	AGENDA ITEM 6
	AFW/04/11
Committee:	**West Essex Area Forum**
Date:	**8 March 2011**

Public Health White Paper on Health and Well-Being Boards

Loretta Sollars, Health Partnerships Delivery Manager will update the Committee on the Public Health White Paper on Health and Well-Being Boards.

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Healthy Lives, Healthy People
Public Health White Paper

West Area Forum

8 March 2011

Background

Health White Paper June 2010:

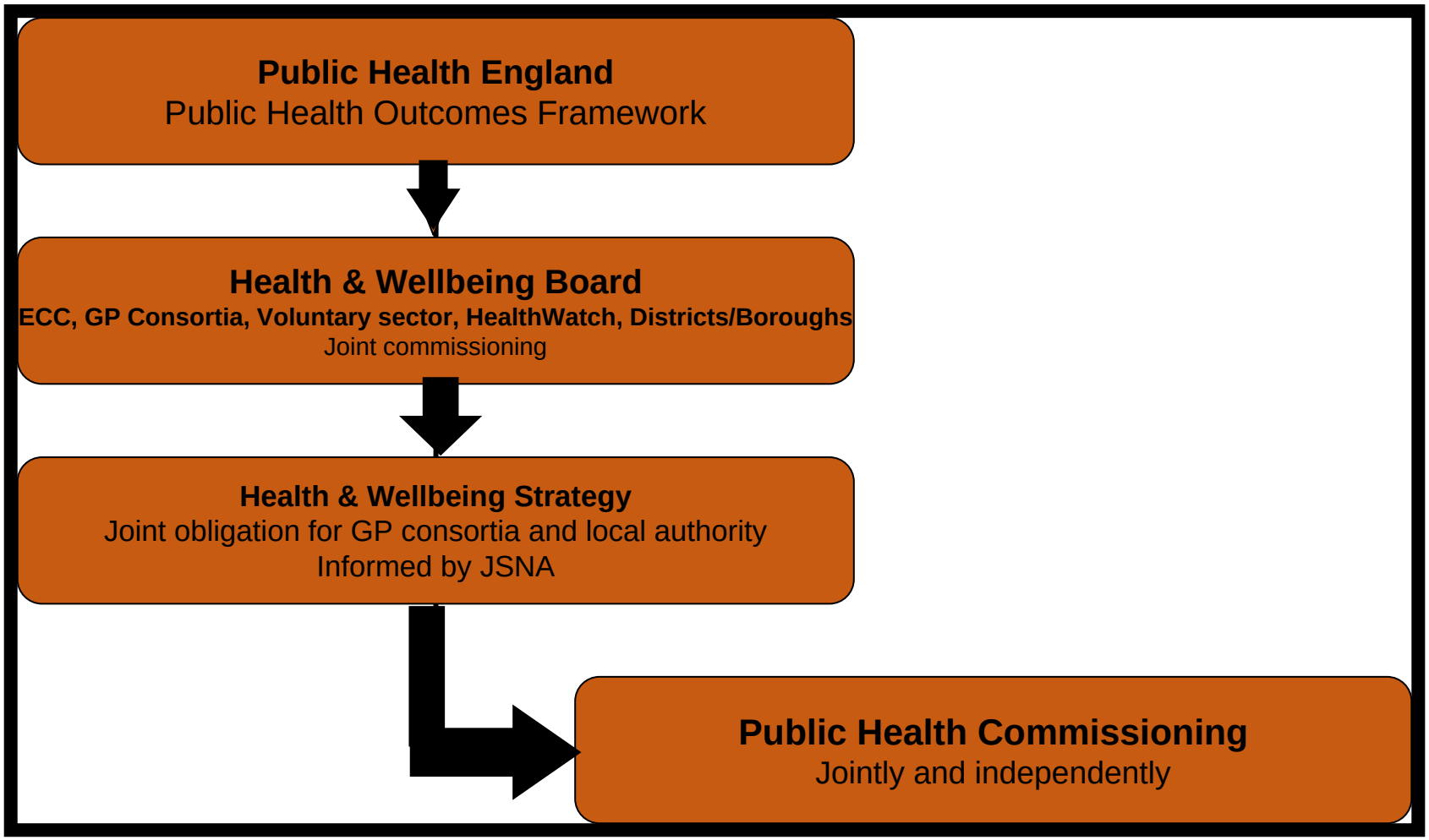
- PCTs to be abolished April 2013
- Commissioning for Primary Care transferred to GP Consortia
- Public Health responsibilty transferred to upper tier local authorities
- NHS Commissioning Board established
- Public Health England, part of Dept of Health, to lead on health protection
- HealthWatch to take over and develop role of LInks
- Directors of Public Health (DPH), lead professional for Public Health, based in local authorities

Health and Social Care Bill published Jan 2011, now going through parliament

Public Health White Paper and other consultations published Dec 2010

Public Health White Paper

Key Proposals



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PH Outcomes Framework

Vision

To improve and protect the nation's health and well-being and to improve the health of the poorest fastest

- Improved life expectancy
- Healthy life expectancy gap between the least and the most deprived communities

Domain 1

Protect the population's health from major emergencies and remain resilient to harm

DETERMINANTS OF ILL HEALTH		*OUTCOMES OF ILL HEALTH*	
Domain 2 Tackling the wider determinants of health	**Domain 3** Health Improvement	**Domain 4** Prevention of ill-health	**Domain 5** Healthy live expectancy and preventable mortality
Tackling the factors which affect health and wellbeing	Helping people to live healthy lifestyles and make healthy choices	Reducing the number of people living with preventable ill health	Preventing people from dying prematurely

