Appendix A

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 1

Healthy Lives, Healthy People: Our Strategy for Public Health In England published on 30 November 2010. Consultation closes on 8 March 2011. The full document, which includes details of how to respond to the consultation, is available from
http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

Introduction

Healthy Lives, Healthy People: Our Strategy for Public Health In England sets out the Coalition Government's new approach to public health and some of the structures and processes that will support delivery. The vision is to protect the population "from serious health threats, helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest fastest".

What the new approach will do

- Protect the population from health threats
- Empower local leadership and encourage wide responsibility across society to improve everyone's health and well being and tackle the wider factors that influence it
- Focus on key outcomes and doing what works to deliver them
- Provide transparency and accountability through a new public health outcomes framework
- Reflect the government's core values – freedom, fairness, responsibility by
    - strengthening self esteem, confidence and personal responsibility
    - positively promoting healthy lifestyles
    - adapting the environment to make healthier choices easier
- Balance the freedoms of individuals and organisations with a need to avoid harms to others, using the Nuffield Council on Bioethics 'ladder' or interventions;
- Be responsive, resourced, rigorous and resilient

Health and wellbeing throughout life

The key issues are set out as:

- Empowering local government and communities with new resources, rights and powers to shape their environments and tackle local problems.
- Taking a coherent approach to different life stages and key transition points instead of tackling individual risk factors in isolation.
- Emphasis on mental health
- Giving every child in every community the best start in life
    - Reducing child poverty
    - Increasing health visitor numbers
    - Doubling reach of Family Nurse Partnership programme
    - Refocusing Sure Start Children's Centres on those that need them most
    - Olympic style sports programme for schools from 2012
- Making it pay to work through comprehensive welfare reforms.
- Working with employers as champions of public health
- Designing communities for active age and sustainability
- Working collaborative with business and the voluntary sector through the public health Responsibility Deal. Five networks on:

- Food – less salt, better information for consumers
- Alcohol – more responsible retailing and consumption
- Physical activity
- Health at work
- Behaviour change – develop Change4Life, vouchers for healthy lifestyle choices

Approach

- Localism - with responsibilities, freedoms and funding devolved wherever possible;
- Directors of Public Health (DsPH) will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors.
- A new, dedicated professional public health service – Public Health England – will be set up as part of the Department of Health to strengthen emergency preparedness and health protection
- There will be a ring-fenced public health funding for upper-tier and unitary local authorities (LA's) from within the overall NHS budget – currently estimated at £4 billion - and a new health premium to reward LA's for progress made against elements of proposed public health outcomes framework, taking into account local health inequalities.
- The best evidence and evaluation to be used, supporting innovative approaches to behavioural change. New NIHR School for Public Health Research to be established
- The Chief Medical Officer (CMO) will have a central role in providing independent advice to the secretary of state for health and the government
- Public health will be part of the NHS commissioning board's (NHSCB) mandate
- There will be stronger incentives for GPs so that they play an active role in public health

Structures

The Government plans to:

- Enable the creation of Public Health England (PHE) from 2012
- Transfer local health improvement functions to local government with ring-fenced funding allocated to local government from April 2013 and
- Give local government new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health.
- Further consultation documents on outcomes framework, funding and commissioning arrangements for public health and specific areas of health improvement

Role of the Director of Public Health

- Principle adviser on all health matters to the local authority
- Key role in new function of LAs. Contribute to Joint Strategic Needs Assessment (JSNA), Joint Health and Wellbeing Strategy and produce authoritative independent Annual Report

