MAIDSTONE
Borough Council

REPORTS FOR DECISION BY THE
CABINET MEMBER FOR COMMUNITY SERVICES

Date Issued: 24 March 2011

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Agenda Item 1

MAIDSTONE BOROUGH COUNCIL

CABINET MEMBER FOR COMMUNITY SERVICES

REPORT OF THE HEAD OF CHANGE AND SCRUTINY

Report prepared by Orla Sweeney
Date Issued: 24 March 2011

1. HEALTHY LIVES, HEALTHY PEOPLE – CONSULTATION RESPONSES

1.1 Issue for Decision

1.1.1 To agree the consultation responses to the Department of Health's Healthy Lives, Healthy People White Paper:

- Transparency in Outcomes, Proposals for a Public Health Outcomes Framework; and
- Consultation on the funding and commissioning routes for public health.

1.2 Reason for Urgency

1.2.1 The deadline for responding to the Department of Health's consultation is 31 March 2011; therefore a decision needs to be taken in time to return the response.

1.2.2 The response has been produced by the Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee. As Overview and Scrutiny have given the response due consideration it is recommended that the call-in period be waived in order to meet the consultation deadline.

1.3 Recommendation of Joint Health Scrutiny

1.3.1 It is recommended that the Cabinet Member agrees to support the responses to the consultation documents (Appendix A and Appendix B) in response to the Departments of Health's Healthy Lives, Healthy People White Paper formulated by the Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee.

1.4 Reasons for Recommendation

1.4.1 The White Paper Healthy Lives, Healthy People describes a new era for public health and sets out the Government's overarching ambition for public health in the future. A fundamental part of this will be the establishment of Public Health England as part of the Department of Health 'and the return of local public health leadership and responsibility to local government.'

1.4.2 The consultation document 'Transparency in Outcomes' considers the new Outcomes Framework for public health at national and local levels. It will be 'evidence-driven, taking into account the different needs of different communities.' One of the aims of the Public Health Outcomes Framework will be to promote joint working where local organisations share common goals. To ensure the Framework works from the outset and to break down barriers to delivery, the consultation document seeks views on the approach proposed, asking how it can be improved.

1.4.3 The consultation on the 'funding and commission routes for public health' is to consider the proposed 'ring fenced public health funding within the NHS budget.' Local authorities will have a new role in improving the health and well being of their communities as part of the new system. The majority of the public health budget will be spent on local services by local authorities through a ring fenced budget or via the NHS. The consultation document describes in more detail the proposed key public health functions and responsibilities, setting out the proposed commission and funding arrangements for delivery. The document asks questions on how the proposals should be implemented.

1.5 **MAIDSTONE BOROUGH COUNCIL AND TUNBRIDGE WELLS BOROUGH COUNCIL – JOINT RESPONSE**

1.5.1 **The following is the response of Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee's response to the questions raised in the Department of Health's consultation paper entitled "Transparency in outcomes – proposals for a public health outcomes framework".**

1.5.2 **In formulating this response, the Joint Scrutiny Committee heard evidence from a range of witnesses, including local authority professional staff.**

1.5.3 The Joint Committee was mostly supportive of the key proposals set out in the Outcomes Framework. Issues of concern at district council level are largely related to understanding the level of activity that will be devolved by the County Council. There is a strongly-held belief –

backed up by evidence – that it is at district council level where most of the knowledge, experience and awareness of greatest need lies.

1.5.4 Two key points: (a) it would be unacceptable to waste the beneficial outcomes that district councils have achieved to date, should they fail to be given the opportunity to continue their targeted health improvement work; (b) West Kent might be seen as having a relatively healthy population, but significant inequalities still exist across this part of the County (e.g. a 7-year age gap in life expectancy) and require a continuation of this targeted – and demonstrably effective – work.

1.5.5 Alongside the key issue of district council involvement is one of the associated funding, to be able to commission and deliver the health improvement work. Finally, there is real concern about the transitional arrangements; this is hardly a new concept but it is vital it is planned thoroughly, in order to protect (above all) the most vulnerable people.

1.5.6 There will therefore need to be regular and detailed discussions held between Kent County Council and the district councils.

1.5.7 ***Question 1.*** How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

Key points: You cannot over-stress the importance of continuing 2-way communication;
Many of the outcomes fall within the remit of district councils (e.g. housing, leisure etc) and many are cross-cutting, involving both counties and districts which, taken across the board, results in a good understanding of the outcomes and a healthy willingness to work together towards improvements; and
Vitally, the need for a 'bottom up' approach from parishes and communities.

1.5.8 ***Question 2.*** Do you feel these are the right criteria to use in determining indicators for public health?

Generally, yes, with support for the principles behind the Marmot Report of a whole-life approach, but with a greater focus on early years' provision.

In addition, it was suggested that more qualitative measures would be helpful and that there should be flexibility so as not to be bound by national indicators alone. This would allow local areas to address their local issues, reflecting the localism agenda. In counties such as Kent,

districts can have very different priorities and so the indicators should be flexible enough to reflect this.

1.5.9 ***Question 3.*** How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

There needs to be clarity as to which level the health premium and outcomes framework can be applied for example will it be at upper tier level or can districts and parishes also seek health premium funding?

In addition, concern was voiced about the retrospective nature of the health premium, which might deter innovation and activity in a time when other resources are scarce.

1.5.10 ***Question 4.*** Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

Generally, yes.

1.5.11 ***Question 5.*** Do you agree with the overall framework and domains?

Again, generally yes.

1.5.12 ***Question 6.*** Have we missed out any indicators that you think we should include?

Possibly 'inequalities over access to health services', but generally not in favour of adding too many more indicators.

It was also felt that some indicators might be difficult to collate at a local level so it was important to choose those where one could differentiate amongst some very small geographical areas.

1.5.13 ***Question 7.*** We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

'Early years' are seen to be crucial and those indicators which relate to the first years, including the ante-natal period, of a child's life should be retained, including wider determinants such as housing.

Apart from that, the strongly-held view is that the choice of ranking indicators should be very much a local decision.

1.5.14 ***Question 8.*** Are there indicators here that you think we should not include?

General comment: it is better to use indicators that are strongly embedded, that have a proven track record in terms of showing trends.

The Joint Committee discussed that while some indicators could be seen to be unnecessary for the measurement of health such as 'life years lost from air pollution' indicator (under Domain 1), these should be kept due to the serious and long term health risks

1.5.15 ***Question 9.*** How can we improve indicators we have proposed here?

In two ways:

By ensuring the measures use established indicators therefore allowing comparison and the ability to assess change and improvement; and
By ensuring they are accessible in a centrally-held place and available at the lowest spatial level possible.

1.5.16 ***Question 10.*** Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

Again, two key points:

By concentrating on those behaviours which are the most disadvantageous to health (e.g. smoking, excess drinking, obesity etc); and
Incentives should only be provided for outcomes, not processes, for example incentives for successful weight loss rather than for simple weighing or counting.

1.5.17 ***Question 11.*** What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

Key points here were:

Hospitals also have a vital role to play in prevention/health improvement and this should also be linked with successful outcomes; and
From local experience, there exists a need to better engage GPs in the referral of patients for initiatives such as 'good neighbour programmes', to ensure positive outcomes and a lower risk or re-admittance.

1.5.18 ***Question 12.*** How well do the indicators promote a life-course approach to public health?

There might be scope for further development of 'key transition events' which people experience, e.g. starting school or beginning work or becoming a parent for the first time, where there might be greater willingness towards healthier behavioural changes;
Is there scope for better-informed dietary habits to be formed through the school curriculum? (The old 'domestic science' approach, the principle of which had significant advantages, but within a modern context.); and
Another key life-course period is at pre-natal stage, so that reducing teenage pregnancy rates and avoiding smoking during pregnancy are both major issues.
Maidstone Borough Council and Tunbridge Wells Borough Council – Joint Response – The funding and commissioning routes for public health.

1.6 MAIDSTONE BOROUGH COUNCIL AND TUNBRIDGE WELLS BOROUGH COUNCIL – JOINT RESPONSE

1.6.1 The following is the response of Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee's response to the questions raised in the Department of Health's consultation paper entitled "The funding and commissioning routes for public health".

1.6.2 In formulating this response, the Joint Scrutiny Committee heard evidence from a range of witnesses, including local authority professional staff.

1.6.3 The Joint Committee was generally supportive of the key proposals on funding and commissioning routes, with some important observations: (a) the need to allow for local flexibility to the maximum; and (b) the importance of 'up-front' payments as much as possible, in order to provide for proper planning and reassurance for voluntary/independent service providers.

1.6.4 ***Question 1.*** Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

The view of the Joint Committee was that while this might be acceptable at a County Council level, there should be the flexibility to devolve responsibility to a district council level – or even to a smaller (parish or community) more local level. This would provide a better focus for examining local issues and would better fit with the Coalition's emphasis on localism..

1.6.5 ***Question 2.*** What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible

range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

The Joint Committee felt there were three important factors:

a) The availability of any 'willing provider' and the use of local knowledge to encourage that;
b) The assurance that needs to be given to voluntary/independent organisations of continued funding, beyond a 1-year limit; and
c) The option to commission services at a local (i.e. district) level.

1.6.6 ***Question 3.*** How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Two key points:

a) The need to ensure that a joint strategic needs assessment is built into the working arrangements; and
b) Where possible, commission to accredited service providers or else to service providers who can demonstrate they are fulfilling NICE guidelines. The NHS might look to establish accreditation for service providers where a gap exists, e.g. with obesity.

1.6.7 ***Question 4.*** 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?

The Joint Committee – and the witnesses reporting to it – were unclear about the intention and purpose of this question and needed greater clarity over what was being asked.

1.6.8 ***Question 5.*** Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

There is a need to consider the impact of the proposals on other, related services. In other words, the proposals cannot be considered in isolation but account must be taken of the accumulative effect on services such as adult social care, housing, elderly people services etc.

1.6.9 ***Question 6.*** 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?

There was a strong feeling that there should be flexibility applied, to allow local priorities to be agreed from the list. One size does not fit all and local knowledge and circumstances must be the determining factors.

1.6.10 ***Question 7.*** Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:

a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?

If not, what would work better?

Generally, yes, and there was support for the principle of other services (health visiting was one area) which might more naturally and effectively be undertaken by local authorities, to link with their new responsibilities.

1.6.11 ***Question 8.*** Which services should be mandatory for local authorities to provide or commission?

The Joint Committee agreed with the view expressed by Kent County Council, i.e. this should be determined locally, according to what is most suitable at a county level.

1.6.12 ***Question 9.*** Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

Three key points, which generally align with Kent County Council's position

a) The grant monies need to be paid in full at the start of the year, to ensure security of funding and a proper level of forward planning;
b) The level of grant should be based on 2009/10 actual expenditure, as this reflected realistic service provision, before cuts were applied; and
c) Shadow budgets should be issued as soon as possible, to allow for a realistic level of forward planning to take place.

1.6.13 ***Question 10.*** Which approaches to developing an allocation formula should we ask ACRA to consider?

The Joint Committee voiced support for the preference (and reasoning) expressed by Kent County Council for the 'population health measures' option. This was largely on the basis that the remaining options worked against local (i.e. Kent County) conditions.

1.6.14 ***Question 11.*** Which approach should we take to pace-of-change?

This was difficult to express a view on until key issues such as transitional funding and the full impact of changes were better understood.

1.6.15 ***Question 12.*** Who should be represented in the group developing the formula?

The Joint Committee was not able to assist with this and assumed that national experts on the health premium issue were advising.