↑ ↑ ↑ ↑ ↑ ↑ **For All Domains** ↑ ↑ ↑ ↑ ↑↑

Health Inequalities integrated throughout every domain

National – Local balance required

Local areas to determine how to use indicators for local transparency in response to local needs identified through JSNA and considered within Health and Well Being Strategies

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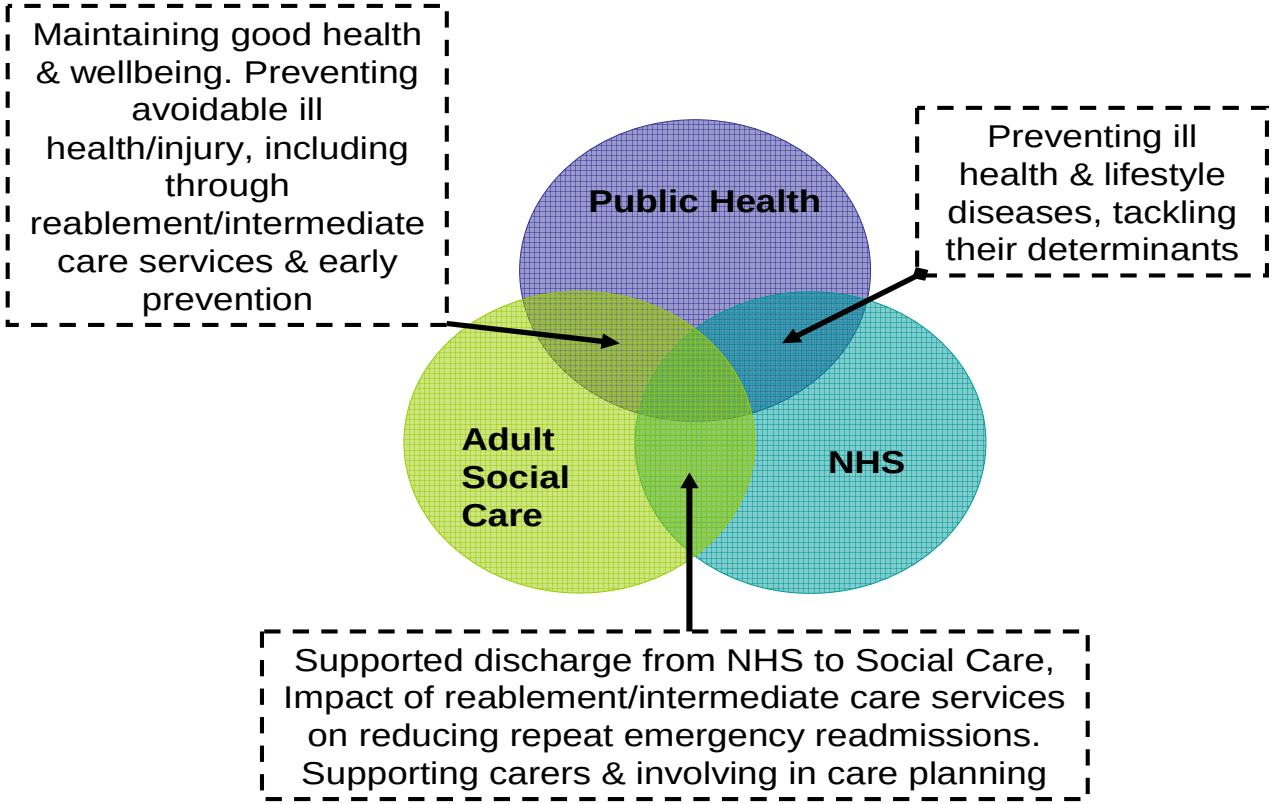
Likely Future Public Health Responsibilities

Some examples…all still subject to consultation

Health Protection Eg flu pandemic	Health Protection Agency with local delivery managed by DPH
Drug and Alcohol Action Teams Prevention and treatment commissioning	Transferred formally to ECC
Health Improvement/Lifestyle Programmes Public awareness campaigns and lifestyle support interventions	National campaigning by Public Health England ECC to commission local intervention programmes
Screening and Immunisations	ECC and NHS Commissioning Board to commission
Prevention and Wellbeing Eg Falls Prevention strategies	ECC to commission in close cooperation with GP consortia

