Government Response to the House of Commons Health Committee Report on Public Health

(Twelfth Report of Session 2010–12)

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Summary

1. The Government welcomes the Committee's report[1] and its endorsement of the Government's intention to give greater prominence and priority to public health policy. In *Healthy Lives, Healthy People*,[2] our White Paper on public health published in November 2010, we set out a compelling vision of a new integrated and streamlined public health system which will more effectively promote and protect the health of the population. To that end, on 20 December 2011 we published policy updates on the new public health system which define the way in which public health is to be delivered nationally through establishing Public Health England as an Executive Agency, and locally through moving responsibility and accountability for public health to local government. The updates were published as factsheets at: http://healthandcare.dh.gov.uk/public-health-system/.

2. In the new system, the Secretary of State for Health will retain his duty to promote a comprehensive health service (including public health services) and will remain accountable for them. He will provide national leadership, resources and the legislative infrastructure for public health. He will also give direction to the system through publishing a Public Health Outcomes Framework.

3. The Secretary of State will have a duty to protect the population's health. He will ensure that central government provides effective and efficient health protection capability, underpinned by a clear line of sight from the centre of government down to the front line, reflecting the core responsibility of government to protect its population. He will also have powers to take steps to improve the nation's health. In brief, the overall responsibility for ensuring that the health system as a whole is equipped to deliver what is needed to protect and improve the health of the population rests with him.

4. To support the Secretary of State in this task will be a new body, Public Health England. Public Health England will bring together a fragmented system, strengthen the national response on emergency preparedness and health protection, and support public health delivery across the three domains of public health (health improvement, health protection and healthcare public health)

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1 House of Commons Health Committee (2011) *Public Health. Twelfth Report of Session 2010–12.* www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1048/104802.htm

2 HM Government (2010) *Healthy Lives, Healthy People: Our strategy for public health in England.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

through information, evidence, surveillance and professional leadership. It will provide a focus for the whole public health profession, and a powerful and authoritative national voice for public health in England.

5. We have taken account of the NHS Future Forum report,[3] which was published on 13 June 2011, and its recommendation, for example, against establishing Public Health England fully within the Department of Health. The Government's response made it clear that Public Health England will be established as an Executive Agency of the Department of Health.

6. Local leadership for public health will rest with unitary and upper-tier local authorities, which will have a duty to take steps to improve their populations' health. They will also play a key role in supporting the whole public health system, ensuring that there are robust plans to protect health and advising the NHS on commissioning. They will therefore have a key role across the three domains of public health: health improvement, health protection and healthcare public health. To deliver these new functions on their behalf, they will appoint Directors of Public Health in a process which will be joint with the Secretary of State.

7. Thus, in health improvement, local authorities will commission public health services for their populations, resourced by a ring-fenced grant. This new duty reflects the fact that they are uniquely placed to give local leadership to promoting public health and to create powerful coalitions to promote health and wellbeing, across the full range of issues that contribute to the wider determinants of health. This includes issues which are major causes of death and serious injury, especially among children and younger adults, such as road safety and fire safety.

8. On health protection, we plan to make it a requirement for the local authority to ensure that plans are in place to protect the health of the local population, under regulation-making powers in the Bill. This will ensure that Directors of Public Health are able to exercise their critical role to ensure appropriate public health responses to the whole spectrum of potential problems, from local incidents and outbreaks to emergencies. They will work closely with Public Health England, which will provide a comprehensive range of health protection services, including assessing risks from infectious diseases, health threats and significant public health events, and will also provide scientific and technical advice for health protection both on a routine basis and in an emergency. This will include specialist services on threats from chemicals and radiation, and critical front-line specialist microbiology laboratory services.

9. With regard to the third domain of public health, public health professionals have an important role to play in ensuring that NHS services are designed to meet the needs of the whole population and are based on the best available evidence. We will therefore ensure that public health advice remains central to NHS commissioning. Local authorities, through their Directors of Public Health, will provide public health advice to clinical commissioning groups (CCGs). To support the detailed implementation of this policy, we have engaged with stakeholders to develop a proposal for the healthcare public health advice to NHS commissioners in CCGs. Following the NHS Future Forum's second

3 NHS Future Forum (2011) recommendations to Government. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

report (published on 10 January 2012)[4] and recommendation on 'every contact counts', the Government will consult on a new responsibility for healthcare professionals to promote healthy living through their daily contact with patients.