1.6.16 ***Question 13.*** Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

Two key points:

a) The need to know whether the health premium can be paid to levels <u>below</u> County Council; and
b) The need for clarity over the timing of payments, i.e. a preference would be for half the premium to be paid in advance and the remainder retrospectively. This would have a significant impact on planning service provision and any other process would detract from voluntary/independent commitment.

1.6.17 ***Question 14.*** How should we design the health premium to ensure that it incentivises reductions in inequalities?

Key points:

a) Some of the funding needs to be 'up-front', to provide the necessary incentives; and
b) Clarity is needed in measuring achievements. For instance, take life expectancy: this requires much longer timescales to make a judgement and what geographical area will be used for a comparison to be drawn?

1.6.18 ***Question 15.*** Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

There was a strong feeling that no, this would not be the right approach. For instance, some areas face a significant challenge in bringing about health improvements, with external factors (e.g. large-scale unemployment through the loss of a major employer or if in a largely middle-class area where there is a higher level of positive response to health messages) skewing the outcomes. Such circumstances could lead to unfair treatment and penalty.

1.6.19 ***Question 16.*** What are the key issues the group developing the formula will need to consider?

Income
Social profile
What spatial levels will be used? (County? District? Parish/Community?)
Up-front funding
The importance of not overlooking the general benefit of public health improvement by over-concentrating on areas of deprivation and poverty.

1.7 Alternative Action and why not Recommended

1.7.1 The Cabinet Member could decide not to support this consultation which could result in a missed opportunity to feed into the policy making process.

1.8 Impact on Corporate Objectives

1.8.1 The proposals in the consultation could impact on two of the Council's strategic priorities: A place that has strong, healthy and safe communities.

1.9 Risk Management

1.9.1 There are no risks associated with choosing to respond to this consultation.

2.0 Other Implications

2.1

1.	Financial	
2.	Staffing	
3.	Legal	
4.	Equality Impact Needs Assessment	

5.	Environmental/Sustainable Development	
6.	Community Safety	
7.	Human Rights Act	
8.	Procurement	
9.	Asset Management	

2.2 There are no implications at this stage.

IS THIS A KEY DECISION REPORT?

Yes [ ] No [X]

If yes, when did it first appear in the Forward Plan?

……..

This is a Key Decision because: ……..

…….

Wards/Parishes affected: ……..

……..

How to Comment

Should you have any comments on the issue that is being considered please contact either the relevant Officer or the Member of the Executive who will be taking the decision.

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Healthy Lives, Healthy People: Transparency in Outcomes

Proposals for a Public Health Outcomes Framework

A Consultation Document

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Performance	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Policy
Gateway Reference	15184
Title	Healthy Lives, Healthy People: transparency in outcomes
Author	Department of Health, Public Health Development Unit
Publication Date	20 Dec 2010
Target Audience	Directors of PH, Local Authority CEs
Circulation List	Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	A consultation on the proposed public health outcomes framework. The consultation closes in March, after which a summary of consultation responses received will be published.
Cross Ref	Healthy Lives, Healthy People
Superseded Docs	N/A
Action Required	Response to the consultation questions
Timing	**By 31 Mar 2011**
Contact Details	Public Health Development Unit G14 Wellington House 133-155 Waterloo Road SE1 8UG - www.dh.gov.uk
For Recipient's Use	

Healthy Lives, Healthy People: Transparency in Outcomes

Proposals for a Public Health Outcomes Framework

Prepared by the Public Health Development Unit, DH

Contents

How to Respond

The questions for consultation are listed in Annex A of this document, which also provides further detail about the consultation process. This consultation will close on 31 March 2011. You can contribute to the consultation by providing written comments to:

By email: 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

Foreword

The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals.

In our White Paper *Healthy Lives, Healthy People*, we set our ambition for the future of public health. Core features are the establishment of a new body, Public Health England, as part of the Department of Health, and the return to local government of public health leadership and responsibility.

There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. Integrating public health into local government will allow that to happen – services will be planned and delivered in the context of the broader social determinants of health, like poverty, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen.

We propose a new Outcomes Framework for public health at national and local levels. It will be evidence-driven, taking into account the different needs of different communities.

Public health is everyone's business. So the Outcomes Framework will set out how we will measure success in public health both nationally and locally.

One of the aims of the Public Health Outcomes Framework will be to promote joint working where local organisations share common goals. It will therefore be crucial to make the Framework work from day one, to break down barriers to delivery. This consultation document seeks views on the proposed approach and asks how we can improve to make it.

We propose a broad structure for this Outcomes Framework. There are five domains: health protection and resilience, tackling the wider determinants of ill health, promoting healthy choices and healthy lifestyles, preventing ill health, and focusing on premature mortality and the health of the most vulnerable.

We want your help in shaping this framework further and in particular, we want to work with you to refine and clarify the indicators. We are required to consult on the proposals set out in this paper. However, we want to do more than that. We want to co-produce this Outcomes Framework with you, and see the consultation period as a continuation of the engagement and involvement we have already begun.

Anne Milton, Parliamentary Under Secretary Public Health

Introduction

1. Society, government and individuals share the collective responsibility to improve and protect the health of the population. In our White Paper *Healthy Lives, Healthy People*, we set our overarching ambition for public health for the future. A core element of this will be the establishment of Public Health England as part of the Department of Health, and the return of local public health leadership and responsibility to local government.

2. In recent years there have been far too many central initiatives and targets, often well meaning, but without a hope of success when dictated to local areas. It is time to free-up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without interference from the centre. It is time also to restate the national responsibilities of Government, of business and industry; and it is time to reassert the voluntary sector's critical role in connecting with communities.

3. Public health challenges are not static, and our system will have to respond actively to evolving challenges. The new public health system will effectively protect and improve the health of the nation through a dynamic new system approach that involves integration, localism, partnership and collaboration.

4. At the local level, an integrated approach through Health and Wellbeing Boards and Health and Wellbeing Strategies will enable an efficient and effective focus and response to local health needs. We will focus on enabling and incentivising local government with the wider public health sector, the NHS, the voluntary sector and local communities, through local partnerships to do this, but will not prescribe how it should be done.

5. At the same time, the national level has its responsibilities too. Within Public Health England and across Government, we will focus on those functions that are best performed at the national level either because they are irreducibly Government's responsibility or where economies of scale can be achieved. The role of Government should be strong leadership to support local delivery and to add value – not hinder it with top-down performance management.

6. Ultimately we want to achieve the same goal whether we work at a national or a local level; whether we work in local government or in the NHS or in the voluntary sector – we want to improve and protect the health and wellbeing of all people and especially those with the poorest health in our society. This means that we need a system where everyone at all levels understands the contribution they can and should make to this goal.

7. We propose to put in place a new strategic outcomes framework for public health at national and local levels, based on the evidence of where the biggest challenges are for health and wellbeing, and the wider factors that drive it. This will be different to old style top down frameworks used to drive targets and performance management – rather it will set out the outcomes for public health across public services and at all levels of responsibility – national to local.

8. We make these proposals for a new *Public Health Outcomes Framework* in light of the recent consultations on the *NHS Outcomes Framework* and the ongoing consultation on *Transparency in Outcomes: A Framework in Adult Social Care* Together these three

aligned frameworks will set out the outcomes that local government, the health and care sectors are responsible for achieving. It is essential that outcomes and indicators are aligned across the frameworks to enable joined up working and where it matters most to people, hold organisations to account for delivering integrated services.

The purpose of this consultation

9. In this consultation, we make detailed proposals for a Public Health Outcomes Framework in parallel with the Public Health White Paper, so that local government, the wider public health sector and local communities can take the lead in designing it.

10. In particular, we are seeking views on the overall structure and scope of the framework and the range of outcomes and measures within it, including views on those measures that should be incentivised.

Co-production

11. Based on what councils and voluntary organisations and communities themselves tell us, we believe that a co-produced and nationally applicable Outcomes Framework is the best vehicle for combining requirements in one place. Government should not dictate what is contained in the data set, but can support its production and maintenance.

12. We have worked closely with the public health community and consulted the Local Government Association informally on the current set of outcomes and indicators that we think may be included within the framework. The co-operation and direct involvement of Directors of Public Health (DsPH) from across the country and specialist representative bodies including the Faculty of Public Health, the Royal Society of Public Health, the UK Public Health Association and the Association of Directors of Public Health has been critical to the development of the proposals in this framework document. The LGA, represented on the Chief Medical Officer's Stakeholder Group, has also contributed to the development of proposals for the Public Health Outcomes Framework.

13. We do not want to stop there with our plans for engagement. We need to consult on the Outcomes Framework and we will continue to work closely with public health and local government colleagues to do so. However, we want to go further and co-produce the final set of outcomes with our partners in the public health sector and local government, to ensure that we arrive at a robust set of indicators. Later in this document, we will set out how you and your organisations can contribute to the development of this framework through the consultation process. We would very much appreciate your responses to a set of core questions relating to aspects of our proposals within this consultation at Annex A.

14. Getting the leadership right will be important, and there will be a need to build new partnerships to co-produce the Outcomes Framework. This will not just be about central government inviting public health and local government to join in the consultation process, but about a real shared endeavour, which reflects localism.

Q1 Consultation question: How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

How have we developed these proposals?

15. There are huge opportunities to go further and faster in tackling today's causes of premature death and illness. People in the poorest areas can expect to live up to seven years less and live up to 17 years less without disability than richer areas, have higher rates of mental illness, harm from alcohol, drugs and smoking, and child emotional and behavioural problems. Although infectious diseases now account for only 1 in 50 deaths, rates of tuberculosis and sexually transmitted infections are rising and pandemic flu is still a threat. Responding and acting upon these challenges is the prime function of the proposed Public Health Outcomes Framework.

Principles for development

16. Public health is everyone's business. The Outcomes Framework will have to reflect the collective responsibility of communities, local authorities and their partners and the role of Government in improving and protecting health. To do this, we have been guided by the following principles to develop the Outcomes Framework. It will:

- use indicators which are meaningful to people and communities;
- focus on major causes and impacts of health inequality, disease, and premature mortality;
- take account of our legal duties in particular under equalities legislation and regulations[1].
- take a life course approach, and
- as far as possible, use data collated and analysed nationally to reduce the burden on local authorities.

17. Specifically, we have used the following detailed criteria to guide the selection of indicators for consultation (accepting that indicators may not meet all of the listed criteria).These are set out in the draft Impact Assessment at Annex B and as part of the consultation on this Outcomes Framework.

1) Are there evidence-based interventions to support this indicator?
2) Does this indicator reflect a major cause of premature mortality or avoidable ill health?
3) By improving on this indicator, can you help to reduce inequalities in health?
4) Will this indicator be meaningful to the broader public health workforce and to the wider public?

[1] The **Equalities Act 2010 legislation imposes a duty on public bodies (the protected characteristics are** race, disability, gender, age, sexual orientation, religion or belief, pregnancy and maternity and gender reassignment.) **to have due regard to the need to:**
(a) eliminate unlawful discrimination, harassment, and victimisation;,
(b) to advance equality of opportunity ; and.
(c) foster good relations between people who share a relevant protected characteristic and those people who do not.

5) Is this indicator likely to have a negative / adverse impact on defined groups (groups sharing a characteristic protected by equalities legislation)? (If yes, can this be mitigated against?)

6) Is it possible to set measures, SMART[2] objectives against the indicator to monitor progress in both the short and medium term?

7) Are there existing systems to collect the data required to monitor this indicator; and

- Is it available at the appropriate spatial level (e.g. Local Authority)?
- Is the time lag for data short, preferably less than one year
- Can data be reported quarterly in order to report progress?