- Ensure LA and partners have access to high quality analysis and evidence to inform JSNA, Annual Report, emergency preparedness and response, and all public health services for which responsible.
- Work closely with GP consortia to help identify, prevent and manage a range of conditions (e.g. mental ill health, CVD, diabetes and cancer)
- Input into the commissioning of services for people with established diseases and long term conditions
- Work with NHS colleagues locally in:
    - advising on commissioning and effective operation of population health services;
    - ensuring the provision of services for diverse and potentially excluded groups (for example, people with mental health problems and with learning disabilities; the homeless; people in prisons and ex-offenders; children with special educational needs or disability and looked after children; and travellers);
    - advising on how to ensure equal access and equity of outcome across the population; and
    - working with and supporting health and social care colleagues to increase opportunities for using contacts with the public and service users to influence behaviours positively and thereby improve health.
- Important role in emergency planning and response, supported by local Health Protection Units
- Contribute to Local Resilience Forum (LRF) and ensure sufficient trained Public Health staff to maintain on-call rota
- Responsible for health improvement and addressing health inequalities in health outcomes, and working in partnership locally and with Public Health England to achieve better public health outcomes for the whole of their local population.
- Jointly appointed by LA and PHE. Accountable to Secretary of State for Health and professionally to CMO.

Rod Moore
Deputy Director of Public Health
29 December 2010

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 2.

Healthy Lives, Healthy People: Transparency in outcomes published on 20th December 2010. Consultation closes on 31 March 2011. The full document, which includes details of how to respond to the consultation, is available from http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

Introduction
This is part of a suit of three outcomes frameworks – NHS, Adult Social Care, and Public Health - and is intended to provide equivalent arrangements for the delivery and monitoring of improvements in public health.

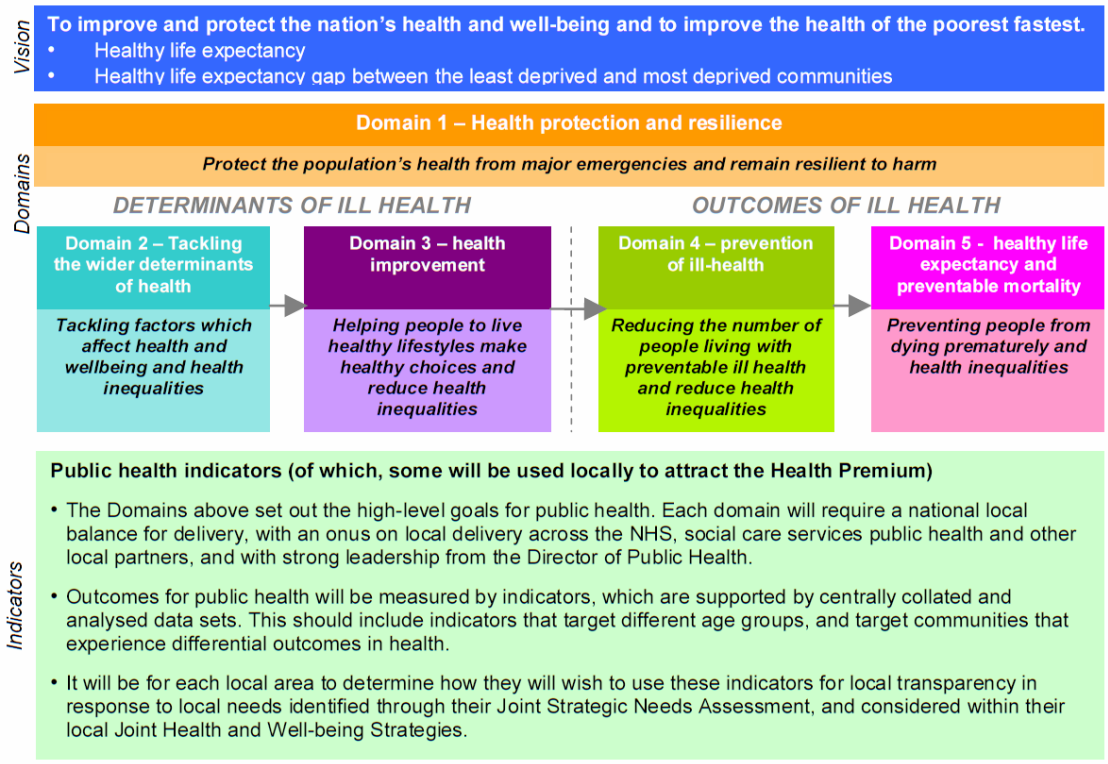
It sets out the government's *goals* in relation to health improvement and health inequalities and provides a *mechanism* for transparency and accountability across the public health system at the national and local level, and a means to incentivise local health improvement and inequality reduction through the "health premium".

