashion in all areas; for example, all immunisation programmes provided or commissioned through local authorities which are essential in protecting public health, or open-access sexual health services. It should be noted that the proposed Health and Social Care Bill does not confer any health protection role on local authorities directly, therefore it will be left to Public Health England to enter into arrangements with local authorities in order that health protection functions are carried out on behalf of the Secretary of State.

3.36 Subject to the approval of Parliament, the forthcoming Health and Social Care Bill will provide that secondary legislation could set out that local authorities should be mandated to provide or commission a particular service. In keeping with our overall approach, this provision will not specify in significant detail how such services should be provided. The Department of Health would wish to make such a list of services as short as possible in order to give local authorities the maximum possible freedom.

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

3.37 Medicine supply is especially complex as supply of medicines is governed by legislation wider than NHS legislation and current routes of supply include those which are intricately linked with primary care contractual arrangements including General Medical Services and Pharmaceutical Services. The Department of Health will ensure that the supply of medicines is fully considered in the arrangements made for funding and commissioning of services in the new system.

3.38 Alongside identifying strategic health needs through Joint Strategic Needs Assessments, health and wellbeing boards will have responsibility for producing pharmaceutical needs assessments, which will inform the commissioning of community pharmacy services by

the NHS Commissioning Board and local public health commissioning decisions. The Department of Health will build on this as we establish the new system.

### *Baseline spend*

- 3.39 As a first step in determining the future budgets for public health, including the ring-fenced grant that will be paid to local authorities in order to fund the exercise of their functions, the Department is working to establish baseline spending on activities that will be funded from the public health budget in future. Building on the proposed commissioning responsibilities in Table A, early estimates suggest that current spend on areas that are likely to be the responsibility of Public Health England could be over £4bn. This estimate aims to include spend by the Department of Health, Strategic Health Authorities, Arms Length Bodies, as well as local spend by PCTs. Our estimate of local spend is based in part on a local informed survey of 2009-10 public health spending by NHS North West. The Department will be putting estimates of local spend through a validation and triangulation process to better inform the national estimate of spend.
- 3.40 We will ensure that the ring-fenced grant to Local Authorities is of an appropriate size and, as described below in paragraph 3.45, where provision of a service is mandatory, and would become a statutory function of local authorities, this will be supported by a transfer of the necessary resources, following the New Burdens principle.
- 3.41 However, this estimate is subject to further significant revision. In particular as responses on the responsibilities to be funded from the public health budget lead to revisions in the design of the service, the estimated spend, and hence future budgets, will be revised.

### *Accountability*

- 3.42 The accountability arrangements for Public Health England and local authorities are described in *Healthy Lives, Healthy People*, including, as illustrated in figure 4.1 of the same document, the key principle that accountability is that it should follow the funding.
- 3.43 The Secretary of State for Health remains accountable for resources allocated to the health and social care system as a whole, for strategy and the legislative and policy framework and for progress against national outcomes. These are core departmental functions.
- 3.44 As part of the Department of Health, Public Health England will be accountable to the Secretary of State for Health in relation to the functions it exercises, for example for delivery of a robust and effective set of health protection functions, including the appropriate input into NHS resilience arrangements, and for national contributions to various public health outcomes. For those services commissioned by the NHS, there will need to be clear accountability lines, for example through a service level agreement.