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

[2] Specific, Measurable, Attainable, Realistic, Timely

The Purpose of the Outcomes Framework

18. Having set out the challenge above, we believe that this Outcomes Framework should have three purposes:

    - to set out the Government's goals for improving and protecting the nation's health, and for narrowing health inequalities through improving the health of the poorest, fastest;

    - to provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and

    - to provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

19. As set out above and within the White Paper itself, we know that public health is everyone's responsibility. Therefore, the Outcomes Framework needs to reflect the breadth of contributions all partners should make at the national and local level and across public services.

20. The Government is radically shifting power to local communities, enabling them to improve health across people's lives, reduce inequalities and focus on the needs of the local population. The Outcomes Famework will include measures that allow us to assess health improvement across all years of life, and enable a focus on those key life changes where there can be good opportunities to influence health outcomes.

21. Further, it is clear from the work of Sir Michael Marmot's independent review[3] that health is not experienced equally across our society. In the poorest places, people die 7 years earlier and spend 17 years in poorer health than the wealthiest. Health inequalities are systematic; they are not caused by chance. This Outcomes Framework, in its breadth and focus and the health premium we will implement (see paragraph 23) alongside our other reforms, are explicitly designed to tackle these inequalities.

22. Frank Field has published an independent review of Poverty and Life Chances. We will look closely at the Review's findings and, where appropriate reflect them within the Public Health Outcomes Framework.

Q3 Consultation question: How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

23. The Local Authority Public Health allocation and the health premium are the subject of a separate consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*.

[3] The Marmot Review Team (2010) *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities post-2010*. Available at, www.**marmotreview**.org/

24. The Public Health Outcomes Framework will provide a context for public health activity across the whole of the public health system. The current plan is that it will include a set of indicators based on nationally collated and analysed data relating to public health (thereby minimising the burden on local authorities). We have deliberately proposed a much larger number of indicators for consultation than we expect will form the final framework. We have committed to reducing the burden of data collection and reporting on local authorities, so our approach intends to demonstrate the scope of issues and priorities identified through our engagement with the public health and local government sectors, with a view that through the consultation process we will be able to refine these indicators to a core set.

Transparency of outcomes

25. The backbone of our proposed approach is to make publicly available a set of data and information relating to the public's health at national and where possible at local authority levels. To ensure transparency and to reduce data burdens, we propose specific data are published in one place by Public Health England. Public health data come from a number of sources, and people have told us that the best way to support analyses is to publish this in one place, and in a common format. At the national level, this information will allow our partners and us across government and beyond, to understand the key priorities for health and aid in our efforts to prioritise action. At the local level, this will allow people to interrogate the information as they want, and minimise costs of reproduction on councils. This will also make it easy for local areas to compare themselves with others across the country, and where possible how performance is changing within areas, and lever improvements. So that we drive equality in public health outcomes, it is vital that we are able to disaggregate public health data by key equality characteristics and neighbourhoods where possible. We will work with the Association of Public Health Observatories during the consultation process.

26. In addition, information about health and care services 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,* this 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.

27. The Public Health Outcomes Framework is not a performance management tool, and it must not replicate the approach of the previous National Indicator Set. It should be a consistent means of presenting the most relevant, available data on public health for national and local use. Our current thinking is that a small number of the indicators would focus on health improvement relating to the causes of the greatest burden on disease and death (eg indicators relating to obesity, smoking, alcohol and level of physical activity). The rest of the indicators would 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.

28. For a subset of those indicators, which we will agree with our public health and local government partners, we would attached a 'health premium' which aims to incentivise councils to make progress on health improvement priorities and reduce health inequalities.

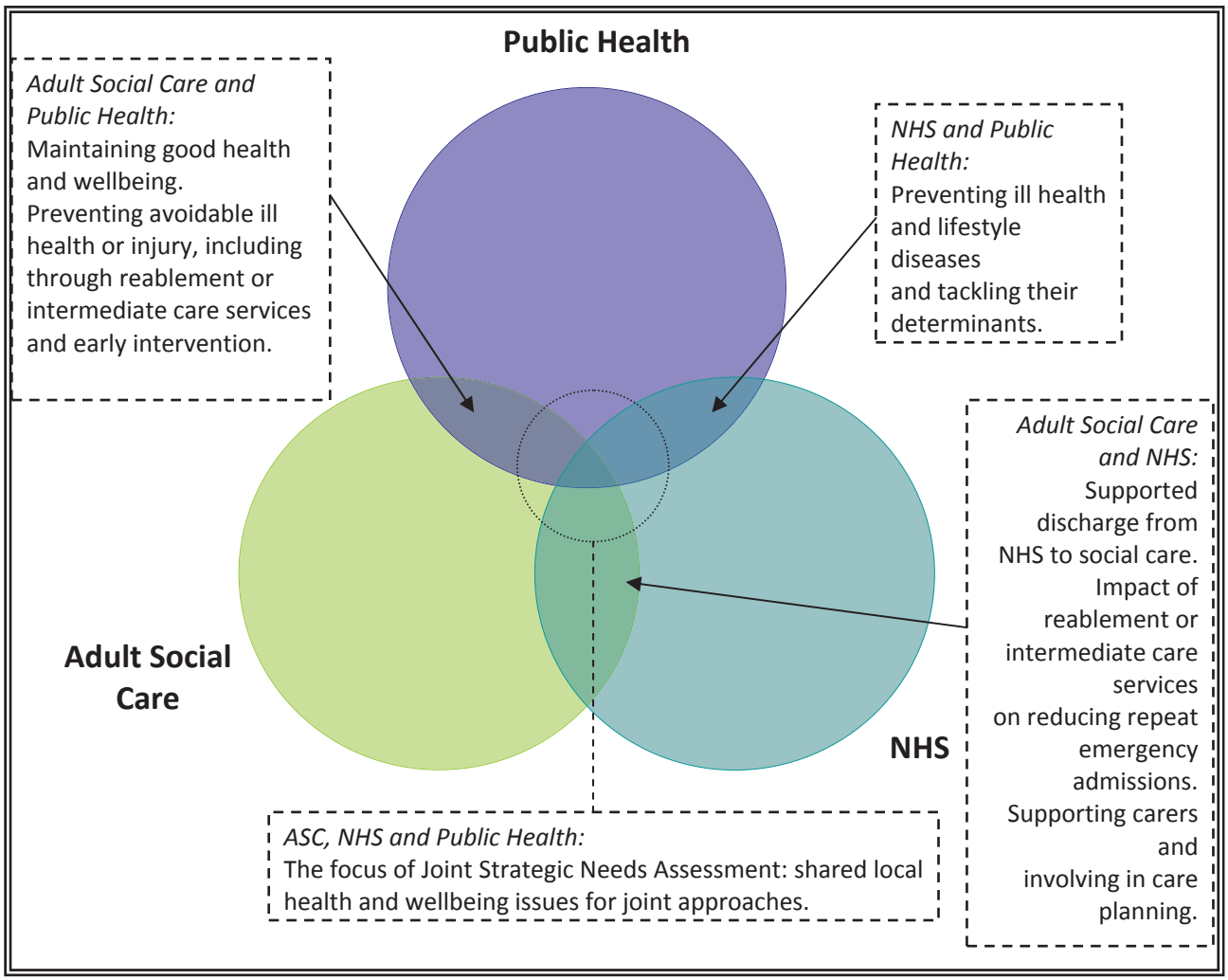
Relationship with other outcome frameworks

29. As noted above, one of the most important aims of the Public Health Outcomes Framework will be to support local partners to work together where they share common outcome goals. To do so, it will be critical that alignment is built in with the partner frameworks for the NHS, adult social care and others from the outset, and to avoid creating barriers, which might act against delivery.

30. Figure 1 below shows how we might envisage the relationship between public health, the NHS and adult social care in terms of shared outcomes.

31. This diagram shows some key areas of overlap, where local services share an interest and where a whole-systems approach could support better outcomes. By sharing the same or complementary measures between sectors, there is a stronger incentive for local services to work together and measure their progress on the same basis. This approach assumes that the three Outcomes Frameworks act as whole rather than three separate entities.

Figure 1



32. Our aim has been that all three Outcomes Frameworks align well and tell the 'story' of health from a whole systems approach. A core function of public health is tackling the wider determinants of health and wellbeing, whereas the NHS and adult social care

frameworks cover those outcomes for people who are in need of health and social care services.

33. There are other local services crucial to achieving outcomes, and which public health will work with in partnership – children's services, employment services, leisure, transport and housing, for instance. Whilst this diagram does not yet include all the relevant areas of overlap and focus for all partners, we are clear that the contribution to public health from these services is vital.

34. It is also critical we understand that many of these services operate at a range of levels. In areas in the country with a two-tier local government system, many of these services operate at a lower local authority tier. Given our aim is that public health leadership in the form of the Director of Public Health, sits at the upper tier, it is imperative that district and city councils are able to play their part in driving health improvements through close collaboration.

35. Later in this document, we make specific proposals to go further than alignment across these frameworks. Responses to the consultation of the NHS Outcomes Framework were clear. There is a strong case for explicitly recognising the shared responsibility of public health and the NHS to reduce rates of premature mortality. The NHS has a clear role in premature mortality amenable to healthcare, whilst public health's role is to reduce premature mortality through preventative approaches. We set out detailed proposals later in this paper on shared outcomes to reduce premature mortality.

36. The Government has also announced a new Transparency Framework[4] as part of the Spending Review. Under the new framework, each Department has published its Business Plan, including the reforms it will make and the key indicators on inputs (costs and activity) and impact (results achieved) by which the public can form their own judgment at the national level. Public health will play a part in that framework, with a clear relationship between the outcome measures proposed in this document and the indicators in the Transparency Framework to reinforce a common view of the most important areas shared nationally and locally.

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

[4] The Transparency Framework was announced as part of the Spending Review 2010. See the full document at http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

Our Proposed Approach

37. The Outcomes Framework we propose will therefore be based on:

- A high-level vision for public health,

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

- Supported by 5 key domains for public health outcomes that reflect national, local and community level actions;

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Health Protection and Resilience: protect the population's health from major emergencies and remain resilient to harm	**Tackling the wider determinants of health:** tackling factors which affect health and wellbeing and health inequalities	**Health Improvement:** Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities	**Prevention of ill health:** reducing the number of people living with preventable ill health and reduce health inequalities	**Healthy life expectancy and preventable mortality:** preventing people from dying prematurely and reduce health inequalities

- Delivered through actions that are evidenced based, can be measured, and which can be used by the public to hold local services to account for improvements in health. This is shown in diagrammatic form (figure 2).

38. The five domains for public health represent those high-level goals that we want to achieve through the Public Health England to deliver our overarching vision for public health. Domains are sequenced to reflect the spectrum of public health ranging from influencing the wider determinants of health, to opportunities to improve and protect health, through to preventing ill health (morbidity) and avoiding premature death (mortality). Overarching this spectrum is Domain 1, a central focus for Public Health England and supported by local delivery mechanisms.