The new framework for Public Health Outcomes will be in operation from April 2012.

Goals/domains
The outcomes framework (see figure 1 below) proposes five domains:
1. Health Protection and resilience
2. Tackling the wider determinants of health
3. Health Improvement
4. Prevention of ill health
5. Healthy life expectancy & preventable mortality

The framework also specifies responsibility for these domains (see Figure 2).

Figure 1 A framework for public health outcomes



The consultation document indicates:
- the strong case for domain 5, reducing rates of premature mortality, to be shared with the NHS;

- that local authorities and their partners must also seek to advance equalities, eliminate the impact of discrimination and narrow inequalities in health behaviours between communities;
- that further consideration will be given to whether outcomes relating to safeguarding and child protection should be included in the framework in the light of the national review of Child Protection to be completed in April 2011.

Indicators
Each domain includes a set of indicators (see figure 2) to be supported by nationally collated and analysed data which will be published in a common format by Public Health England. This should include indicators that target different age groups, and target communities that experience differential outcomes in health.

A small number of indicators will focus on health improvement relating to the causes of the greatest burdens of disease and death (e.g. obesity, smoking, alcohol and the level of physical activity). The remaining indicators will cover other domains of public health including health protection and preventative services, and reflect the wider determinants of health, to link in the different local services that play a part in delivering health and wellbeing and to hold national Government to account.

For a sub set of those indicators, to be agreed with public health and local government partners, a "health premium" will incentivise councils to make progress on health improvement priorities and reduce health inequalities.

Purposes
The framework is not intended as a performance management tool, rather the information:
- at the national level will allow partners and government to understand the key priorities for health and aid efforts to prioritise actions.
- at the local level will be interrogated as required and used to compare areas with others across the country, and where possible how performance is changing within areas, and lever improvements.
- it will be for each local area to determine how they will wish to use the final indicators for local transparency in response to local needs identified through the JSNA and in the Joint Health and Well Being Strategy developed by Health and Wellbeing Boards.
- the government will work to ensure that public health data can be disaggregated by key equality characteristics and neighbourhoods where possible
- will support local partners to work together where they share common outcome goals

Consultation
The consultation document includes questions and invites suggestions as to which indicators will finally be included in the outcomes framework and on the structure of the framework itself.

Figure 2 'Long list' of proposed indicators for each domain of the Public Health Outcomes Framework.
NB. Detailed definitions of the indicators are provided in the consultation document. Indicators marked in *italics* are to be developed.

VISION – To improve and protect the nation's health and wellbeing and to improve the health of the poorest, fastest.
- Healthy life expectancy

- Differences in life expectancy and healthy life expectancy between communities.
1. Health Protection and resilience
National coordination by Public Health England with contribution from LAs
- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle. Systems failures identified through testing or through response to real incidents are identified and improvements implemented. - Systems in place to ensure effective and adequate surveillance of health protection risks and hazards. - Life years lost from air pollution as measured by fine particulate matter - Population vaccination coverage (for each of the national vaccination programmes across the life course) - Treatment completion rates for TB - Public sector organisations with a board approved sustainable development management plan.
2. Tackling the wider determinants of health
Health and Wellbeing Boards and "all public services"
- Children in poverty - School readiness: foundation stage profile attainment for children starting Key Stage 1 - Housing overcrowding rates - Rates of adolescents not in education, employment or training at 16 and 18 years of age - Truancy rate - First time entrants to the youth justice system - Proportion of people with mental illness *and or disability* in settled accommodation** - Proportion of people with mental illness *and or disability* in employment *, ** - Proportion of people in long-term unemployment - Employment of people with long-term conditions - Incidents of domestic abuse** - Statutory homeless households - Fuel poverty - Access and utilisation of green space - Killed and seriously injured casualties on England's roads - The percentage of the population affected by environmental, neighbour, and neighbourhood noise - Older people's perception of community safety** - Rates of violent crime, including sexual violence - Reduction in proven reoffending - *Social connectedness* - *Cycling participation* **Shared responsibility with the NHS* *** Shared responsibility with Adult Social Care*
3. Health Improvement
Local Government led by DsPH in partnership with Health and Wellbeing Boards
- Prevalence of healthy weight in 4-5 and 10-11 year olds - *Prevalence of healthy weight in adults* - Smoking prevalence in adults (over 18) - Rate of hospital admissions per 100,000 for alcohol related harm - Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week) - Hospital admissions caused by unintentional and deliberate injuries to 5-18 year