3.45 The primary accountability for local government will be to their local populations:

- a) **Through transparency** - Public Health England will publish data on national and local performance against the public health outcomes framework. This will enable democratic accountability for performance against those outcomes, make it easy for local areas to compare themselves with others across the country, allow local people to assess the performance of their local authority – where possible to local neighbourhood level - and contribute to the process of priority setting, and increase the incentives for local authorities to improve their performance;
- b) **Through the health and wellbeing board** - The health and wellbeing board will provide a forum in which elected representatives, such as local mayors or councillors, DsPH, Children and Adult Services, GP consortia, the NHS Commissioning Board where necessary, HealthWatch and potentially local community and voluntary organisations can come together to co-ordinate commissioning of NHS, social care and public health services, by undertaking the Joint Strategic Needs Assessment and to develop a high level joint health and wellbeing strategy aimed at addressing local needs; and
- c) **Through new statutory functions** –Subject to Parliamentary approval, a new health improvement duty on local authorities will be provided for in the forthcoming Health and Social Care Bill, and will underpin local authorities' new role. The Health and Social Care Bill will seek to place some health protection duties on the Secretary of State for Health, on which the Secretary of State may, in the exercise of those functions, agree with local authorities that they should lead. It will also (subject to the approval of parliament) provide for a power to specify in secondary legislation those services which all local authorities should provide (see discussion of this in paragraphs 3.35-3.36). This will ensure that where a service is essential, its provision is mandatory, and would become a statutory function of local authorities, supported by a transfer of the necessary resources through the ring-fenced budget, following the New Burdens principle. This would mean that local authorities will take on a broader public health role than merely health improvement, backed by the appropriate resources, whilst the Secretary of State for Health would have a back-up power to ensure delivery of essential services, should this prove necessary. In keeping with our overall approach, this provision would not specify in significant detail how such services should be provided; to use the example of open access sexual health services, it would be for local authorities to determine how best to deliver such open-access.

3.46 There will also be a relationship between the national Public Health England and local authorities, which means that local government will be accountable to Public Health England:

- a) **Through transparency** of progress against the outcomes framework as set out above, and in the consultation document on public health outcomes; and
- b) **For the proper use of the ring-fenced grant.** The local authority will need to be able to demonstrate that the ring-fenced grant has been spent appropriately, including ensuring value for money.

3.47 To ensure transparency, specific data and information about health and care services and outcomes will need to be made available in order to support Public Health England and local government to assess the impact of public health interventions and action. In terms of information about health and care services more generally, as set out in the consultation *Liberating the NHS: An Information Revolution*, the Government is committed to moving away from a culture in which information has been held close and recorded in forms that are difficult to compare, to one characterised by openness, transparency and comparability. We also want to move away from government being the main provider of all information about the quality of services, to a range of organisations being able to offer health and care service information to a variety of audiences. This will enable local and national democratic accountability for progress against those outcomes, making it easy for local areas to compare themselves with others across the country, and increase the incentives to improve their outcomes.

3.48 The public health grant to local authorities will be made under section 31 of the Local Government Act 2003 and as a ring-fenced grant will carry some conditions about how it is to be used. These conditions could be used to ensure the ring-fenced grant is spent appropriately, including ensuring value for money. For example, conditions could describe the purpose of the grant at various levels of detail, or more specifically, conditions could address what sort of services should or should not be provided using the grant. A condition on the grant could be used to set out expectations about processes surrounding the grant, for example, to specify the role of the Director of Public Health in relation to spending decisions: or, to provide for other accountability arrangements. However, we will need to balance the need to ensure accountability for spend against the desirability of maximising the capacity for local decision-making about how best to spend the money and to minimise bureaucracy. We intend to seek to ensure this balance in any conditions that we impose on the grant.

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

3.49 Local authorities and DsPH will have the freedom to pool and align budgets locally as part of a local application of community (place-based) budgets where this is the best route to improving health and wellbeing outcomes for local people, and to support preventative public health work to benefit the local area. For example, when tackling drug misuse in younger people, local authorities may prefer a multi-agency response, with treatment, youth offending, mental health and children's services all working together to ensure

support is in place. Local authorities may also want to consider pooling funding across local authority areas.

- 3.50 In addition, the health premium will provide an incentive to better performance providing a formula based and results based payment to incentivise action to reduce health inequalities; (as discussed in chapter 5 on the health premium). However, there will be no centrally imposed targets, and no performance management of local authorities by the centre. It will be for local authorities to determine their priorities.
- 3.51 Directors of Public Health will be jointly appointed by the relevant local authority as well as Public Health England. While local authorities will have the power to dismiss DsPH for serious failings across the full spectrum of their responsibilities, the Secretary of State for Health will have the power to dismiss them for serious failings in discharge of their health protection functions. Alongside this, there will be lines of professional accountability from DsPH to the Chief Medical Officer.