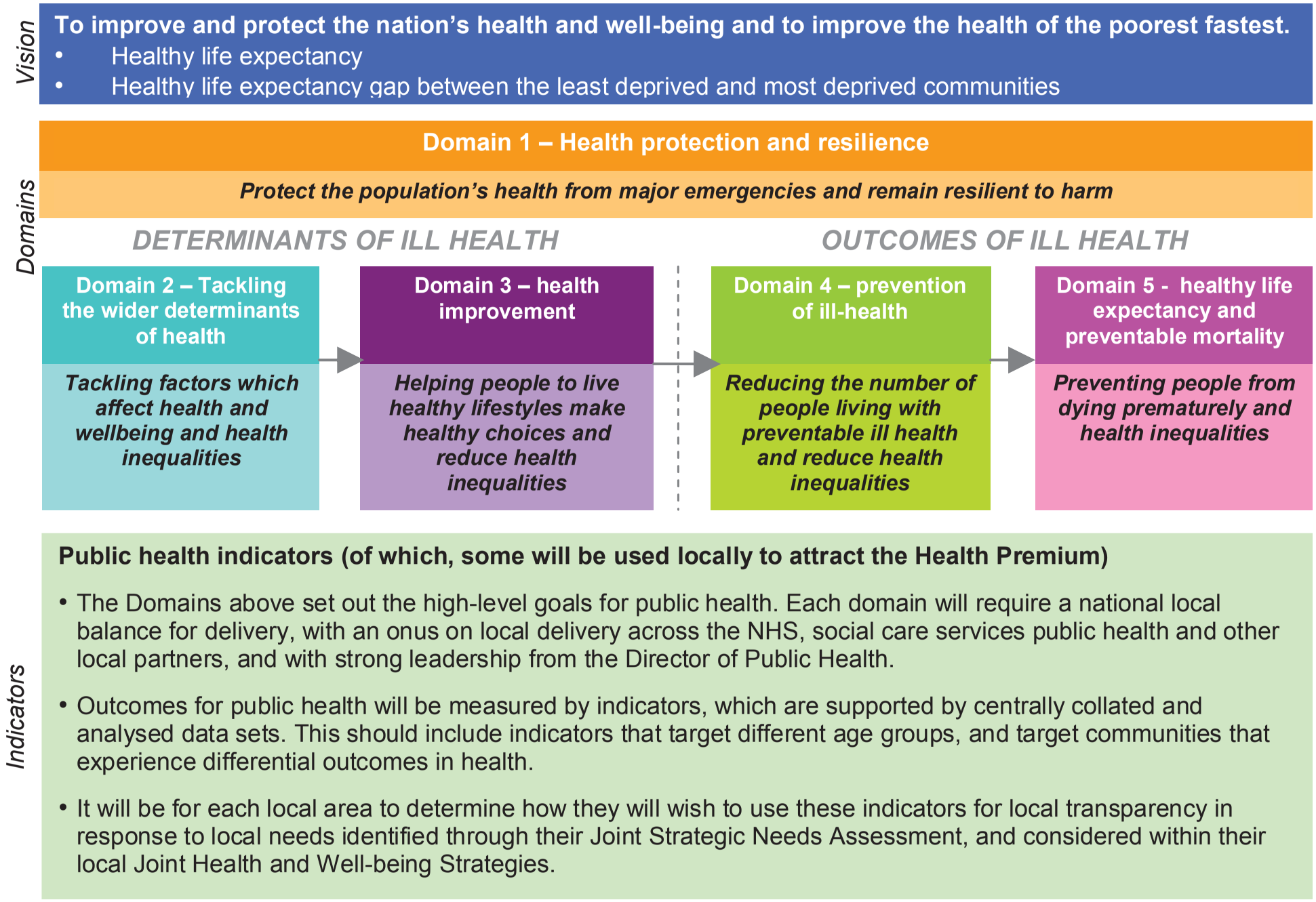
39. The overarching aim of this Outcomes Framework is *to improve and protect the nation's health, and to improve the health of the poorest, fastest*. In focusing on how to improve the public's health in its broadest sense, local authorities and their partners must also seek to advance equalities, eliminate the impact of discrimination and narrow inequalities in health behaviours between communities. This will be a core element of each domain through the disaggregation of all indicators by the different equality characteristics and down to neighbourhood level, where feasible.

40. We know that safeguarding is a very important issue on which local health and wellbeing partnerships across public health, the NHS, social care and other children's services will need to work together. Professor Eileen Munro is currently conducting a review of Child Protection and is due to report finally in April 2011. We will look at the findings of the Review to see whether there are outcomes relating to safeguarding and child protection that should be included in the Public Health Outcomes Framework.

41. We are also keen to hear any thoughts or proposals during the consultation period on how we might appropriately reflect safeguarding and child protection outcomes in the Public Health Outcomes Framework.

Q5 Consultation question: Do you agree with the overall framework and the domains?

Figure 2 – A frame work for public health outcomes



The Indicators

42. We have worked closely with public health professionals in the development of these proposed indicators. Expert input has been essential to the development of these and we want to get your views on how we can develop these further.

43. We remain committed to reducing data burdens on local government and across the health and care sectors. We will seek to collate and analyse data centrally where possible and to use information already routinely collected by Local Authorities, the NHS and from wider local government – we will avoid as far as possible the creation of new data burdens. Therefore across all three aligned Outcomes Frameworks (for the NHS, public health and adult social care), we want to reduce the overall number of indicators. However, whilst we expect the number of health improvement and protection indicators will reduce from previous indicator sets, stakeholders have been keen to see a broader approach to public health, requiring a breadth of measures across the five domains set out above. We want to work with you to achieve these aims.

How can we measure improvement in public health?

44. Below we have set out measures that help define and deliver the above Domains, and then describe the broad contributions to these that can be made at the local and national levels. More detail on the rationale for these indicators and other details can be seen at Annex C. Proposed developmental indicators are shown in italics. These are indicators that are not yet routinely collected and where further development is required to ensure appropriate and high quality data at local as well as national levels can be provided. Some developmental indicators will require significant work to progress, whereas others may already be work in progress. We will work with you during the consultation period to develop these further whist reviewing any other suggestions for developmental indicators.

45. Each domain includes indicators that to a varying degree will be reliant on national or local delivery. Whilst local government will have an important and leading role in public health, this Outcomes Framework proposes indicators that will require the joint efforts of the NHS and other public services as well as local government. This Outcomes Framework will be for all partners and at all levels to deliver.

VISION **To improve and protect the nation's health and wellbeing and to improve the health of the poorest, fastest.**
These are over-arching indicators that can be used nationally and locally to give a good snapshot of health inequalities and general health status. They cut across the proposed domains as do health inequalities and are intended to be available for use at a local as well as a national level.
Proposed Indicators
- Healthy life expectancy - Differences in life expectancy and healthy life expectancy between communities.

Domain 1:

Health Protection and Resilience: Protect the population's health from major emergencies and remain resilient to harm

The activities to deliver this domain can most appropriately be co-ordinated nationally by Public Health England, which will have oversight of population health protection and resilience across the country.

Local authorities will want to contribute to these outcomes particularly in their role in leading local resilience arrangements, and in providing surveillance information.

Proposed Indicators

- 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[5] across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan.

46. Health protection measures will be critically important at all levels of delivery and as stated above will require the collective efforts of Public Health England, Local Authorities and the NHS to deliver. We anticipate the actions required to improve outcomes in this domain are essential and will not be subject to the same local determinations as for the other domains. Hence, we have presented this domain as having a prominent place within Figure 2 above. We will also need to consider through the consultation period, the impact of these proposed measures on the Devolved Administrations where there are shared health protection functions.

[5] Including for example, the childhood, adolescent, cervical cancer and seasonal flu immunisation programmes.

Domain 2:

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

Locally, Health and Wellbeing Boards will take a broad approach to health improvement requiring the full participation by all partners to focus on improving the wider determinants of health that drive poor health outcomes especially in the most disadvantaged.

The very nature of the indicators we've proposed require the combined efforts of all public services to focus on the factors that drive health problems amongst the poorest and most disadvantaged in our communities.

Proposed Indicators

- 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*[6] in settled accommodation**
- Proportion of people with mental illness *and or disability*[6] 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*

[6] Further work is required to define disability in the context of these indicators and to identify appropriate data sources

47. We will need to continue working across Government at national and local levels to refine and agree the full range of measures that best reflect the wider determinants of health and where we have good evidence that actions relating to these measures have demonstrable and positive impacts on health and health inequality reduction.

Domain 3:

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

Nationally, there is a clear role for Government in contributing to delivering these indicators, for example through legislation or regulation, and through partnerships with business and industry. Some functions such as some national campaigns, will need to be led at a national level where it is possible to maximise economies of scale and value for money.

However much of the delivery of these indicators will take place at the local level. Here, health improvement will be the responsibility of local government led by DsPH in partnership with proposed Health and Wellbeing Boards. DsPH will be responsible for investing in health improvement using the ring-fenced public health budget.

Proposed Indicators

- 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*

48. The proposed indicators for this domain will help us track the impact of national and local actions to tackle health improvement and reduce the burden of disease related to lifestyle choices.

Domain 4:

Prevention of ill health: Reducing the number of people living with preventable ill health

Nationally the role of Government with its partners in business and industry and beyond will be critical.

Across local health and wellbeing partnerships, public health would share responsibility with the NHS, adult social care and children's services to improve outcomes in this domain.

Proposed Indicators

- 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*

49. A number of proposed indicators within this Domain require a shared contribution across public health and children and adult social care services. The proposed outcomes and transparency framework for adult social care includes a number of shared indicators included within this domain.

Domain 5:

Healthy life expectancy and preventable mortality: *Preventing people from dying prematurely*

At the local level, improvements in these indicators will be driven by local health and wellbeing partnerships with shared responsibility across the NHS, public health and care services.

Healthy life expectancy is considered as an over-arching outcome under vision and not repeated in this domain. Therefore, the indicators below focus on the causes of premature mortality.

Some delivery will be for other local partners to prevent seasonal mortality for example, or Public Health England locally (currently Health Protection Units) on communicable disease.

National contribution across Government, the NHS Commissioning Board and other national bodies in setting policy or to avoid mortality as a result of major emergencies for example.

Proposed Indicators

- 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*

50. In this domain, a set of shared mortality improvement areas where both the NHS and Public Health England can have an impact in improving outcomes will be included in the NHS Outcomes Framework. We propose that this approach is taken in the Public Health Outcomes Framework too. These shared outcomes reflect the fact that it is very difficult to disentangle the relative contributions of Public Health England and the NHS in delivering against them.

51. The outcome of **'reducing premature death in people with mental illness'** is included as a shared mortality improvement area in both frameworks as many of the risk factors to which people with serious mental illness are particularly vulnerable are related to lifestyle as well as healthcare and service access.

52. In using mortality to determine improvement areas, there is a risk that factors impacting on children are not sufficiently reflected, as the numbers of child deaths is so small. Therefore, it is proposed that 'Infant mortality', which captures outcomes for children up to the age of 1, is included as a shared improvement area in both frameworks as it is influenced by both NHS and public health interventions.

Consultation questions

Q6. Consultation question: Have we missed out any indicators that you think we should include?

Q7. Consultation question: We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

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

Q9. Consultation question: How can we improve indicators we have proposed here?

Q10. Consultation question: Which indicators do you think we should incentivise through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

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

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

A New Approach to Partnership and Accountability

53. The proposals set out above aim to engender closer working across organisational cultures and boundaries – driving improved partnership working where there is room for improvement, keeping in step where close and productive partnerships are already strong, and making a difference. The shared responsibility of Government, business and industry is vital to the national contribution to these proposed outcomes. At the local level, partnerships across the local authority, the NHS and other public services will be essential to health improvement and protection and reducing inequalities. However, in the final analysis local communities and neighbourhoods will lead improvement themselves, through holding their local services to account.

Local transparency and accountability

54. Based on the principles of transparency and localism, data will be published in one place by Public Health England enabling national and local democratic accountability for performance against those outcomes. This will make it easy for local areas to compare themselves with others across the country and incentivise improvements. So that we drive equality in public health outcomes, it is vital that we are able to disaggregate public health data by key equality characteristics, and where feasible communities should be able to see how outcomes differ at local neighbourhood level.