olds - Number leaving drug treatment free of drug(s) of dependence - Under 18 conception rate - Rate of dental caries in children aged 5 years (decayed, missing or filled teeth) - *Self reported wellbeing*
4. Prevention of ill health
Health and Wellbeing Boards – public health, NHS, adult social care, children's services
- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds. - Rate of hospital admissions as a result of self-harm - Incidence of low-birth weight of term babies - Breastfeeding initiation and prevalence at 6-8 weeks after birth - Prevalence of recorded diabetes - Work sickness absence rate - Screening uptake (of national screening programmes) - Chlamydia diagnosis rates per 100,000 young adults aged 15-24 - Proportion of persons presenting with HIV at a late stage of infection - *Child development at 2 - 2.5 years* - Maternal smoking prevalence (including during pregnancy) - Smoking rate of people with serious mental illness - Emergency readmissions to hospitals within 28 days of discharge*, ** - Health-related quality of life for older people** - Acute admissions as a result of falls or fall injuries for over 65s** - *Take up of the NHS Health Check programme by those eligible* - *Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed* **Shared responsibility with the NHS* *** Shared responsibility with Adult Social Care*
5. Healthy life expectancy & preventable mortality
Health and Wellbeing Boards –shared by NHS, public health, care services and Public Health England locally
- Infant mortality rate* - Suicide rate - Mortality rate from communicable diseases - Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age* - Mortality rate from cancer in persons less than 75 years of age* - Mortality rate from Chronic Liver Disease in persons less than 75 years of age* - Mortality rate from chronic respiratory diseases in persons less than 75 years of age* - Mortality rate of people with mental illness* - Excess seasonal mortality **Shared responsibility with the NHS*

Rod Moore
Deputy Director of Public Health and Health Improvement
29 December 2010

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 3.

Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health. Published on 20[1st] December 2010. Consultation closes on 31 March 2011. The full document, which includes details of how to respond to the consultation, is available from
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122916

NB: additional headings have been introduced in this summary to help organise the material. Page references to the consultation document are provided.

Introduction

This consultation document provides significant detail to the proposals outlined in Healthy Lives, Healthy People: Our Strategy for Public Health In England which set out the Government's new approach to public health and some of the structures and processes that will support delivery.

Funding and commissioning flows (page 7)

Public Health services will be funded by a new public health budget separate from that managed through the NHS Commissioning Board (NHSCB) for healthcare, to ensure that investment in public health is ring fenced.

Public Health England (PHE) will fund public health activity through three principal routes:

- allocations to local authorities (LAs);
- commissioning services via the NHSCB;
- commissioning or providing services itself.

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 by the NHSCB acting on behalf of PHE, or led by LAs through a ring fenced grant.

For funding purposes, the DH is treating existing functions of LAs as separate from the public health ring-fence, as they are already funded through the existing funding settlement e.g. local authority health protection activity. LAs will be free to integrate management of these functions with their new public health responsibilities, should they wish. Health and Well Being Boards will provide a mechanism for bringing together discussions about investment and cross-cutting services including existing social care primary prevention.

Local authorities (p8)

LAs will:

- have a new statutory duty to take steps to improve the health of their population in addition to other related statutory functions;
- receive a ring fenced grant in order to fund the activities carried out in the exercise of these functions;

The DH expects that:

- the majority of services will be commissioned, as an opportunity to engage local communities and deliver best value and best results;
- local people will have access to information about commissioning decisions and the outcomes that have been achieved.