## 4. Allocations

- 4.1 From April 2013, Public Health England will allocate ring-fenced budgets, weighted for inequalities, to upper-tier and unitary authorities in local government for improving the health and wellbeing of local populations. The ring-fenced budgets will fund both improving population health and wellbeing, and some non-discretionary services, such as open-access sexual health services and certain immunisations. There will be scope, as now, to pool budgets locally in order to support public health work.
- 4.2 There will be shadow allocations to local authorities for this budget in 2012/13, providing an opportunity for planning before allocations go live in 2013/14 and an opportunity to evaluate the allocations process. During the transitional years 2011/12 and 2012/13, we will emphasise the need for the NHS to retain its emphasis on public health. The NHS Operating Framework for 2011/12<sup>ix</sup> sets out the operational arrangements to manage the transition, including that the NHS must continue to lead on improvements to public health in 2011/12, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities.
- 4.3 We intend to ask the independent Advisory Committee on Resource Allocation (ACRA) to support the detailed development of our approach to allocating resources to local authorities in due course, and in particular to support the creation of formula that can be used to calculate each local authority's "target" allocation for improving population health, reducing health inequalities and delivering mandatory services.
- 4.4 We believe there are three general approaches to consider when establishing the formula:
- "utilisation" – based on modelling the statistical relationship between current patterns of public health activity and need across the country. This is based on the premise that higher or lower expenditure in small areas provides information on relative need;
  - "cost-effectiveness" – based on potential gains in health outcomes across the country using available information about the cost-effectiveness of public health interventions, that is gains in health outcomes relative to spend; and
  - "population health measures" – based on measures of health outcomes, such as Standardised Mortality Ratios, or Disability-Free Life Expectancy. Allocations would be higher to areas with poorer health taking into account health inequalities. The measures would link to the Outcomes Framework.
- 4.5 With the evidence presently available, it may be that the third is the most pragmatic, at least in the short term. Information on public health activity and spend for small areas is patchy, and evidence on the cost-effectiveness of public health interventions is not comprehensive. However, depending on the final public health scope of the local authorities, the allocation could include a number of components, taking different approaches. These would be combined to form a single grant, within which local



authorities would be free to prioritise spending in a way that is appropriate to their local circumstances.

- 4.6 As is the case with PCTs currently, we may not be able to set local authorities' actual allocations immediately at the target allocation, as this would involve cutting allocations in some areas, which would risk destabilising existing services. Other areas may see a rapid increase in the available funding that they could not use effectively. Rather, we would move actual allocations from current spend towards the target allocations over a period of time. For PCT allocations this is known as the pace-of-change policy.

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

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

## 5. Health premium

- 5.1 As *Healthy Lives, Healthy People* described, we will incentivise action to reduce health inequalities by introducing a new health premium, which will apply to that part of the public health budget which is for health improvement. Building on the baseline allocation described above, local authorities will receive an incentive payment, or premium, that will depend on the progress made in improving the health of the local population and reducing health inequalities, based on elements of the Public Health Outcomes Framework.
- 5.2 The premium will be simple and driven by a formula developed with key partners, representatives of local government, public health experts and academics. We will develop the formula in a transparent and evidence based way. Disadvantaged areas will see a greater premium if they make progress, recognising that they face the greatest challenges. As well as minimising the administrative burden a formula based approach will ensure the premium is fair, with payments reflecting achievement, not the ability to negotiate a less stretching target.

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

- 5.3 In deciding how to use the Public Health Outcomes Framework elements for the health premium, we will need to balance responsiveness to local action with incentivising interventions offering greater long-term benefits. The design of the health premium also needs to be comprehensive enough not to distort local decisions and needs to incentivise health improvements that are spread across a local authority's population such that inequalities are reduced as overall health improves.

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

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

- 5.4 The Department of Health aims to pay local authorities for the progress they make and to ensure that they do not automatically receive additional funding if the health of the local population deteriorates. Nor should they be punished by seeing their funding reduce if they are successful in improving the health of their population. The health premium will be funded from within the funding available for public health and we will look for opportunities to reprioritise discretionary central public health funding to ensure LAs get the incentive payments they deserve and as part of a progressive rebalancing of central and local budgets.