55. Health and Wellbeing Boards will be core to the assessment and agreement of local priorities. The Outcomes Framework will be used alongside the Joint Strategic Needs Assessment to determine local priorities. Through this process, it will be for Health and Wellbeing Boards to determine local priorities and to set out strategies for which they will be held locally accountable to deliver.

56. We propose that a new health premium will pay local government retrospectively for progress against public health indicators, through a simple formula that incentivises action to improve local health and reduce health inequalities.

57. Our current thinking is that payments would be weighted to their level of health inequalities and the progress made. We are seeking your views on how the health premium is designed as part of the consultation on public health finance, which is taking place alongside this consultation on the Outcomes Framework.

Next Steps

58. We are required to consult on the proposals set out in this paper. However, we want to do more than that. We want to co-produce this Outcomes Framework with you, and see the consultation period as a continuation of the engagement and involvement we have already begun. We want your help in shaping this framework further and in particular, we want to work with you to refine and clarify the indicator set.

59. We intend to run a consultation period for the next 14 weeks ending on 31st March 2011, where we want to hear your views and have your input to the questions we have posed throughout this document. Following this consultation period, we will pull together responses and publish the Outcomes Framework in summer 2011.

60. The new framework will be in operation from April 2012. During 2011/12, we will continue our work with the NHS and local government in preparing for and implementing transition arrangements.

How you can be involved

61. We will take forward a programme of engagement and involvement in developing our proposals further. We have provided a template at Annex A with all the questions from each chapter within this consultation document, which we hope you will find helpful in shaping your response. Please see guidance on how to respond to this consultation below.

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

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

How to respond to this consultation

This consultation closes on the **31 March 2011**. You can contribute to the consultation by providing written comments to:

By e-mail: publichealthengland@dh.gsi.gov.uk

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

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

We will also be arranging a number of consultation events around England. Details will be posted on the DH website as well as through stakeholder networks.

Annex A: Questions for consultation

Question 1.	How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?
Question 2.	Do you feel these are the right criteria to use in determining indicators for public health?
Question 3.	How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?
Question 4.	Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?
Question 5.	Do you agree with the overall framework and domains?
Question 6.	Have we missed out any indicators that you think we should include?

Question 7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?
Question 8. Are there indicators here that you think we should not include?
Question 9. How can we improve indicators we have proposed here?
Question 10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)
Question 11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
Question 12. How well do the indicators promote a life-course approach to public health?

Annex B: Impact Assessment

Title: Public Health Outcomes Framework **Lead department or agency:** **Department of Health** **Other departments or agencies:**	IMPACT ASSESSMENT (IA) **IA NO:** 3027 **DATE: 27/10/10** **STAGE:** CONSULTATION **SOURCE OF INTERVENTION:** Domestic **TYPE OF MEASURE:** OTHER

What is the problem under consideration? Why is government intervention necessary?

The current Government, elected in May 2010, abolished the Public Service Agreement (PSA) system, and the system of Local Area Agreements. Whilst the proposed NHS Outcomes Framework will be able to monitor and drive forward improvements in NHS services, there are no equivalent arrangements in place for the delivery and monitoring of improvements in public health yet. This impact assessment is concerned with the potential costs and benefits of the proposed Public Health Outcomes Framework, though no actual costs and benefits can yet be estimated.

What are the policy objectives and the intended effects?

The Outcomes Framework reinforces the vision for the future of public health, and is a mechanism by which this vision can be achieved. This vision is 'to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest.'. As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes Framework. The consultation will also invite suggestions on the structure of the framework itself. Public Health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.

What policy options have been considered? Please justify preferred option (further details in Evidence Base)

1. Do nothing
2. Develop a Public Health Outcomes Framework

WHEN WILL THE POLICY BE REVIEWED TO ESTABLISH ITS IMPACT AND THE EXTENT TO WHICH THE POLICY OBJECTIVES HAVE BEEN ACHIEVED?	**SEE ANNEX**
ARE THERE ARRANGEMENTS IN PLACE THAT WILL ALLOW A SYSTEMATIC COLLECTION OF MONITORING INFORMATION FOR FUTURE POLICY REVIEW?	**YES**

Ministerial Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:..... Date: .....

Description: Option 2 - Develop a Public Health Outcomes Framework

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate:

COSTS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS		AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL COST (PRESENT VALUE)
LOW	OPTIONAL		OPTIONAL	OPTIONAL
HIGH	OPTIONAL		OPTIONAL	OPTIONAL
BEST				

DESCRIPTION AND SCALE OF KEY MONETISED COSTS BY 'MAIN AFFECTED GROUPS'

AS THE DEVELOPMENT OF THE NEW OUTCOMES FRAMEWORK IS STILL IN ITS EARLY STAGES AND THE FINAL APPROACH TAKEN, AS WELL AS THE INDIVIDUAL OUTCOME INDICATORS SELECTED, WILL BE DETERMINED POST-CONSULTATION, COSTS CANNOT BE ESTIMATED AT THIS STAGE.

OTHER KEY NON-MONETISED COSTS BY 'MAIN AFFECTED GROUPS'

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BENEFITS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS		AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL BENEFIT (PRESENT VALUE)
LOW	OPTIONAL		OPTIONAL	OPTIONAL
HIGH	OPTIONAL		OPTIONAL	OPTIONAL
BEST				

DESCRIPTION AND SCALE OF KEY MONETISED BENEFITS BY 'MAIN AFFECTED GROUPS'

OTHER KEY NON-MONETISED BENEFITS BY 'MAIN AFFECTED GROUPS'

THERE SHOULD BE REFOCUSING AND STRENGTHENING OF PUBLIC HEALTH OUTCOMES AND THEIR
DELIVERY AT LOCAL AND NATIONAL LEVELS. OUTCOME MEASURES MAY INCENTIVISE COST-EFFECTIVE INTERVENTIONS RESOURCES SHOULD BE SAVED FROM REDUCING THE BURDEN OF CURRENT TOP-DOWN PERFORMANCE MANAGEMENT STRUCTURES AND STREAMLINING AS A RESULT
OF SYNERGY ACROSS THE ADULTS SOCIAL CARE AND NHS OUTCOMES FRAMEWORK.

KEY ASSUMPTIONS/SENSITIVITIES/RISKS

Impact on admin burden (AB) (£m):			Impact on policy cost	In
New AB:	AB savings:	Net:	Policy cost savings:	Yes/No

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/04/2012		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			Traded:	Non-traded:	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:	Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	Impact	Page ref within IA
Statutory equality duties[7] Statutory Equality Duties Impact Test guidance	Yes	Appendix I
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment	No	

3.1 [7] Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Wider environmental issues Wider Environmental Issues Impact Test guidance	**No**	
Social impacts		
Health and wellbeing Health and Well-being Impact Test guidance	**Yes**	
Human rights Human Rights Impact Test guidance	**No**	
Justice system Justice Impact Test guidance	**No**	
Rural proofing Rural Proofing Impact Test guidance	**No**	
Sustainable development Sustainable Development Impact Test guidance	**No**	

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier Stages (E.G. Consultation, Final, Enactment).

NO.	LEGISLATION OR PUBLICATION
1	**OUTCOMES NOT TARGETS, CONSERVATIVE PARTY (2008).** **HTTP://WWW.CONSERVATIVES.COM/~/MEDIA/FILES/GREEN%20PAPERS/HEALTH_POLICY_PAPER.ASHX?DL=TRUE**
2	***EQUITY AND EXCELLENCE: LIBERATING THE NHS***
3	**Healthy Lives, Healthy People: Our strategy for public health in England**
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs										
Annual recurring cost										
Total annual costs										
Transition benefits										
Annual recurring										
Total annual benefits										

* For non-monetised benefits please see summary pages and main evidence base section

Public Health Outcomes Framework: Impact Assessment

A1. This Impact Assessment is part of a suite of impact assessments that accompany the public health White Paper. Other impact assessments in this suite are:

- Structure of the public health service;
- Commissioning in the public health service;
- Ring-fenced funding of public health;
- Information and intelligence for public health;
- Social marketing; and
- Health visitors

A2. This Impact Assessment considers what framework and indicators could be used to monitor and drive public health improvements. It directly impacts the public sector only.

A3. The Outcomes Framework provides a vision for the future of public health, and demonstrates a mechanism by which this vision can be achieved. This vision is 'To improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest.' As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes Framework as well as suggestions on the structure of the framework itself. Public Health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.

A4. The current Government, elected in May 2010, abolished the Public Service Agreement (PSA) system, and the system of Local Area Agreements. Whilst the NHS Outcomes Framework will be able to monitor and drive forward improvements in NHS services, there

are no equivalent arrangements in place for the delivery and monitoring of improvements in public health yet. This impact assessment is concerned with the potential costs and benefits of the proposed Public Health Outcomes Framework, though no actual costs and benefits can yet be estimated.

What policy options have been considered?

A5. We have assessed the impact of two options:

1. Do nothing.

2. Develop a Public Health Outcomes Framework.

Option 1 – do nothing

A6. As mentioned above currently there is no single system in place that specifically measures public health outcomes. The Health Bill, building on *Equity and Excellence: liberating the NHS,* published in July 2010 has put forward proposals to abolish the Vital Signs and the National Indicator Set which currently report on selected public health indicators.

A7. Current inefficiencies include:

- There is a top-down bureaucratic focus on processes rather than outcomes.
- Vital Signs tiers do not allow local decisions to be made about priorities for health improvement.
- There is duplication of performance management processes.
- There is a lack of prioritisation of public health and wellbeing outcomes at the expense of NHS process and treatment focused delivery.

A8. Without the introduction of an Outcomes Framework, there would be no robust system in place that is able to monitor the extent of health protection or emergency preparedness measures. Addressing this issue is of vital importance if we are to consider resilience or preparation for emergency events.

A9. In addition to a lack of monitoring of public health outcomes, there is an implicit lack of accountability at the local and national level that would drive forward improvements in health protection, health improvement and wellbeing.

A10. Without a performance framework that addresses delivery and impact on different groups, it will not be possible to continue to assess the impact of services on core public health outcomes for these groups. Doing nothing does not further develop our approach to tackle the gender, age, geographical, or socioeconomic health inequalities that currently exist.

Preferred: option 2 – develop a Public Health Outcomes Framework

A11. In line with the approach taken by the NHS Outcomes Framework and the Social Care Outcomes Framework, the current proposal for the Public Health Outcomes Framework

includes selected indicators in five domains. These domains currently include (subject to change):

A12.

- Domain 1: Health protection and resilience
- Domain 2: Tackling the wider determinants of health
- Domain 3: Health improvement
- Domain 4: Prevention of ill health
- Domain 5: Healthy life expectancy and preventable mortality

A13. The indicators in this Outcomes Framework will be selected because they provide the most robust mechanism by which progress towards the overarching public health outcomes can be monitored

A14. In addition, this framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account.

A15. Regarding the development of candidate indicators pre-consultation, the following criteria were used to inform the selection:

a. HM Treasury Transparency Framework criteria

b. Are there evidence-based interventions to support this indicator?

c. Does this indicator reflect a major cause of premature mortality or avoidable ill health?

d. By improving on this indicator, can you help to reduce inequalities in health?

e. Use indicators which are meaningful to people and communities

f. Is this indicator likely to have a negative / adverse impact on any particular groups? (If yes, can this be mitigated?)

g. Is it possible to set measures, SMART objectives and targets against the indicator to monitor progress in both the short and medium term?

h. Are there existing systems to collect the data required to monitor this indicator and;

i. Is it available at the appropriate spatial level (e.g. Local Authority)?

j. Is the time lag for data short, preferably less than one year?

k. Can data be reported quarterly in order to report progress?