LAs 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 & Wellbeing Board.

Health & Wellbeing Boards should develop a high level Joint Health and Well Being Strategy that spans the NHS, social care, public health (and could potential consider wider health determinants such as housing, or education) to provide the overarching framework within which commissioning plans for the NHS, social care, public health and other services are developed.

The government will place a duty on commissioners to have regard to the JSNA and the joint health and well being strategy when exercising their functions.

These freedoms and the new ring-fenced budgets open up opportunities for local government to take innovative approaches to public health involving new partners including:

- Contracting for services with a wide range of providers;
- Incentivising and rewarding those organisations for improving health and well being outcomes and tackling inequalities;
- Voluntary, community and social enterprise sector organisations;
- Sharing expertise, and wider initiatives such as the Big Society Bank;
- Local communities to support preventative community focussed activities - such as volunteering, peer support , befriending and social networks;
- Generally LAs should be commissioning on an any willing provider/competitive tender basis.

National level (p10)
Where necessary PHE will commission and/or provide services, such as national campaigns and directly provide some activity which will be exercised locally e.g. health protection units.

Sub National or Supra-local commissioning arrangements (p10)
There will be no formal structures for sub national commissioning. Where necessary these could be established as part of PHE, or by LAs choosing to adopt supra–local arrangements for commissioning activities for which they are responsible, through, e.g., one LA leading on behalf of others.

Public health funded services commissioned via the NHS (p11)
PHE may ask the NHS to take responsibility for commissioning public health interventions and services funded from the public health budget e.g. screening programmes. This will be mediated via relationship between PHE and the NHSCB.

Where the NHS takes responsibility for commissioning public health interventions, the NHS commissioning architecture will determine how it does so appropriately – usually via GP consortia. However, it will be possible for PHE to influence how services are commissioned in certain instances e.g. childhood immunisation and cervical screening tests.

NHS funded and commissioned services (p11)
Public health work should remain an integral part of the services provided in primary care, and will continue to be funded from within the overall resources used by the NHSCB to commission these services. This includes public health activity carried out by GP practices, dentists, and community pharmacists.

Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients.

DsPH are able to advise GP consortia on public health issues and nationally via the relationship between the secretary of state/PHE and the NHSCB.

Ensuring flexibility on commissioning services (p12)
Where commissioning arrangements are providing an inadequate service, PHE will be able to change the funding and commissioning route, subject to contractual or other constraints.

GP practices are currently the preferred provider for a range of public health services under the GP contract e.g. childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. There may be a case for PHE and LAs 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.

Defining commissioning responsibilities (pp13-15)

The consultation document details the activities that will be funded by the public health budget, the proposed primary commissioning route and the associated NHS-funded activities.

LAs should be the lead commissioner for:
- Weighing and measuring children
- Dental public health
- Fluoridation
- Medical inspection of school children

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)

Functions of the Current Health Protection Agency (p20)
PHE will take responsibility for functions of the current Health Protection Agency, including:
- Surveillance
- Public Health and Reference microbiology
- Leadership to co-ordinate outbreak investigation and contact tracing
- Public Health advice on infection prevention to the whole health and social care system

The NHS will remain responsible for funding and commissioning infectious disease treatment and related public health activity.

Table A (attached) details the activities that will be funded by the public health budget, the primary commissioning route, and NHS associated activities. The section below expands on this table.

Further detail on the commissioning of specific public health activity

In general, health improvement work will be led by LAs using funds from the ring-fenced public health budget.

Services the Consultation proposes LAs should lead on, will not be commissioned by PHE at a national level, or commissioned by the NHS using public health funds.

Immunisation (p20)
PHE 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 through LAs and the NHSCB.

LAs should be responsible for commissioning immunisation programmes primarily delivered through schools, such as HPV and the Teenage Booster from a range of providers.