Outcomes Frameworks



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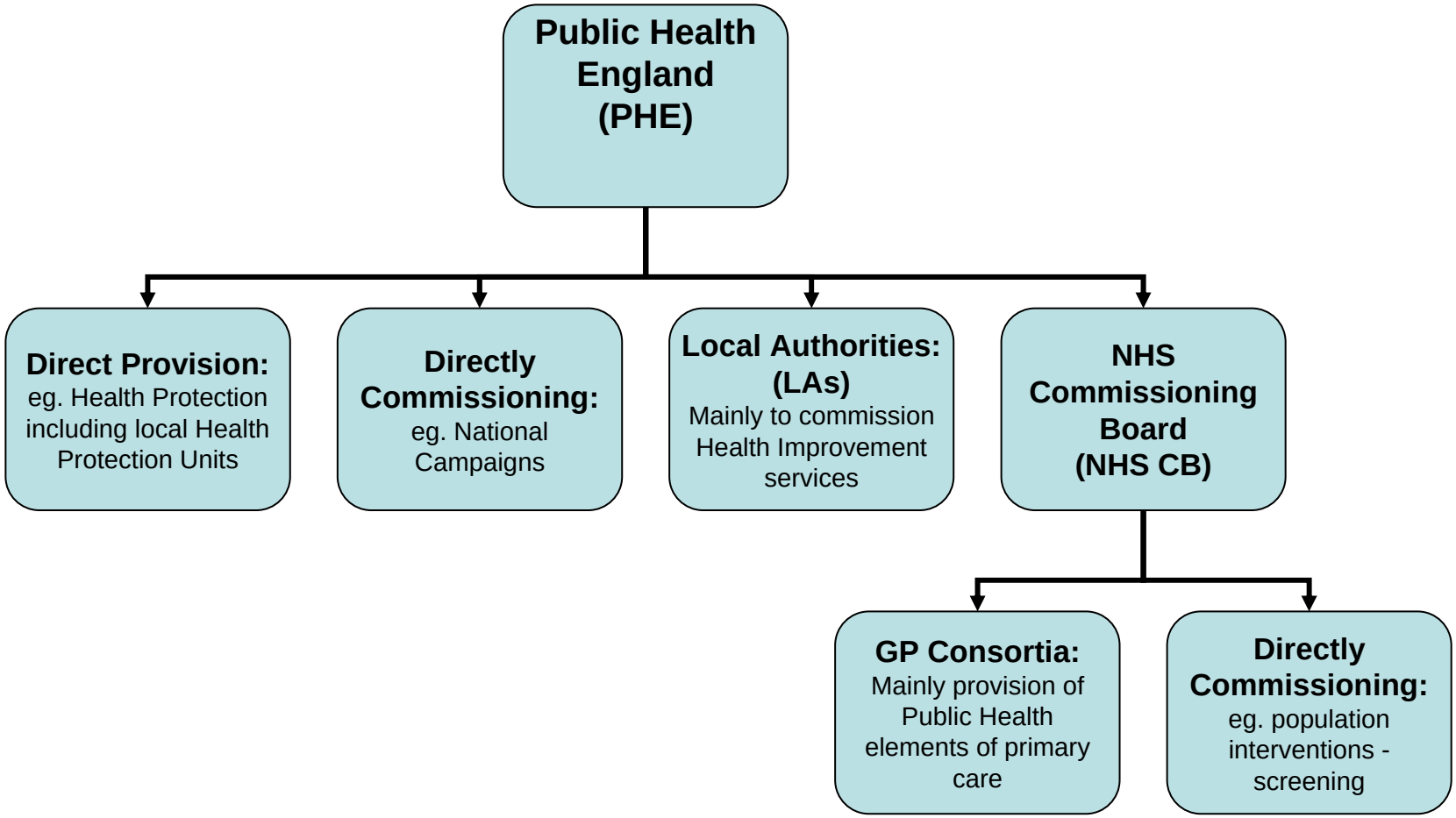
Funding Routes



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Funding

- 4% of NHS Budget??
  £100M across Essex PCTs !!! Health Warning !!!

- "Ring fenced"
  LAs accountable for transparency of progress against local outcomes and for demonstrating value for money

- Health Premium
  "Substantial"
  Payment for results - Progress to reduce health inequalities

Timescales

April 2011	Shadow Health and Wellbeing Board established DPH arrangements in place
2011-2012	Essex Health and Wellbeing Strategy produced Essex and ECC PH visioning and design
April 2012	Shadow Budget allocated to Local Authorities
April 2013	Public Health fully transferred to Local Authorities

Consultation Documents

Online from Dept of Health:
http://www.dh.gov.uk/en/Aboutus/Features/DH_122253

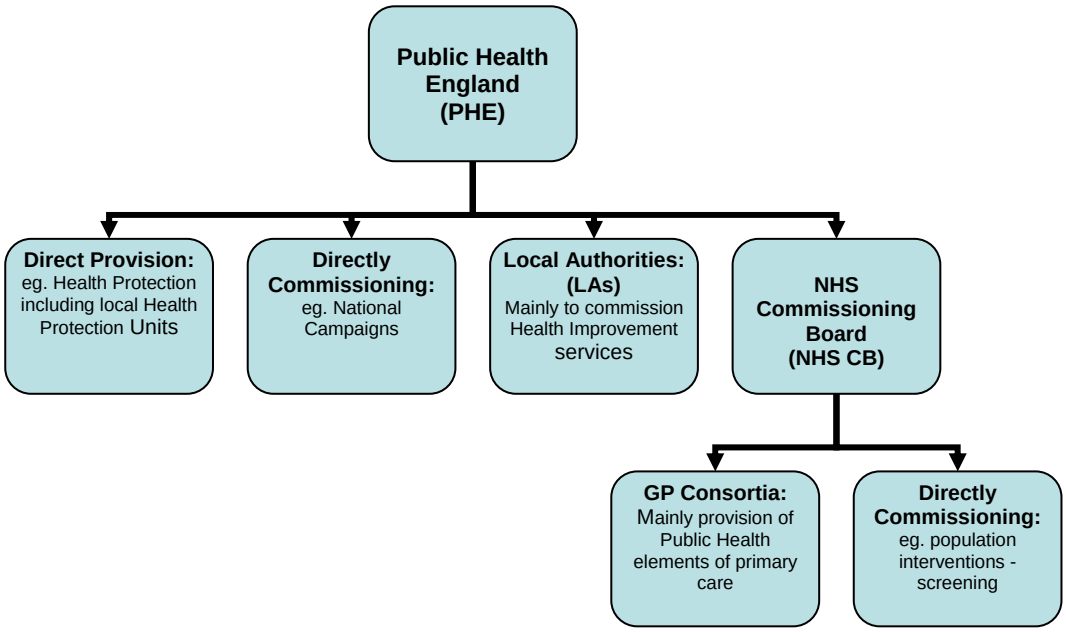
1. **Public Health White Paper**
   Overview of proposals
   Consultation deadline now extended to 31 March 2011