A16. Post consultation on the candidate indicators, additional criteria will be applied prior to final publication incorporating the following three principles/analytical tasks:

- Risk-adjustment. Underlying characteristics (e.g. socio-economic profile) could impact on achievement at a local level. This will pose challenges for comparing indicators between areas and negotiating local contributions to national ambitions. It is anticipated that a process of risk adjustment will be developed and applied where feasible and based on data broken down by agreed characteristics. This process might be applied differently to differentiate between those health improvement indicators where a financial incentive might be applied and those indicators used for monitoring purposes.

- Calibration. Where feasible, the analytical, research and development functions of the PHS will review the incremental contribution of indicators in terms of their relative importance to contributing to the over-arching public health outcomes of 1) improving healthy life expectancy and 2) reducing the healthy life expectancy gap between the least deprived and most deprived communities. This will enable Health and Wellbeing Boards to formulate their priorities. It is important to note that for indicators, which focus on the broader determinants of health, requiring cross-cabinet collaboration, the analytical and Research & Development support might sit outside of the Public Health Service.

- Comprehensiveness: A broad set of candidate indicators will be circulated as part of the consultation process including those that focus on the broader determinants that impact on the public's health. The consultation should expose any gaps and ensure that the list remains comprehensive, reflecting the areas of public health activity most likely to impact on the aforementioned over-arching outcomes. Comprehensiveness will be considered prior to publication of the final indicator set alongside the need for representativeness and balance.

A17. It is important to note that these principles will pose significant challenges with regards to their translation into practice, (e.g. data availability) which will be fully considered post the initial consultation period.

A18. Achievement of public health outcomes requires a cross-government approach and this must be supported by the alignment of the outcome framework across the NHS, public health and adult social care, taking a life-course approach. The Secretary of State for health has made clear the value of evaluation and we will continue to build proposals and options based on strong evidence where it is available.

A19. Consultation will include:

- Departmental stakeholder events;

- Engagement with public health community (Directors of Public Health Advisory Group), BME communities;

- Engagement across Government, and wider public health workforce, including regional teams (Public Health Observatories, Regional Public Health Groups); and

- Formal 12 week consultation

A20. Secretary of State has made clear his intention that an Outcomes Framework, which will drive forward improvements in public health, will be fully implemented by 2012/13. He has also made clear his intention that the Public Health Outcomes Framework will have strong links with the Outcomes Frameworks for both the NHS and Adult Social Care.

Impacts, Costs and Benefits of preferred option

Costs and benefits

A21. Identifying impacts as a result of achieving different outcomes would be the subject of a further Impact Assessment after the consultation period. Local level contribution to the outcome indicators will be driven by local need, dependent on the outcomes chosen and any associated level of ambition agreed regarding outcome indicators.

A22. Regarding the Outcomes Framework under development, anticipated positive impacts are:

- An overall reduction in the performance monitoring burden at a local level;
- Refocusing and strengthening of public health outcomes and their delivery at local and national levels;
- Alignment between the NHS Outcomes Framework/ Adult Social Care Framework and Public Health Outcomes Framework; and
- Prioritisation of health indicators with the greatest potential to impact on the public's health (and health inequalities), supported by an evidence base of intervention to improve health outcomes.

A23. Regarding the Outcomes Framework under development, possible negative impacts are:

- Current proposal for the Public Health Outcomes Framework may be seen by Local Authorities, and others as regressive because of its top-down nature;
- Continuity may be difficult to achieve between existing frameworks (e.g. Vital Signs / National Indicator Set) and the new Outcomes Framework;
- The prioritisation process to develop top-level indicators could result in unintended consequences e.g. they become the focus for local action over and above local need / priorities; and
- There may be limitations in the evidence base underpinning the interventions required to improve selected outcome indicators.

A24. The Outcomes Framework is under development and the final approach taken as well as the individual outcome indicators selected will be determined post-consultation. Therefore, it is not possible to estimate costs at this stage.

Anticipated costs

- If new data collections are needed to monitor outcomes, then these will have cost implications for the public health service. In most cases, data underpinning outcome indicators may already be collected. However, the frequency and timeliness of existing indicators may have to be improved in order to be suitable for accountability purposes.

- In other cases, based on the final indicator set, new data collection systems may need to be established incurring additional costs including as appropriate, the setting up and evaluation of pilots.

- To be determined at local level, additional costs may be as a result of diverting public health expenditure to meet locally agreed ambitions resulting in opportunity costs.

Anticipated benefits

- Outcome measures may incentivise cost-effective interventions. It is not possible to quantify these at this stage.

- Resources saved from reducing the burden of current top-down performance management structures and streamlining as a result of synergy across the Adults Social Care and NHS Outcomes Framework.

- Until the framework is fully developed and indicator set agreed following consultation, it will not be possible to quantify or evaluate the net benefit of this approach.

A25. Wherever possible, we will use existing data sources, and will report on progress at the national level. We anticipate the National Child Measurement Survey as being the only area where responsibility will transfer from the NHS to Local Government.

Summary and weighing of options

A26. Option 2, representing the setting up of an Outcomes Framework, is the preferred option.

A27. Provided the outcome indicators and levels of ambition selected are appropriate, and fulfil the conditions explained above and in the Consultation document, we would expect benefits to outweigh costs .

A28. However, the full costs and benefits of establishing an Outcomes Framework cannot be estimated at this stage, with considerable uncertainties about the likely shape and content of the framework

Annex C – Proposed Public Health Indicators: Technical Detail

NB – indicators in *italics* are included as potential developmental indicators
TBC – to be confirmed

Vision: To improve and protect the nation's health and wellbeing and for improving the health of the poorest fastest

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equality characteristic[8] (Y- Yes, N- No, P- Partial)	Frequency of Collection
V1	Healthy life expectancy	Life expectancy is increasing and it is desirable for increased years of life to be spent in good health. The measure uses a self-reported health assessment, applied to life expectancy data. In part, this is a subjective measure but is an indicator of whether efforts are being appropriately targeted at conditions or behaviours that improve people's lives.	ONS (based on death registrations, population estimates, and general health questions in modules of the Integrated Household Survey)	National (currently). Local Authority data should become available in late 2011 (subject to ONS development work)	P	Annual
V2	Differences in life expectancy and healthy life expectancy between communities.	These 2 measures would work as a package covering both morbidity and mortality, and addressing within-area differences and between-area differences.	ONS for Life Expectancy (LE) and Healthy Life Expectancy (HLE) or Disability Free	(1) Within-LA measure: at LA level with a national summary measure.	P overall. Y for gender and area deprivation. N for ethnicity. Age would be possible but essentially we are	Annual

[8]The majority of outcome indicators (where applicable) can be disaggregated by some equality domains (e.g. age and gender) but not all (e.g. sexual orientation). However, following consultation, further work will be undertaken to review the final indicators selected, identifying and addressing gaps in existing data collection where it is possible to do so.

	This uses 2 underpinning measures: (1) The slope index of inequality in life expectancy within every Local Authority (LA) area and (2) the gradient of inequality in healthy life expectancy between LAs	They support action to improve health in small pockets of deprivation everywhere as well as larger areas of deprivation, which are below the national average at LA level but may have small within-area gaps.	Life Expectancy (DFLE)	(2) Between-LAs; National-level. The underpinning data is available at national, LA and super output area (SOA) for Life Expectancy and at National levels for HLE/DFLE. (LA level is under development)	proposing measures which capture all-ages. It would be possible to breakdown into certain age categories.	

Domain 1: Health Protection and Resilience

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)	Frequency of Collection
D1.1	Comprehensive, agreed, inter-agency plans for responding to public health incidents in place, audited and assured to an agreed standard and tested to ensure effectiveness on a regular cycle.	Rationale is based on a principle of most incidents should be manageable at a local level. Reference to Civil Contingencies Act 2004, National Risk Assessment (Cabinet Office)	No data collected on compliance or performance re; health emergency preparedness & response by DH. National Capability Survey (NCS) held by Cabinet Office every 2 years	NCS National but aggregated up from local and regional organisations	N/A	NCS every 2 years
D1.2	Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.	(Technical detail under discussion).	TBC	TBC	TBC	TBC
D1.3	Life years lost from air pollution as measured by fine particulate matter	Comparing a 2008 birth cohort exposed over their lifetimes to 2008 levels of anthropogenic fine particulate matter (PM2.5) with a birth cohort not exposed	UK National Air Quality Archive and Health Protection Agency	National (UK)	N/A	Annual

		to anthropogenic PM2.5 at all over their lifetime (which represents the hypothetical removal of anthropogenic PM2.5) shows a loss in life expectancy of about 6 months per person. (see http://www.defra.gov.uk/environment/quality/air/airquality/panels/igcb/documents/100303-aq-valuing-impacts.pdf Adding similar calculations for other cohorts suggests a cumulative overall impact of between 18.2 and 32.4 million life-years lost for the current UK population.				
D1.4	Population vaccination coverage (for each of the national vaccination programmes across the life course)	Immunisation is a central public health intervention that continues to evolve as more diseases become amenable to cost effective immunisation programmes. The purpose of this outcome measure is to ensure that successful immunisation programmes are in place and that the protection provided by existing and newly introduced programmes can continue to be improved.	Various reporting mechanisms are used including COVER, KC50 and ImmForm with significant input by the HPA. This will require central coordination by Public Health England	National, Local Authority and Output Area	P	Annual/Quarterly (subject to vaccination programme and reporting mechanism)
D1.5	Treatment completion rates for TB	Tuberculosis has been on the increase in England, reaching 8423 cases in 2009 (an increase of 5.3% from the previous year).	Enhanced Surveillance TB System (currently coordinated by HPA)	National, Local Authority	P	Annual

		Properly completed treatment can prevent development of drug resistance and reduce treatment costs by at least 80% and treatment time by at least a year and a half per case.				
D1.6	Public sector organisations with board approved sustainable development management plan.	(Technical detail under discussion)	TBC	TBC	TBC	TBC