- 5.5 The Department of Health intends the support for progress in reducing health inequalities to be clear and significant. Potentially, an area that makes no progress might receive no growth in funding for these services, but, other than losing the opportunity of the incentive payment, which would be a legitimate local decision, there would be no automatic financial detriment to not making progress on the indicators. Nor is this an all-or-nothing payment. There would be a sliding scale depending on the size and extent of a local authority's progress and relative to the authority's position in terms of relative health outcomes. Local Authorities will also want to have regard to the opportunities to gain additional incentives offered by the Payment by Results component of the Early Intervention Grant.
- 5.6 This is not a target regime. Central Government will not be dictating detailed targets. We believe that a combination of a national framework, financial incentives, local freedom on how outcomes will be achieved and greater transparency will be far more effective in energising and empowering local services to deliver of their best, rather than having to work to prescriptive targets for which they have little or no ownership.

***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?***

- 5.7 We will only be able to set out a detailed model when we have established the baseline and potential scale of the premium clearly, and have agreement about how the Public Health Outcomes Framework will be used. The Department of Health will then bring together a group of key partners. However, a number of the issues we will have to consider in the detailed design of the premium are already clear. These include:
- a) the sensitivity of indicators and outcomes to public health interventions;
  - b) the possibility of changes in indicators and outcomes for reasons unconnected with public health interventions;
  - c) the relative focus on the long-term outcomes and progress in the shorter term on those factors that drive these outcomes;
  - d) the frequency of reporting; and
  - e) the relative ease of making a difference to an indicator or outcome, and how this varies between areas with different characteristics.

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

- 5.8 We intend local authorities' share of funding for non-discretionary services, where the health premium will not apply, to grow in line with the estimated relative need of the population.

## 6. How to respond

6.1 The Department wants to make sure that it seeks the help and expertise of relevant organisations. We will arrange a programme of consultation events around England to facilitate this process. Details will be posted on the Department of Health website as well as advertised through stakeholder networks.

6.2 Consultation on the specific questions as set out below closes on 31 March 2011. You can contribute to the consultation by providing written comments to:

By email: [publichealthengland@dh.gsi.gov.uk](mailto:publichealthengland@dh.gsi.gov.uk)

Online: <http://consultations.dh.gov.uk/healthy-people/funding-and-commissioning>

By post: Public Health Consultation  
Department of Health, Room G16  
Wellington House  
133-155 Waterloo Road  
London SE1 8UG

## Consultation Questions

<p><b>Question 1.</b> Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?</p>
<p><b>Question 2.</b> 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?</p>
<p><b>Question 3.</b> How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?</p>
<p><b>Question 4.</b> 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?</p>
<p><b>Question 5.</b> 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?</p>
<p><b>Question 6.</b> 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?</p>

<p><b>Question 7.</b> Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:</p> <p>a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and</p> <p>b) reduce avoidable inequalities in health between population groups and communities?</p> <p>If not, what would work better?</p>
<p><b>Question 8.</b> Which services should be mandatory for local authorities to provide or commission?</p>
<p><b>Question 9.</b> Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?</p>
<p><b>Question 10.</b> Which approaches to developing an allocation formula should we ask ACRA to consider?</p>
<p><b>Question 11.</b> Which approach should we take to pace-of-change?</p>
<p><b>Question 12.</b> Who should be represented in the group developing the formula?</p>
<p><b>Question 13.</b> Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?</p>

<b>Question 14.</b> How should we design the health premium to ensure that it incentivises reductions in inequalities?
<b>Question 15.</b> Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
<b>Question 16.</b> What are the key issues the group developing the formula will need to consider?

## The consultation process

### *Criteria for consultation*

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

### *Comments on the consultation process itself*

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

**contact**      Consultations Co-ordinator  
Department of Health  
3E48, Quarry House  
Leeds  
LS2 7UE

**e-mail**      [consultations.co-ordinator@dh.gsi.gov.uk](mailto:consultations.co-ordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

### *Confidentiality of information*

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).



If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

### *Summary of the consultation response*

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at

<http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

## Glossary

**Big Society Bank** – the Big Society Bank will ensure that all the money from dormant bank accounts made available to England is put to good use for the benefit of society.