2. **Consultation on the Funding & Commissioning Routes**
   Proposals for who does what and where the money comes from
   Consultation deadline 31 March 2011

3. **Transparency in Outcomes**
   Proposals for Outcomes Framework
   Consultation deadline 31 March 2011

Healthy People – Healthy Lives – Public Health White Paper
Consultation on the funding and commissioning routes for public health
Summary

Funding Channels



Local Authority funding

Commissioning

- Expectation that health improvement services will be commissioned on an any willing provider/competitive tender basis.
- Expectation that voluntary, community and social enterprise sector organisations will provide some services and this could be through grant funding to support community activities eg. volunteering peer support, befriending and social networks.
- LAs can join up to commission on a supra-local basis eg. sexual assault referral centres, female genital mutilation clinics.
- Primary commissioning routes (Table A – page 3&4) do not rule out activity in other parts of the system. Directors of PH will have wide ranging freedom to decide how best to improve PH in their LAs.

Funding Allocations

- Funding will be ring fenced and is "new" money additional to funding currently received for health protection or spent on social care primary prevention and other public health associated activities.
- Funding allocations to be calculated by establishing baseline spend in 2009/10 and putting this through a validation and triangulation process to make the national estimate of spend more accurate.
- Shadow ring fenced budgets to be allocated for 2012/13 with actual budgets from 2013 onwards. Allocations to be made against a formula which will include consideration of:
  - Utilisation - modelling of the statistical relationship between need and expenditure
  - Cost effectiveness – gains in health outcomes relative to spend
  - Population health measures – linked to PH Outcomes Framework eg. standardised mortality rates, disability free life expectancy and higher for areas with poorer health taking into account health inequalities.

  Calculation to be supported by independent Advisory Committee on Resource Allocation (ACRA).
- Allocation could include a number of different components combined into 1 single grant for LAs to prioritise spending as appropriate to their local circumstances.
- Some allocations will be very different to current expenditure levels (more or less) so plan to move towards target levels over a period of time – calling this pace of change policy.
- LAs to be accountable for transparency of progress against their local outcomes and for demonstrating that ring fenced grant has been spent appropriately giving value for money.

Health Premium

- Will apply to the part of the allocation for health improvement and will be an incentive payment to LAs depending on progress made to improve population health and reduce health inequalities – as measured through the Public Health Outcomes Framework
- Disadvantaged areas will receive a greater premium if they make progress. Amounts will be calculated on a formula based approach so that payments will reflect achievement not the ability to negotiate easy targets.
- Issues to consider in the design of the premium include:
  - Sensitivity of indicators and outcomes to PH interventions;
  - Possibility of changes in indicators and outcomes for reasons unconnected with PH interventions;
  - Relative focus on long term outcomes and progress in the shorter term on those factors that drive these outcomes;
  - Frequency of reporting;
  - Relative ease of making a difference to an indicator or outcome and how this varies between areas with different characteristics.

Health and Wellbeing Boards (HWB), JSNA and Health and Wellbeing Strategy

- HWB to provide mechanism for bringing together discussions about investment in cross-cutting services eg social care primary prevention.
- LAs and GP consortia to have an equal and explicit obligation to prepare the JSNA through the HWB.
- All HWBs to develop a joint Health and Wellbeing Strategy spanning NHS, social care, public health and possibly wider health determinants, to provide an overall framework within which commissioning plans for NHS, social care, public health and other services (agreed by HWB) are developed.
- Duty on commissioners to have regard to the JSNA and Health and Wellbeing Strategy.
- Early implementer HWBs (Essex is one of these) to provide feedback on partnership working and how cross cutting services can deliver effective outcomes

Consultation Questions and Timescales

1. Is the HWB the right place to bring together ring-fenced PH and other budgets?
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?
3. How can we best ensure that NHS commissioning is underpinned by the necessary PH advice?
4. Is there a case for PHE to have a greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?
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 policy?
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 2nd column of Table A (pages 3 & 4 of this summary)?
7. Do you consider the proposed primary routes for commissioning of public health funded activity (3rd column) to be the best way to:
   a. ensure the best possible outcomes for the population as a whole, including the most vulnerable?
   b. reduce avoidable inequalities in health between population groups and communities?

   If not, what would work better?
8. Which services should be mandatory for local authorities to provide or commission?
9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?
10. Which approaches to developing an allocation formula should we ask ACRA to consider?
11. Which approach should we take to pace-of-change?
12. Who should be represented in the group developing the formula?
13. Which factors do we need to consider when considering how to apply elements of the PH Outcomes Framework to the health premium?
14. How should we design the health premium to ensure that it incentivises reductions in health inequalities?
15. Would linking access to growth in health improvement budgets to progress on elements of the PH Outcomes Framework provide an effective inventive mechanism?
16. What are the key issues the group developing the formula will need to consider?