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Domain 2: Tackling the Wider Determinants of Health						
Reference	**Outcome Indicator**	**Rationale/Description**	**Data Source**	**Spatial Level Available**	**Can be disaggregated by equalities/ inequalities (Y-Yes, N-No, P-Partial)**	**Frequency of Collection**
D2.1	Children in Poverty	Growing up in poverty damages children's health and wellbeing adversely affecting their future health and life chances as adults. This is currently measured as % of children living in families receiving means tested benefits.	Based on data provided by Department for Work and Pensions	National / Local Authority / Output Area	P	TBC
2.2	School readiness: foundation stage profile attainment for starting Key Stage 1	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.3	Housing overcrowding rates	DCLG can provide data on overcrowding rates (based on bedroom standard) for households and individuals by tenure.	Department for Communities and Local Government (DCLG) English Housing Survey	National and regional. LA level may be possible and is currently being investigated.	P	TBC
D2.4	Rates of adolescents not in education, employment or	Non-participation in education, employment or training between the ages of 16 and 18 is a predictor of later unemployment, low income, depression,	Client case-load information system (CCIS) currently maintained by	National / Local Authority	TBC	Annual

	training at 16 and 18 years of age	involvement in crime and poor mental health.	Local Authorities (collection post 2011 to be confirmed)			
D2.5	Truancy rate	Research has shown that children who are not in school are most vulnerable and are easily drawn into crime. Those children who play truant are more likely to offend than those who do not. Secondary school persistent absence rate has been used to measure truancy.	NB Department for Education (DFE) have not included this in their impact indicators. Previously managed by DFE predecessor and based on Termly School Census	National / Local Authority	TBC	Annual
D2.6	First time entrants to the youth justice system	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.7	Proportion of people with mental illness *and or disability* in settled accommodation	(Technical detail under discussion) Further work is required to define disability in the context of these indicators and to identify appropriate data sources	TBC	TBC	TBC	TBC
D2.8	Proportion of people with mental illness *and or disability* in employment.	Costs of working age ill health in the UK is £100 billion per year. There were 9.8 million working days lost in 2009/2010 due to work-related stress, depression or anxiety. It is expected there will be a rise of 60% over the next 10 years in people with 3 or more long-term conditions. Further work is required to define disability in the context of these indicators and to identify appropriate data sources	TBC	TBC	TBC	TBC
D2.9	Proportion of	There is a strong evidence to suggest that	Department for	TBC	TBC	TBC

	people in long-term unemployment	work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context, and that worklessness is associated with poorer physical and mental health.	Work and Pensions			
D2.10	Employment of people with long-term conditions	The data source exists to measure this outcome, however the method by which the employment rate of people with long-term conditions will be mapped to the employment rate of the general population needs to be developed.	Labour Force Survey	Not currently available but possible to construct	P	Not currently published but data is available quarterly
D2.11	Incidents of domestic abuse	Domestic abuse victims have the highest level of repeat victimisation, often with the severity of incidents escalating over time. In addition, alcohol use is indicated in a high proportion of incidents.	APACS (Assessments of Policing and Community Safety)	National / Local Authority	TBC	Quarterly
D2.12	Statutory Homeless households	Homelessness is a social determinant of health and an indicator of extreme poverty. Statutorily homeless households contain some of the most vulnerable members of society.	DCLG via P1E-Local Authority returns	National/Local Authority	P	Quarterly
D2.13	Fuel Poverty	Low income, poorly insulated housing and expensive and inadequate heating systems may contribute to fuel poverty, which itself contributes to excess winter mortality.	TBC	TBC	TBC	TBC
D2.14	Access and utilisation of green space	There is strong evidence to suggest that there is a positive relationship between green space and the general health of the population. Studies indicate that better health is linked to green space provision, regardless of the socio-economic status of the people who use it. There is strong	Monitor of Engagement with the Natural Environment (MENE) survey	TBC	TBC	TBC

		evidence to suggest that green spaces have a beneficial impact on mental wellbeing and cognitive function through both physical access and usage. This indicator measures the number of people using green spaces for personal health and exercise.				
D2.15	Killed and seriously injured casualties on England's roads	Road user safety is a public health issue as incidents and collisions on the roads are a significant cause of death and injuries; disproportionately so among young age groups and in disadvantaged areas. They have a large affect on the resources of health and rescue services and there are strong synergies between active travel, road safety and health. Road safety is also one of the key factors affecting how pleasant an area is to live in. This indicator will monitor progress in this area by showing the changes in the number of people killed and seriously injured on English roads.	Stats 19 reports / Department for Transport	National / Local Authority	P	Annual
D2.16	The percentage of the population affected by environmental, neighbour, and neighbourhood noise.	The first aim of the **Noise Policy Statement for England** is to avoid significant adverse impacts on health and quality of life from environmental, neighbour and neighbourhood noise. This outcome would assist in achieving this aim.	National Noise Attitude Survey (NAS).	England	P	Every 2 years
D2.17	Older people's perception of community safety	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.18	Rates of violent crime, including sexual violence	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.19	*Reduction in*	*(Technical detail under discussion)*	*TBC*	*TBC*	*TBC*	*TBC*

	proven reoffending					
D2.20	*Social connectedness*	*This is a strong candidate indicator for measures of social capital that have a bearing on health. Evidence suggests that where individuals have an opportunity to discuss health issues in social groups they are less likely to make poor decisions about their own health. In a UK setting, this effect is likely to be measured best by using survey measures to assess social connectedness rather than, for example, membership of groups.*	*Existing questions in DCLG 'citizenship survey' adapted locally for measures at LA level.*	*TBC*	*TBC*	*TBC*
D2.21	*Cycling participation*	*Measures the percentage of the population cycling by frequency (no. of days) during previous 4 weeks.* *Evidence suggests that cycling may be a good proxy for physical activity participation.* *Nearly all frequent (once a week or more) cyclists meet recommended physical activity levels.*	*Sport England's Active People Survey.* *Rolling national phone survey. Data collection started Oct 2010.* *(Note this is a new additional question tracking any cycle journey).*	*National / Local Authority*	*P* *The data (at a national and LA level) could be further analysed by gender, age range, ethnic profile, educational level, household type, car ownership, disability, working status and job type, and income.*	*Quarterly*

Domain 3: Health Improvement

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)	Frequency of Collection
D3.1	Prevalence of healthy weight in 4-5 and 10-11 year olds	Obese/overweight individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight.	National Child Measurement Programme	National, Local Authority & Output Area	P	Annual
D3.2	*Prevalence of healthy weight in adults*	*Obese/overweigh individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight. The potential inclusion of this proposed indicator is subject to further work to develop an accurate and cost-effective means of measurement at local authority level.*	*Health Survey for England*	*National / Regional*	*P*	*Annual*
D3.3	Smoking prevalence in adults (over 18)	Causes approximately 80,000 deaths in England each year and costs the NHS between £2.5 - £5bn per annum.	Integrated Household Survey	National, Regional & Local Authority	P	Quarterly
D3.4	Rate of hospital admissions per 100,000 for alcohol related harm	There are substantial differences in the health consequences of alcohol use between affluent and deprived communities. Deprived areas suffer higher levels of alcohol related mortality, hospital admission, crime, absence from work, school exclusions, teenage pregnancy and road traffic accidents linked to greater levels of alcohol consumption. Much of this harm is preventable - one in eight of	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly

		those drinking at higher-risk levels will reduce their drinking if they receive brief advice - reaping economic and health benefits for individuals and communities. Alcohol-related admissions are considered to be sensitive to the impact of prevention interventions - i.e. when prevention interventions are improved, hospital admission for specific chronic and acute conditions should slow in the short, medium and long term. This indicator will therefore measure the impact of prevention interventions for alcohol, without creating an additional burden for local healthcare organisations Estimates of alcohol-related deaths between 9,000 and 30,000 each year and costs to the NHS of approximately £2.7bn per annum.				
D3.5	Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)	Physical inactivity costs the NHS approximately £1.8bn per annum and WHO report that it is one of the 10 leading causes of death in developed countries.	Sport England's Active People Survey - derived	TBC	TBC	TBC
D3.6	Hospital admissions caused by unintentional and deliberate injuries to 5-18s	Injuries are the leading cause of death in children and disproportionately affect children from lower socioeconomic groups. This indicator concerns finished in-year emergency admissions for patients aged between 5 and 18 years of age with an external cause of morbidity. Focusing on this age group addresses strong evidence on the incidence of self-harm and serious accidents.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Annual

D3.7	Number leaving drug treatment free of drug(s) of dependence	Illicit drug misuse can cause significant harm to individuals, their families and communities. Illicit drug misuse costs the NHS between £0.85 - £1.05 billion per annum. The indicator is defined as the number of drug users that left drug treatment successfully as recorded in the National Drug Treatment Monitoring System (NDTMS), who do not then re-present to treatment again within 12 months.	National Drug Treatment Monitoring System	National, Local Authority	P	Monthly
D3.8	Under 18 conception rate	Evidence shows that teenage parenthood leads to poorer health outcomes for both teenage parents and their children - babies born to teenage parents have a 60% higher risk of infant mortality and teenage mothers and three times more likely to suffer from post-natal depression.	ONS	National, Local Authority	P	Quarterly - 14 month time lag
D3.9	Rate of dental caries in children aged 5 years (decayed missing or filled teeth)	Dental disease is more common in deprived, compared with affluent, communities. The indicator is good direct measure of dental health and an indirect, proxy measures for child health and diet. (See Health Profile Indicator Guide (APHO): http://apho.org.uk/resource/view.aspx?RID=50204	Currently the Dental Observatory	National, Local Authority (but not where the sample size is <30)	P	Every 2 years
D3.10	*Self reported wellbeing*	*TBC –* *Promoting wellbeing can improve health outcomes, life expectancy as well as educational, social and economic outcomes. We can explore the potential to use the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) tool incorporated into the Health Survey for England. Alternatively, EQ5D data may be captured via the GP survey.*	*TBC - Potential to use Health Survey for England and or / National GP Survey*	*TBC*	*TBC*	*TBC*

Domain 4: Prevention of Ill Health

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N-No, P-Partial)	Frequency of Collection
D4.1	Hospital admissions caused by unintentional and deliberate injuries (1-5 years)	Injuries are a leading cause of death in children and disproportionately affect children from lower socioeconomic groups. This indicator concerns finished in-year emergency admissions for patients between 1 and 5 years of age with an external cause of morbidity. In addition a focus on this age group links to early years child protection activities led by local government.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Annual
D4.2	Rate of hospital admissions as a result of self-harm	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D4.3	Incidence of low-birth weight of term babies	Low birth weight is a known risk factor for infant mortality. This indicator measures live and stillborn infants with low birthweights as a percent of all live and stillborn infants with a stated birthweight.	ONS	National / Local Authority	TBC	Quarterly
D4.4	Breastfeeding initiation and prevalence at 6-8 weeks after birth	There is evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer term (beyond the period of breastfeeding). See http://www.nhs.uk/Planners/breastfeeding/Pages/breastfeeding.aspx	Currently PCT coordinated Child Health Information Records.	Currently at PCT level	P	Reported to DH at quarterly intervals

D4.5	Prevalence of recorded diabetes	There were an estimated 3 million people with diabetes in England in 2009; estimates suggest that the number of people with diabetes could rise to 4.6 million by 2030. Based on the indicator currently used in the Local Health Profiles (APHO), this proposed indicator will measure prevalence of QOF-recorded diabetes (in adults aged 17+) in the population.	Quality Management Analysis System	National, Local Authority & GP Practice	P	Annual
D4.6	Work sickness absence rate	The costs of working age ill health in the UK is estimated at £100 billion per year, greater than the annual budget for the NHS. Around 172 million working days were lost to sickness absence in 2007, at a cost to the economy of over £13 billion.	Department of Work and Pensions	TBC	TBC	TBC
D4.7	Screening uptake	This indicator will measure screening uptake. Discussion is underway regarding which of the national screening programmes will be included.	TBC	TBC	TBC	TBC
D4.8	Chlamydia diagnosis rates per 100,000 young adults aged 15-24	29.9% of the population aged 15-24 were tested for chlamydia in 2009/10 and 142,200 (7.2%) tested positive. This indicates a high burden of infection in young people. Annual testing and testing at partner change in this age group is expected to reduce the transmission rate, leading to a fall in prevalence and a secondary reduction in the incidence of new infections. Early diagnosis and treatment will reduce the severe effects of chlamydia in women, such as pelvic inflammatory disease and infertility.	Currently Health Protection Agency	National / Local Authority / Output Area	TBC	Annual
D4.9	Proportion of persons presenting with HIV at a late stage of infection	Late diagnosis is the single most important factor associated with HIV-related morbidity and mortality in the UK. Late diagnosis is defined as a CD4 count of less than 350 mm^3 within three months of diagnosis. The sooner a person with HIV is diagnosed the sooner they can benefit from effective treatment when	Currently Health Protection Agency	National / Local Authority/ Output Area (subject to numbers)	P	Annual