PHE will transfer funds from the Public Health budget to the NHSCB to allow them to commission the remaining immunisation programmes – including the childhood, seasonal flu and pneumococcal vaccination programmes.

The NHSCB will be responsible for commissioning a service for the whole population. Where GPs are not preferred providers, or where individual GPs opt out or are decommissioned from providing a service, the NHSCB will commission alternative providers as appropriate e.g. community pharmacists.

The NHS will continue to commission targeted neonatal hepatitis B and BCG vaccination provision, funded by PHE.

Screening (p21)
PHE will be responsible for funding all national screening programmes. The NHSCB will commission established programmes on behalf of PHE with funding transferred for that purpose.

Sexual Health (p21)
LAs will be responsible for commissioning comprehensive open-access sexual health services using funds from the ring-fenced public health budget, including:

- testing and treatment of STIs, (including opportunistic Chlamydia testing)
- high quality partner notification activity
- working with GP practices to encourage opportunistic testing and treatment of STIs in primary care
- fully integrated termination of pregnancy services (services that also offer the full range of contraception, STI testing and, where appropriate, treatment

PHE will fund the commissioning by the NHSCB of contraceptive provision through primary care commissioning arrangements. LAs 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.

PHE will work with the NHSCB to provide more specialised commissioning for human immunodeficiency virus (HIV) treatment and care, where efficiencies can be made.

Tobacco contact, obesity, physical activity and nutrition (p22)

LAs will be responsible for smoking cessation services and other local tobacco control activities, including commissioning or providing STOP smoking services, prevention activities, enforcement and local communication.

Obesity and physical activity programmes, including encouraging active travel, will also become the responsibility of the LAs as will the National Child Measurement Programme at the local level, with PHE co-ordinating the programme at the national level.

Any local initiative relating to nutrition will be commissioned or undertaken by LAs. However, PHE will be responsible for running national nutrition programmes, such as Healthy Start.

The LAs should have responsibility for workplace health at a local level.

Alcohol and drug misuse (p22)
LAs will be responsible for commissioning treatment, harm reduction and prevention services for the local population, providing an opportunity to more comprehensively join up the commissioning of drug and alcohol interventions and recovery services locally. This will be supported by PHE which will provide evidence and effectiveness, guidance and comparative analysis to support local areas in the task.

The NHS Health Check Programme (p22)
LAs will commission the NHS Health Check Programme with PHE responsible for design, piloting and role out of any extension of the programme.

Early presentation and diagnosis (p23)
PHE will be responsible for designing and funding initiatives to promote early presentation and diagnosis e.g. national bowel symptom campaign. LAs may also choose to commission such initiatives from the local ring-fenced budget

Reducing birth defects (p23)
PHE will be responsible for the surveillance of birth defects and anomaly registers.

PHE will lead on the co-ordination of oral health surveys.

Dental Public Health (p23)
LAs will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes.

Contracts for existing (and any new) fluoridation schemes will become the responsibility of PHE.

Consultations on proposals for new schemes will be conducted by LAs using a majority rule where a scheme covers more than one local authority area.

Public mental health (p23)
LAs will take on responsibility for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities.

Treatment of mental ill health, including improving access to psychological therapies e.g. (IAPT) will be funded and commissioned by the NHS. Health and Wellbeing Boards will need to ensure appropriate integration.

Emergency preparedness and response (p24)
PHE 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 NHSCB will be responsible for mobilising the system in times of emergency in ensuring the resilience for preparedness of the NHS to respond to emergency situations.

Most incidents will be managed locally with the public health response being led by the Director of Public Health and PHE Health Protection Units, as part of multi-agency local response arrangements.