The deadline for responding to the Department of Health is 31 March 2011
To download the full Consultation Document go to:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123114.pdf

Table A – Public Health Funded Activity

Key

incl.	including	**LAs**	Local Authorities	**NHS CB**	NHS Commissioning Board
PH	Public Health	**PHE**	Public Health England	**Progs**	programmes
Cell shaded blue	This area is not under consultation and will be as proposed in forthcoming legislation				

Public Health Area	Proposed Activity	Proposed Commissioning Route(s)	Examples of proposed associated activity to be funded from NHS budget
Infectious disease	Current functions of HPA and PH oversight of prevention & control, incl. coordination of outbreak management	PHE LAs to support	Treatment of infectious disease (see sexual health below) Co-operation with PHE on outbreak control & related activity
Sexual Health	Contraception, testing & treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach & prevention	LA to commission all sexual health services except contraceptive services - commissioned by NHS CB (via GP contract)	HIV treatment & promotion of opportunistic testing & treatment
Immunisation against infectious disease	Universal immunisation programmes & targeted neonatal immunisations	Vaccine programmes for children, flu and pneumococcal vaccines via NHS CB (including via GP contract) Targeted neonatal immunisations via NHS LA to commission school progs eg HPV & 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	PHE	-
Radiation, chemical & environmental hazards, incl. PH impact of climate change	Current functions of the HPA in this area, & PH oversight of prevention & control, incl. coordination of outbreak management	PHE LAs to support	-
Seasonal mortality	Local initiatives to reduce excess deaths	LAs	-
All screening	PHE to design & provide quality assurance & monitoring for all screening progs	NHS CB (cervical screening incl. in GP contract)	–
Accidental injury prevention	Local initiatives eg falls prevention services	LA	-
Public mental health	Mental health promotion, mental illness prevention & suicide prevention	LA	Treatment for mental ill health incl. Improving Access to Psychological Therapies (IAPT)
Nutrition	Running national nutrition progss incl. Healthy Start Any locally-led initiatives	PHE, some LA activity	Nutrition as part of treatment services, dietary advice in a healthcare setting & brief interventions in primary care
Physical activity	Local progs to address inactivity & other interventions to promote physical activity eg. improving the built environment, maximising physical activity opportunities offered by the natural environment	LA	Provision of brief advice during a primary care consultation eg. Lets Get Moving
Obesity programmes	Local progs to prevent & address obesity eg, delivering the National Child Measurement Progs & commissioning of weight management services	LA	NHS treatment of overweight & obese patients eg. provision of brief advice during primary care consultation, dietary advice in a healthcare setting, bariatric surgery
Drug misuse	Drug misuse services, prevention	LA	Brief interventions

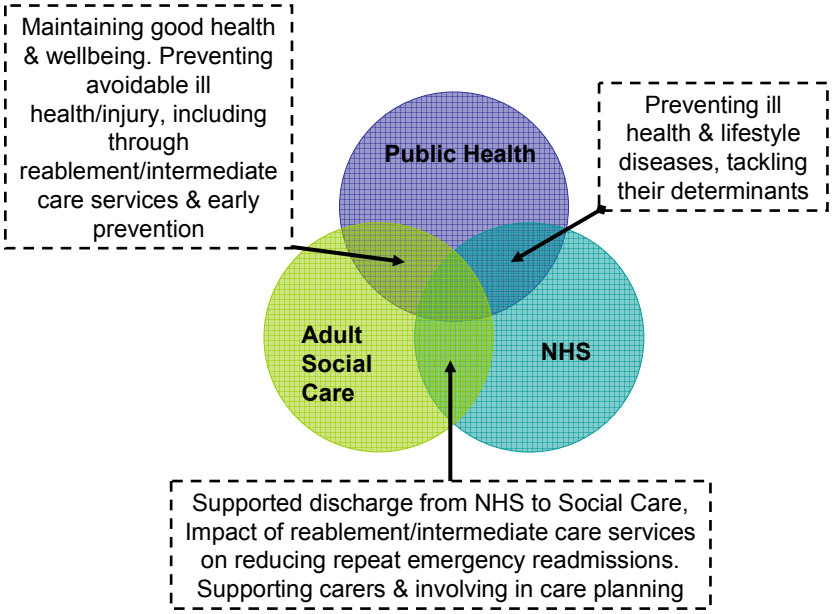
Public Health Area	Proposed Activity	Proposed Commissioning Route(s)	Examples of proposed associated activity to be funded from NHS budget
	& treatment		
Alcohol misuse	Alcohol misuse services, prevention & treatment	LA	Alcohol workers' in a variety of healthcare settings
Tobacco control	Tobacco control local activity, incl. stop smoking services, prevention activity, enforcement & communications	LA	Brief interventions in primary care, secondary, dental and maternity care
NHS health check programme	Assessment & lifestyle interventions	LA	NHS treatment following NHS health check assessments & ongoing risk management
Health at work	Any local initiatives on workplace health	LA	NHS occupational health
Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects	LA and PHE	Interventions in primary care eg. pre-pregnancy counselling or smoking cessation progss & secondary care services eg. specialist genetic services
Prevention and early presentation	Behavioural/lifestyle campaigns to prevent cancer, long term conditions, campaigns to prompt early diagnosis via awareness of symptoms	LA	Integral part of cancer services, outpatient services & primary care. Majority of work to promote early diagnosis in primary care
Dental PH	Epidemiology & oral health promotion (incl. fluoridation)	LA supported by PHE coordinating surveys	All dental contracts
Emergency preparedness & response & pandemic influenza preparedness	Emergency preparedness incl. pandemic influenza preparedness & the current functions of the HPA in this area	PHE LAs to support	Emergency planning & resilience remains part of core business for NHS. NHS CB will have responsibility for mobilising NHS in emergencies
Health intelligence & information	Health improvement & protection intelligence & information, incl. data collection & management, analysing, evaluating & interpreting data, modelling, & using & communicating data. Incl. many existing functions of PH observatories, cancer registries & HPA	PHE and LAs	NHS data collection & information reporting systems eg. secondary uses service
Children's PH for under 5s	Health Visiting services incl. leadership & delivery of the Healthy Child Prog. For under 5s, prevention interventions by the multiprofessional team & family Nurse Partnership	NHS CB	All treatment services for children (except those listed above as PH funded)
Children's PH 5-19	Healthy Child Prog. for school-age children, incl. school nurses & incl. health promotion & prevention interventions by the multiprofessional team	LA	All treatment services for children (except those listed above as PH funded eg. sexual health services, alcohol misuse)
Community safety & violence prevention & response	Specialist domestic violence services in hospital settings, & voluntary & community sector organisations providing counselling & support services for victims of violence incl. domestic violence & non confidential information sharing activity	LA	Non-confidential information sharing
Social exclusion	Support for families with multiple problems, eg intensive family interventions	LA	Responsibility for ensuring that socially excluded groups have good access to healthcare
PH care for those imprison or custody	All of the above	NHS CB	Prison healthcare