		indicated and make any behavioural changes to prevent further HIV transmission.				
D4.10	*Child development at 2 - 2.5 years*	*We will explore the development of an outcome indicator of young children's health and well-being at age 2-3 that can be used locally and nationally as a basis for monitoring and accountability. This will reflect the importance of parenting and neurological development during pregnancy and the early years of life and children's development at age 5 and beyond. It will assess the feasibility of providing a common outcome measure that supports the HCP, health visiting, Family Nurse Partnership and Sure Start Children's Centres.* *Work to develop and test the measure will take place over the next 12 to 18 months using indicators based on existing measures of children's development, as there are a number of established validated tools.*	*TBC*	*TBC*	*TBC*	*TBC*
D4.11	Maternal Smoking Prevalence	Smoking during pregnancy contributes to 6% of all infant deaths and accounts for about a third of the difference in infant deaths between the most and least deprived groups in the population. The proportion of mothers who smoked throughout their pregnancy is much higher in mothers under 20 years of age.	DH (Health Improvement Analytical Team)	National / currently commissioning Primary Care Trusts	P	Quarterly
D4.12	Smoking rate of people with serious mental illness	People with mental ill health are much more likely to smoke and die younger. Almost half of total tobacco consumption and smoking-related deaths occur in people with a mental disorder. People with schizophrenia have an average 25-year lower life expectancy than the general population, which is primarily due to smoking.	Adult Psychiatric Morbidity Survey	National and Regional	P	Currently every seven years
D4.13	Emergency readmissions to hospital within 28	This indicator demonstrates the success of secondary prevention measures in delaying dependency and supporting effective reablement and rehabilitation. It provides a link between public health and the NHS and	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly

	days of discharge	adult social care outcome frameworks.				
D4.14	*Health-related quality of life for older people (placeholder)*	*This candidate indicator is intended to reflect the role of public health and social care prevention activity in promoting active ageing, and improving quality of life for older people. This indicator is likely to be available from the GP Survey, and more analysis is needed.*	*GP Patient Survey*	*National, Local Authority*	*TBC*	*Annual*
D4.15	Acute admissions as a result of falls or fall injuries for over 65s	Falls account for the majority of hospital admissions for unintentional injury in older people, and falls prevention is one of the key public health priorities. This indicator reflects the success of prevention in reducing admissions resulting from falls, and provides a strong link to the NHS and adult social care.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly
D4.16	*Take up of the NHS Health Check programme by those eligible*	*This indicator intends to measure take up of the NHS Health Check programme, a clinically and cost effective preventative programme which aims to reduce the number of people with heart disease, stroke, diabetes and chronic kidney disease. Everyone receiving a NHS Health Check will have a personal risk assessment and be given individually tailored advice and support to help them stay well for longer*	*National data collection*	*National and Local Authority Level*	*P*	*Quarterly*
D4.17	*Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed*	*(Technical detail under discussion)*	*TBC*	*TBC*	*TBC*	*TBC*

Domain 5: Healthy Life Expectancy and Preventable Mortality

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)	Frequency of Collection
D5.1	Infant Mortality	Infant mortality is a widely used indicator of the overall health of a population. It reflects a broad range of determinants including upstream determinants such as economic development, general living conditions and social and environmental factors.	ONS Mortality Extract	National, Local Authority	P	Annual
D5.2	Suicide rate	This indicator intends to measure the age standardised mortality rate from suicide and injury of undetermined intent. (3-year rolling average) Suicide is related to a number of socio-economic factors including social exclusion and inequalities in access to relevant service provision.	ONS Mortality Extract	National / Local Authority (subject to numbers)	P	Annual
D5.3	Mortality rate for communicable diseases	There are evidence-based prevention, detection and treatment interventions for most communicable diseases yet the incidence of certain diseases continues to increase (e.g. Mycobacterium Tuberculosis). This indicator intends to reflect the effectiveness of primary and secondary prevention activity to reduce mortality from communicable diseases. This indicator includes mortality as a result of health care acquired infections (HCAIs). Incidence of HCAIs is a separate indicator proposed in the NHS Outcomes Framework.	ONS Mortality Extract	National / Local Authority	P	Annual
D5.4	Mortality rate	Circulatory diseases are the biggest cause of	ONS	National/	P	Annual

	from all cardiovascular disease (including heart disease and stroke) persons less than 75 years of age	preventable death in England and a major cause of health inequality. In 2008, approximately 40,000 persons under 75 years died from circulatory diseases in England (NHS Information Centre)	Mortality Extract	Local Authority/ Output Area		
D5.5	Mortality rate from cancer in persons less than 75 years of age	Cancer is one of the three leading causes of death in people of all ages. Inequalities exist in cancer mortality rates between the most deprived areas and the most affluent. Approximately 62,000 persons under 75 years of age died of cancers in England 2008. (NHS Information Centre).	ONS Mortality Extract	National/ Local Authority/ Output Area	P	Annual
D5.6	Mortality rate from Chronic Liver Disease in persons under 75 years of age	Liver disease mortality is rising by 10% per annum and has increased 2 fold in the past two decades. There has been a 3-fold increase in cirrhosis during that time and a 5-fold increase in the 35-55 year age group in the last 10 years in contrast to our neighbours in France, Italy & Spain all of which have decreased during that time. The average age of death from liver disease is currently 59 years and continues to fall. The main cause appears to be alcohol but there are increased trends from fatty liver (obesity) and hepatitis B&C viruses.	ONS Mortality Extract	National/ Local Authority	P	Annual
D5.7	Mortality rate from chronic respiratory diseases in persons less than 75 years of age	(Technical detail under discussion)	ONS Mortality Extract	National/ Local Authority	P	Annual
D5.8	Mortality rate of	(Technical detail under discussion)	TBC	TBC	TBC	TBC

	people with mental illness					
D5.9	Excess seasonal mortality	(Technical detail under discussion)	TBC	TBC	TBC	TBC

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

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Policy	Estates
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Document Purpose	Policy
Gateway Reference	15142
Title	Healthy Lives Healthy People: a consultation on the funding and commissioning routes for public health
Author	Department of Health, Public Health Development Unit
Publication Date	21 Dec 2010
Target Audience	Directors of PH, Local Authority CEs, Directors of Finance,
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Directors of Nursing, Directors of Adult SSs, PCT PEC Chairs, Directors of HR, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	A consultation on the proposed funding and commissioning routes for Public Health England, including the ring-fenced budget provided to local authorities. The consultation closes on 31 March, after which a summary of responses received will be published.
Cross Ref	Healthy Lives, Healthy People
Superseded Docs	N/A
Action Required	Response to the consultation questions
Timing	**By 31 Mar 2011**
Contact Details	Public Health Development Unit G14 Wellington House 133-155 Waterloo Road SE1 8UG - www.dh.gov.uk
For Recipient's Use	

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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Published to DH website, in electronic PDF format only.
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Contents

Executive summary

1. The White Paper *Healthy Lives, Healthy People*[i], 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

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*[ii].

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.

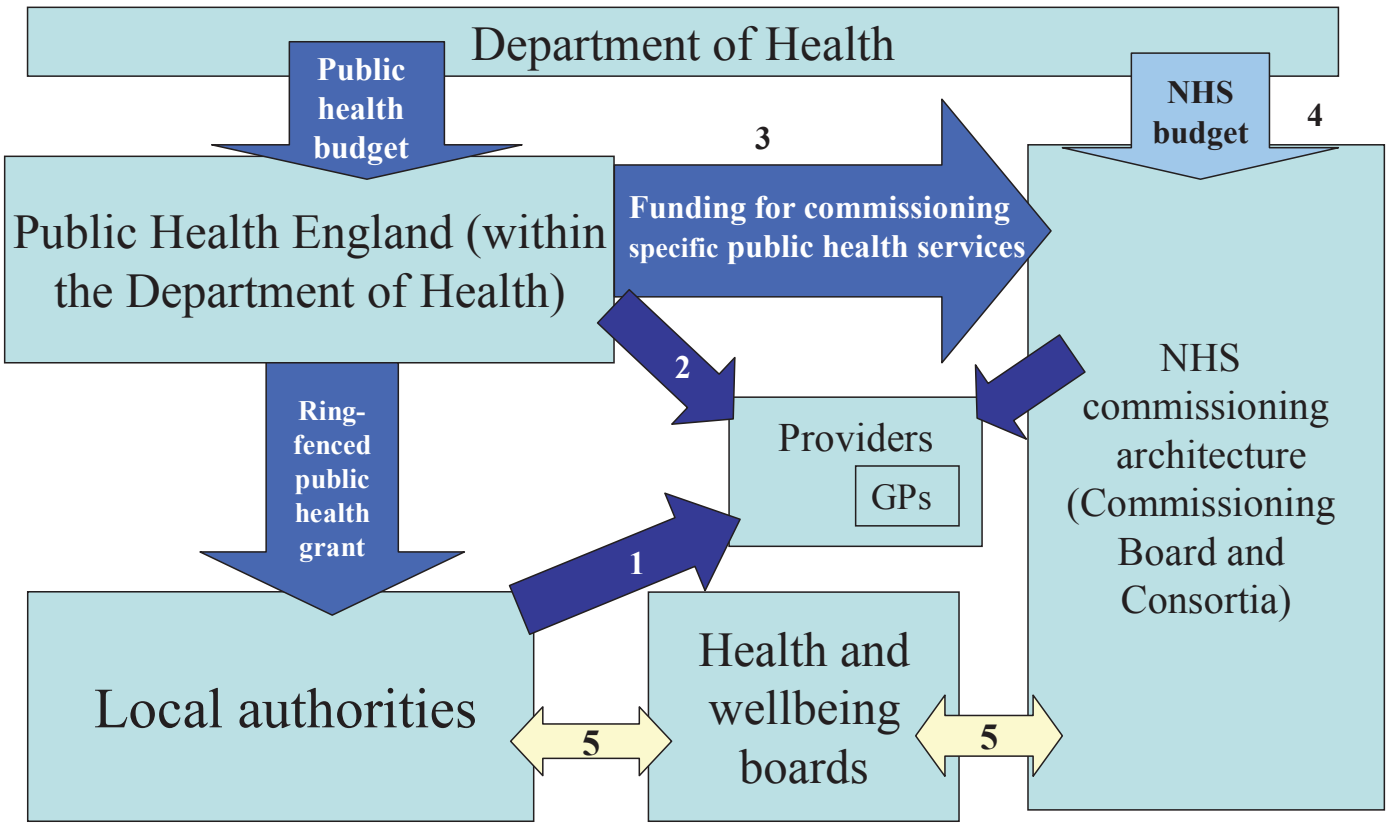
2. Funding and commissioning flows

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[iii]. 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 recognitition 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*[iv] 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"[v] 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[vi].

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). [vii]

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[viii] 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

	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

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 pneumoccocal (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[ix] 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 intenventions 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

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

Question 1.	Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?
Question 2.	What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?
Question 3.	How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?
Question 4.	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?
Question 5.	Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?
Question 6.	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?

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

Question 14. How should we design the health premium to ensure that it incentivises reductions in inequalities?
Question 15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
Question 16. 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

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 back 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.

Endnotes

[i] 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

[ii] Department of Health (2010) *Equity and Excellence: Liberating the NHS*, www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[iii] 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

[iv] Department of Health (2010) *Liberating the NHS: Legislative framework and next steps* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

[v] 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

[vi] 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

[vii] Griffiths, S., Jewell, T. and Donnelly, P. (2005) Public health in practice: The three domains of public health. *Public Health*; 119(10): 907–13.

[viii] 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

[ix] Department of Health, (2010) *Operating Framework for the NHS in England 2011/12* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738*