Public Health information and intelligence (p24)
PHE 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 function of the HPA. This will include:

- collecting and managing data
- analysing, evaluate and interpret data to assess needs, set priorities and forecast future requirements, focusing effort on public health and wellbeing outcomes and inequality reductions supporting the specific requirements of LAs
- Identify interventions which are most cost effective and linked to improved health outcomes.
- modelling the potential impact of particular interventions for different groups and communities where possible and providing economic assessments of costs and benefits in specific settings.
- The public health budget will support information and functions at a national level that will provide the basis for effective DsPH Annual Reports and Joint Strategic Needs Assessment, for example the Public Health Compendium.
- Establishing an accessible and authoritative web based evidence system for public health professionals;
- Sharing good practice using the Chief Medical Officer's Public Health Awards.
- LAs will require a core of information and evidence capacity to support DsPH, although large scale analysis will be done once at a national level.
- Communicating with the public will be a priority for LAs, providing people and communities within their areas with the knowledge and understanding they need to challenge their local health system.
- Equivalent standards will be set for social care and public health services to those in the NHS for management and use of data relating to care. Where data is collected from the NHS (consortia and providers) for public health purposes, whether by PHE or by LAs or their agents, this will need to conform to those information standards set by the NHSCB.

Children's Public Health (p25)
Public health services for children under 5 years will be a responsibility of PHE, which will fund the delivery of health visiting services, including healthy child programme for under 5's, health promotion and prevention interventions by the multi-professional team and the Family Nurse Partnership. The need for local areas to consider how they join up with Sure Start Children's Centres is recognised.

In the first instance, these services will be commissioned on behalf of PHE via the NHSCB. In the longer term, it is expected that health visiting will be commissioned

locally. The Department will be publishing shortly an implementation plan for a larger, reenergised health visiting service.

NHS partners will need to help to focus on child protection and the early intervention end of supporting families through local Safe Guarding Children's Board.

LAs will commission from the ring-fenced public health budget services for children aged 5 – 19, including public mental health for children. The healthy child programme 5 – 19, health promotion and prevention interventions by the multi-professional team and the school nursing services.

LAs may wish to encourage active travel for children and the needs of vulnerable groups.

Community safety, violence prevention and social exclusion (p26)
Using their ring-fenced public health budget when they decide it is appropriate, LAs 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 super-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 (p26)
Where public health services are delivered in prison or for those in custody, these will be funded by PHE but commissioned by the NHSCB as part of an integrated service.

Armed forces public health_(p26)
Public health activity for the armed forces will not be funded from the national public health budget.

Quality and outcomes framework (p26)
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.

The funding for this will be held within the public health budget. 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 PHE will decide on the level of investment in QOF public health primary prevention indicators, based on priorities for improving people's health and reducing inequalities.

A requirement to provide certain services? (p27)

The consultation acknowledge that some Public Health services for which LAs will take responsibility will need to be provided in a universal fashion in all areas e.g. immunisation programmes, open-access sexual health services.

Secondary legislation could set out that local authorities should be mandated to provide or commission a particular service.

The Department of Health will ensure that the supply of medicines is fully considered and arrangements made for funding and commissioning of services in the new system.

Health and Well Being Boards will have responsibility for producing pharmaceutical needs assessments which will inform the commissioning of community pharmacy services by the NHSCB and local public health commissioning decisions.

Funding and accountability

Baseline spend (p28)

Based on the commissioning responsibilities in table A early estimates suggests that the current spend in the region of £4 billion in England. This includes the spend by DH, SHAs arm's length bodies and PCTs. There will be further validation and triangulation process to better inform the national estimate of spend.

Ring-fenced grant to LAs will be of an appropriate size and where provision of a service is mandatory, and would become a statutory function of LAs, this will be supported by a transfer of the necessary resources.

Estimate of cost is subject to further significant revision, including responses to this consultation.

Accountability (p28)

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.

As part of the Department of Health, PHE will be accountable to the Secretary of State for Health. For services commissioned by PHE from the NHS there will need to clear accountability lines for example through a service level agreement.