"Healthy Lives, Healthy People" – Public Health White Paper
Transparency in Outcomes – Consultation on Public Health Outcomes Framework
Summary

Purpose of the Public Health Outcomes Framework

- 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 national and local level for health improvement, protection and health inequality reduction
- To provide a mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the health premium.

Relationship between the 3 New Outcomes Frameworks



Relationship with Safeguarding and Child Protection to be reviewed pending publication of report from Professor Eileen Munro April 2011.

Public Health Framework

<table>
<tr><td colspan="4">Vision
To improve and protect the nation's health and well-being and to improve the health of the poorest fastest
• Improved life expectancy
• Healthy life expectancy gap between the least and the most deprived communities</td></tr>
<tr><td colspan="4">Domain 1</td></tr>
<tr><td colspan="4">Protect the population's health from major emergencies and remain resilient to harm</td></tr>
<tr><td colspan="2">DETERMINANTS OF ILL HEALTH</td><td colspan="2">OUTCOMES OF ILL HEALTH</td></tr>
<tr><td>Domain 2
Tackling the wider determinants of health</td><td>Domain 3
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Health Inequalities integrated throughout every domain
National – Local balance required
Local areas to determine how to use indicators for local transparency in response to local needs identified through JSNA and considered within Health and Well Being Strategies</td></tr>
</table>

Principles behind the Framework

- Use indicators that are meaningful to people and communities
- Focus on major causes and impacts of health inequality, disease and premature mortality
- Take account of legal duties especially equalities legislation and regulations
- Take a life course approach
- Use data collated and analysed nationally to reduce the burden on local authorities (as far as possible).

Criteria for Selection of Indicators

- Are there evidence-based interventions to support the indicator?
- Does it reflect a major cause of premature mortality or avoidable ill health?
- By improving on this indicator, can you help to reduce health inequalities?
- Will this indicator be meaningful to the broader public health workforce and to the wider public?
- Is it likely to have a negative/adverse impact on defined groups (ie those protected by equalities legislation). If yes, can it be mitigated against?
- Is it possible to set SMART objectives to monitor progress in the short and medium term?
- Are there existing systems to collect the data?
- Is it available at the appropriate spatial level?
- Is the time lag for data short (preferably less than 1 year)?
- Can data be reported quarterly in order to report progress?

Proposed Indicators

Table below indicates whether the indicator was included in the National Indicator Set (although the framework is to be a consistent means of presenting the most relevant data and is not a performance management tool), if it is also proposed for inclusion in the Adult Social Care and NHS Outcomes Frameworks and if it has been in the Essex LAA. There are deliberately more indicators in this proposed list than will appear in the final framework. Some indicators should target different age groups and target communities that experience differential outcomes in health. A subset of these indicators will have a health premium (incentive payment) attached to them.

Ref.	Outcome Indicator	Status (Existing NIS)	PH	ASC	NHS	LAA
D2.1	Children in Poverty	Yes	●			No
D2.2	School readiness: foundation stage profile attainment for starting Key Stage 1	Yes	●			Yes
D2.3	Housing overcrowding rates	No	●			No
D2.4	Rates of adolescents not in education, employment or training at 16 and 18 years of age	Yes	●			Yes
D2.5	Truancy rate	No	●			No
D2.6	First time entrants to the youth justice system	Yes	●			Yes
D2.7	Proportion of people with mental illness *and or disability* in settled accommodation	Yes	●	●		No
D2.8	Proportion of people with mental illness *and or disability* in employment.	Yes	●	●	●	Yes
D2.9	Proportion of people in long term unemployment	Yes	●			No
D2.10	Employment of people with long-term conditions	No	●			No
D2.11	Incidents of domestic abuse	Yes	●	●		Yes
D2.12	Statutory Homeless households	No	●			No*
D2.13	Fuel Poverty	No	●			No
D2.14	Access and utilisation of green space	No	●			No
D2.15	Killed and seriously injured casualties on England's roads	Yes	●			Yes
D2.16	The percentage of the population affected by environmental, neighbour, and neighbourhood noise.	No	●			No
D2.17	Older people's perception of community safety	No	●	●		No
D2.18	Rates of violent crime, including sexual violence	Yes	●			No
D2.19	Reduction in proven reoffending	Yes	●			Yes
D2.20	*Social connectedness*	No	●			No
D2.21	*Cycling participation*	No	●			No
D3.1	Prevalence of healthy weight in 4-5 and 10-11 year olds	Yes	●			Yes
D3.2	*Prevalence of healthy weight in adults*	No	●			No
D3.3	Smoking prevalence in adults (over 18)	Yes	●			Yes
D3.4	Rate of hospital admissions per 100,000 for alcohol related harm	Yes	●			Yes
D3.5	Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 mins p/week)	Yes	●			Yes
D3.6	Hospital admissions caused by Unintentional and deliberate injuries to 5-18s	No	●			No
D3.7	Number leaving drug treatment free of drug(s) of dependence	Yes	●			No