**Commissioning** – the process of assessing the needs of a local population and putting in place services to meet those needs.

**Devolved Administrations** – refers to the governments of Scotland (the Scottish Government), Wales (the National Assembly for Wales) and Northern Ireland (the Northern Ireland Assembly).

**Directors of Public Health (DsPH)** – currently a role within NHS primary care trusts, moving to local authorities in the future; the lead public health professionals who focus on protecting and improving the health of the local population.

**Health and Social Care Bill** – proposals for a Health Bill were included in the Queen’s Speech for the first Parliamentary session of the Coalition Government. The Health and Social Care Bill will bring forward the legislative changes required for the implementation of the proposals in this White Paper.

**Health premium** – a component of the new funding mechanism for public health that will reflect deprivation and reward progress against health improvement outcomes in local areas.

**Health Protection Agency (HPA)** – the current non-departmental public body responsible for a range of health protection functions.

**Local authorities** – see **Local government**, below.

**Local government** – refers collectively to administrative authorities for local areas within England, with different arrangements in different areas, including:

- two-tier authorities: several district councils (‘lower-tier’, responsible for, for example, council housing, leisure services, recycling, etc.) overlap with a single county council (‘upper-tier’, responsible for, for example, schools, social services and public transport);
- unitary: a single layer of administration responsible for local public services, including: metropolitan district councils; boroughs; and city, county or district councils;
- town and parish councils: cover a smaller area than district councils and are responsible for, for example, allotments, public toilets, parks and ponds, war memorials, local halls and community centres; and
- shared services: where it is considered appropriate, local government may share services across areas greater than individual administrative bodies, for example, for policing, fire services and public transport.

**National Institute for Health and Clinical Excellence (NICE)** – an independent organisation which provides advice and guidelines on the cost and effectiveness of drugs and treatments.

**National Treatment Agency for Substance Misuse (NTA)** – current special health authority established to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

**NHS Operating Framework** – sets out the priorities for the NHS, the business rules to support their delivery and the accountability process for each financial year.

**Primary care trust (PCT)** – the NHS body currently responsible for commissioning healthcare services – and, in most cases, providing community-based services such as district nursing – for a local area.

**Provider** – an organisation that provides services directly to patients, including hospitals, mental health services and ambulance services.

**Public Health England** – A new integrated public health service that will be set up as part of the Department of Health (including the current functions exercised by the National Treatment Agency and the Health Protection Agency) to ensure excellence, expertise and responsiveness, particularly on health protection, where a national response is vital.

**Public Health Observatories** – existing organisations that serve the public health intelligence needs of different regions in England.

**Spending Review** – set out the Government's priorities, and spending plans to meet these priorities, for the period 2011/12–2014/15.

**Unitary authority** – see **Local government**, above.

**Upper-tier authority** – see **Local government**, above.

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## Endnotes

- <sup>i</sup> Department of Health (2010) *Healthy Lives Healthy People: our strategy for public health in England*,  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121941](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941)
- <sup>ii</sup> Department of Health (2010) *Equity and Excellence: Liberating the NHS*,  
[www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm](http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm)
- <sup>iii</sup> For more information see Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens*,  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121508](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508)
- <sup>iv</sup> Department of Health (2010) *Liberating the NHS: Legislative framework and next steps*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122661](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661)
- <sup>v</sup> Early implementer Health and Wellbeing Boards will take the form of non-statutory partnership arrangements in 2010/11, to recognise local energy and enthusiasm where it exists. They are described in *Liberating the NHS: Legislative framework and next steps*, as above.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122661](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661)
- <sup>vi</sup> For more information see Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens*,  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121508](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508)
- <sup>vii</sup> Griffiths, S., Jewell, T. and Donnelly, P. (2005) Public health in practice: The three domains of public health. *Public Health*; 119(10): 907–13.
- <sup>viii</sup> The Equality Impact Assessment was published alongside the White Paper, *Healthy lives healthy people: Our strategy for public health in England*, Department of Health (2010)  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121941](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941)
- <sup>ix</sup> Department of Health, (2010) *Operating Framework for the NHS in England 2011/12*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122738](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738)