The primary accountability for local government will be to their local populations –

- Through transparency – PHE will publish data on national and local performance against the public health outcomes framework
- Through the Health and Well Being Board which will provide a forum in which elective representatives, DsPH, children and adult services, GP consortia, the NHSCB where necessary , Health Watch and potentially local community and voluntary organisations can come together to coordinate commissioning of NHS, social care and public health services.
- Through new statutory functions. The secretary of state for health will place some health protection duties on LAs or through secondary legislation specify services which all LAs should provide. This would mean that LAs would take on a broader public health role than merely health improvement, backed by the appropriate resources.
- to PHE through transparency of progress against the outcomes framework and for the proper use of the ring-fenced grant.

To ensure transparency, specific data and information about health and care services and outcomes will need to be made available in order to support PHE and local government to assess the impact of public health interventions and actions.

Public health grants to LAs will be made under section 30 under the local government act 2003 and as a ring-fence grant will carry some conditions about how it is to be used.

LAs 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 well being outcomes for the local people, and to support preventative public health work to benefit the local area. LAs may also want to consider pooling funding across local authority areas.

The health premium will provide an incentive to better performance providing a formula and results based payment to incentivise action to reduce health inequalities. It will be for LAs to determine their priorities in this regard.

Directors of public health will be jointly appointed by the local authority and PHE. LAs will have the power to dismiss DSPH for serious failings across the full spectrum of the 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 a line of professional accountability from DsPH to the Chief Medical Officer.

Allocations (p32)

From April 2013 PHE will allocate ring-fence budgets, weighted for inequalities, to upper-tier and unitary authorities and local government for improving the health and well being of local population.

There will be shadow allocations to LAs for this budget in 2012/13 and allocations will go live in 2013/14. During the transitional years 2011/12 and 2012/13 a need for the NHS to retain its emphasis on public health will be stressed.

The independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development resource allocation to LAs and the creation of a formula that can be used to calculate each local authority's target allocation.

The consultation identifies three general approaches to establishing a formula –

- "Utilization" based on model and statistical relation between current patterns of public health activity and need across the country;
- "Cost effectiveness" based on potential gains in health and outcomes using available information about the cost effectiveness of public health interventions;
- "Population health measures" based on measures of health outcomes, such as standardised mortality ratios, or disability-free life expectancy. Allocations will be higher to areas with poorer health taking into account health inequalities. These measures will link to the outcomes framework.

Depending on the final public health scope of the LAs, the allocation could include a number of components, taking different approaches. But these would be combined to form a single grant within which LAs would be free to prioritise spending in a way that is appropriate to their local circumstances.

A pace-of-change policy would apply as the government may not be able to set LAs actual allocations immediately at the target allocation, and would move toward this over a period of time.

Health premium (p34)

LAs will receive an incentive payment, or premium, depending on the progress made in improving the health of the local population and reducing health inequalities. The Health Premium will:

- be simple and driven by a formula developed with key partners, representative of local government , public health experts and academics;
- based on elements of the public health outcomes framework;
- be greater for disadvantaged areas if they make progress;
- aim to balance responsiveness to local action with incentivising interventions offering greater long term benefits;
- be comprehensive enough not to distort local decisions and needs to incentivise health improvements that will spread across a local authority's population such that inequalities are reduced as overall health improves;
- be a sliding scale depending on the size and extent of the local authority's progress and relative to the authority's position in terms of relative health outcomes;
- will not be a target regime dictated by central Government. The view is that the combination of a national framework, financial incentives, local freedom of how outcomes will be achieved and greater transparency will be far more effective and energising empowering local services delivered of their best, rather than having to work to prescriptive targets for which they have little or no ownership.

The DH aims to pay LAs 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 reduced if they are successful in improving the health of the nation. 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 indica tors.

It is intended that LAs share of funding for non-discretionary services, where the health premium will not apply, will grow in line with the estimated relative need of the population.

The detailed model will be set out once the baseline and potential scale of the premium have been established, and there is an agreement about how the public health outcomes framework will be used (separate consultation). Partners will be consulted on the premium.

Rod Moore
Deputy Director of Public Health and Health Improvement
30 December 2010

Table A – Public health funded activity

	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	**Proposed commissioning route/s for this activity (including direct provision in some cases)**	**Examples of proposed associated activity to be funded by the NHS budget (including from all providers)**
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