D3.8	Under 18 conception rate	Yes	●			Yes
D3.9	Rate of dental caries in children aged 5 years (decayed missing or filled teeth)	No	●			No
D3.10	*Self reported wellbeing*	Yes	●			No
D4.1	Hospital admissions caused by unintentional and deliberate injuries (1-5 years)	No	●			No
D4.2	Rate of hospital admissions as a result of self-harm	No	●			No
D4.3	Incidence of low-birth weight of term babies	No	●			No
D4.4	Breastfeeding initiation and prevalence at 6-8 weeks after birth	Yes	●			No
D4.5	Prevalence of recorded diabetes	No	●			No
D4.6	Work sickness absence rate	No	●			No
D4.7	Screening uptake	No	●			No
D4.8	Chlamydia diagnosis rates per 100,000 young adults aged 15-24	Yes	●			No
D4.9	Proportion of persons presenting with HIV at a late stage of infection	No	●			No
D4.10	*Child development at 2 - 2.5 years*	No	●			No
D4.11	Maternal Smoking Prevalence	No	●			No
D4.12	Smoking rate of people with serious mental illness	No	●			No
D4.13	Emergency readmissions to hospital within 28 days of discharge	No	●	●	●	No
D4.14	*Health related quality of life for older people (placeholder)*	No	●	●		No
D4.15	Acute admissions as a result of falls or fall injuries for over 65s	No	●	●		No
D4.16	*Take up of the NHS Health Check programme by those eligible*	No	●			No
D4.17	*Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed*	No	●			No
D5.1	Infant Mortality	No	●		●	No
D5.2	Suicide rate	No	●			No
D5.3	Mortality rate for communicable diseases	No	●			No**
D5.4	Mortality rate from all cardiovascular disease (including heart disease and stroke) persons less than 75 years of age	Yes	●		●	No**
D5.5	Mortality rate from cancer in persons less than 75 years of age	Yes	●		●	No**
D5.6	Mortality rate from Chronic Liver Disease in persons under 75 years of age	No	●		●	No**
D5.7	Mortality rate from chronic respiratory diseases in persons less than 75 years of age	No	●		●	No**
D5.8	Mortality rate of people with mental illness	No	●		●	No**
D5.9	Excess seasonal mortality	No	●			No**

Indicators in italics are not yet routinely collected. Further development is required to ensure appropriate and high quality data at local and national levels can be provided. Some developmental indicators will require significant work to progress, whereas others may already be work in progress.

* The LAA does include a measure on Households in temporary accommodation which relates to homelessness

** The LAA does include a measure on Mortality rate but does not break down by these groups

Consultation Questions and Timescales

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?
2. Do you feel these are the right criteria to use in determining indicators for public health?
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?
4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?
5. Do you agree with the overall framework and domains?
6. Have we missed out any indicators that you think we should include?
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?
8. Are there indicators here that you think we should not include?
9. How can we improve indicators we have proposed here?
10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)
11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
12. How well do the indicators promote a life-course approach to public health?

The deadline for responding to the Department of Health is 31 March 2011

To download the full Consultation Document go to:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123113.pdf

Healthy People, Healthy Lives
Public Health White Paper December 2010
Summary

What is Public Health?

"The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society."
It includes:

- Health improvement – interventions to support healthy lifestyles, health inequalities issues, wider social influences on health
- Health protection – infectious diseases, environmental hazards, emergency preparedness
- Health services – service planning, efficiency, audit and evaluation.

Health and Wellbeing

Reference throughout to health and *wellbeing* – "a positive physical, social and mental state. Good wellbeing does not just mean the absence of illness – it brings a wide range of benefits including reduced health risk behaviour (e.g. smoking), reduced mortality, improved educational outcomes and increased productivity at work."

The Government's Approach

It is up to individuals to take personal responsibility for their own personal health & wellbeing, with some positive nudging from government. Government to set overall policy approach with broad guidelines on specific interventions at different stages of life journey, but total emphasis on local determination to interpret local needs and which interventions are most appropriate. Belief that:

- Protecting and improving health covers a wide spectrum demanding different approaches with recognition of role of broader/social determinants of health (e.g. education, worklessness, physical environment)
- Need to balance individual and organisations' freedoms with avoiding serious harm to others
- Different approaches are needed for different groups of population – taking into account significant barriers faced by some.

Marmot Report on Health Inequalities accepted in most aspects.

Use of ladder of interventions adopting the least invasive level required to get the desired effect:

1. Do nothing/monitor situation
2. Provide information – inform and educate
3. Enable choice – to change behaviours
4. Guide choice through changing the default
5. Guide choice through incentives
6. Guide choice through disincentives
7. Restrict choice
8. Eliminate choice.

Roles

Public Health England:
Part of Dept of Public Health, incorporating Health Protection Agency, National Treatment Agency, Public Health Observatories, some of Strategic Health Authority Public Health role.

Functions:

- Funding of Local Authority Public Health function – see below
- Commissioning of some national services (including Health Visitors initially)
- National Public Behaviour Change Campaigns, - Change4Life, rationalising of branding
- Commissioning Research/Data Analysis/Intelligence gathering – from National Institute for Health Research School of Public Health + new Policy Research Unit on Behaviour & Health. Consolidation of data sets

- Holding all accountable through ***Public Health Outcomes Framework:*** 5 Domains – (i) Health Protection & Resilience, (ii) Tackling wider determinants of health, (iii) Reducing no of people with preventable ill health, (iv) Health Improvement, (v) Preventing people from dying prematurely
- Joint appointment of Directors of Public Health
- Health Protection/Emergency Preparedness and responses to Health Emergencies – new national framework for delivery with (local) Health Protection Units.

Chief Medical Officer:
Leading professional expert and Government Advisor. Publish Annual Public Health Report. Leads professional network of Directors of Public Health (DsPH).

Local Authorities:
New duty to take steps to improve the health of their population using multi disciplinary teams led by DPH. Expected to tackle social determinants of health (e.g. housing, environment, transport, planning etc) and work in partnership with others (e.g. NHS, police, business, schools, voluntary sector). Host Health and Wellbeing Boards (see below). Additional licensing roles.

Directors of Public Health (DsPH):
Employed by local authority. Joint appointment with Public Health England. Accountable to LA for health improvement, Public Health England for health protection, Chief Medical Officer for professional role. Public Health Expert Advisor for Local Authority. Publish Annual Public Health Report. Responsible for delivering health improvement including health inequalities, health protection (as directed by Public Health England) – must ensure there are sufficient qualified public health staff to maintain on-call duties in emergencies.

Employers:
Responsibility for supporting health and wellbeing of their staff – use of Equality Act to scale down pre employment health screening and empower employers to divert resources to preventive initiatives for all staff. **Public Health Responsibility Deal** – 5 business led networks to provide self regulation: (i) Food, (ii) Alcohol, (iii) Physical Activity, (iv) Health at Work, (v) Behaviour Change.

Funding

Full Public Health budget to be set as 4% against baseline of 2009/10 PCT expenditure on Public Health, but still subject to running cost reductions and efficiency gains across the whole system. **Local Authority allocation** will be ring fenced and weighted according to health inequalities, there will be a new **health premium** to reward local authorities for progress made against elements of the proposed public health outcomes framework, taking into account health inequalities. Ring fenced for improving population health and wellbeing with some non discretionary services e.g. Open access sexual health services, some immunisations. LA CEO to be accountable officer. Premium calculated according to a formula and based on making progress against elements of Outcomes Framework and taking into account health inequalities. **GPs** to be incentivised through at least 15% of current value of QOF devoted to evidence based public health and primary prevention indicators. Funding streams for drug and alcohol treatment services across community and criminal justice settings to be aligned by DoH.

Health and Wellbeing Boards (HWB)

Mandatory minimum membership: elected members, GP consortia, DsPH, Directors of Childrens Services, Directors of Adult Social Services, local HealthWatch, NHS Commissioning Board (where appropriate) **Optional membership:** district councils, clinicians, voluntary groups, businesses, providers.

GP Consortia and DsPH to have equal and explicit obligation to produce JSNA and to do this through the HWB arrangements. HWB expected to use JSNA to produce Health and Wellbeing Strategy – a concise, high level strategy not a large technical document duplicating other plans. Should include consideration of whether existing flexibilities to pool budgets and joined up commissioning can deliver the strategy. HWB to produce Pharmaceutical Needs Assessment to inform NHS Commissioning Board to commission Community Pharmacy Services. Response to Health White Paper Consultation will give more detail on arrangements.

Timescales

Dates	Action	Publications
Dec 2010 – March 2011	• Consultation Period for Public Health White Paper (deadline 8 March 2011)	• Drug Strategy 2010 (published 8/12/10) • NHS Operating Framework for 2011/12 including PCT role for Public Health • Public Health Outcomes Framework Consultation • Funding & Commissioning of Public Health Consultation • Health Visitors Proposals • Mental Health proposals • Tobacco Control Proposals
2011	• Set up shadow Public Health England in DoH • Set up working arrangements with Local Authorities starting with matching of DsPH	
Spring 2011		• Public Health Responsibility Deal • Obesity Proposals • Physical Activity Proposals • Social Marketing Proposals • Sexual Health and Teenage Pregnancy Proposals • Pandemic Flu Proposals
Autumn 2011	• Develop Professional Workforce Strategy including transfer arrangements for PCT staff to local authorities	• Health Protection, Emergency Preparedness and Response Proposals
April 2012	• Public Health England takes on full responsibility	• Shadow Public Health Budget for Local Authorities
April 2013	• Public Health responsibility with budget transferred to local authorities	

Consultation Questions and Timescales

a. Role of GPs and GP practices in public health: Are there additional ways in which we can ensure GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?
b. Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?
c. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?
d. Public Health evidence: What can partners nationally and locally contribute to improving the use of evidence in public health?
e. Regulation of public health professional: Welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary-registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialist?

The deadline for responding to the Department of Health is 8 March 2011.

To download the full White Paper go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941