10. Local authorities will be accountable first and foremost to their local populations for delivery of their new public health functions, and improvements will be driven by transparency and local scrutiny and accountability. Public Health England will publish data that will make it clear how local authorities are performing against the outcomes in the Public Health Outcomes Framework, and council overview and scrutiny functions will track performance. To support local authorities, Public Health England will offer expertise and assistance and, where necessary, constructive challenge.

11. Placing specialist Directors of Public Health and their teams in local authorities, supported by the expertise of Public Health England, offers an excellent opportunity to make the best possible use of their skills. They will act as the lead officer for health in a local authority and will champion health across all the authority's business. Directors of Public Health will have a statutory requirement to produce an annual report, which the local authority must publish, on the health of the local population. They will also be statutory members of health and wellbeing boards and will be the person whom elected members and senior officers will consult on a wide range of public health issues.

12. Directors of Public Health will work with colleagues within and beyond the local authority to promote opportunities for action for health across the 'life course'. The commitment to reducing health inequalities is a priority for all parts of the public health system, drawing on the Marmot Review[5] to address the wider determinants of health and complementing the role of the NHS to reduce inequalities in access to and outcomes from health services.

13. The NHS will also continue to play its vital role in commissioning and providing public health services. While local authorities will become the lead local body for many public health services, we will also ask the NHS Commissioning Board to commission specific services funded from the public health budget, where appropriate.

14. In summary, the White Paper *Healthy Lives, Healthy People* set out a bold vision for a reformed public health system in England. It generated real enthusiasm for a new approach to public health and a commitment across local authorities and the public health profession to improving the health of the public. We want to maintain this momentum and continue to plan and build the local relationships and partnerships that will be key to implementing the new public health system.

4 NHS Future Forum (2012) – Summary report – second phase www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132085.pdf

5 Marmot M (2010) *Fair Society, Healthy Lives*. www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Government response to the Health Committee's conclusions and recommendations

The Secretary of State for Health

We welcome the Government's intention to give greater prominence and priority to public health policy, whilst also emphasizing that "public health is everybody's business". We also welcome the new emphasis on the public health role of the Secretary of State for Health and the embodiment of this in new statutory duties in relation to health protection and statutory powers in relation to health improvement. (HC 1048, paragraph 28)

1. We welcome the Committee's recognition of the priority given to public health.

We do not understand why the Secretary of State's new statutory duty to reduce health inequalities under the Bill appears to apply only to the exercise of his functions in relation to the health service. We recommend that the Bill be amended to make it clear that the Secretary of State's duty to reduce health inequalities applies in the exercise of all his functions, including those applying to public health. (HC 1048, paragraph 29)

2. The Secretary of State's new statutory duty to reduce health inequalities applies to all health services, ie including public health. We believe, therefore, that such an amendment would be unnecessary. Clause 3 of the Health and Social Care Bill already covers all the Secretary of State's functions relating to the health service, which includes public health as well as the NHS. Subject to the passage of the Bill, he will therefore have a duty to have regard to the need to reduce health inequalities with respect to the benefits that the people of England can obtain from the health service as a whole, including public health. In addition, the Government intends to bring forward an amendment to the Bill during Report stage which will strengthen this duty further. The amendment would require the Secretary of State to report annually on how effectively he has discharged his duty to have regard to the need to reduce health inequalities.

3. In the context of delivering public health as part of the *Open Public Services* White Paper,[6] there is also a cross-government requirement, endorsed by No.10, to ensure fair access for both rural and urban communities.

The creation of the Cabinet Sub-Committee on Public Health, chaired by the Secretary of State for Health, is a significant step forward in developing a much-needed cross-departmental approach to public health. We recommend that its remit should be defined to include consideration and publication of evidence-based health impact assessments prepared by each department of state on policies within its sphere of responsibility. (HC 1048, paragraph 30)

4. We welcome the Health Committee's recognition of the importance of the Cabinet Sub-Committee. We expect that the Sub-Committee will provide a strategic oversight of wider government policies. It will not be a replacement for existing policy clearance mechanisms, which are a more appropriate means for ensuring that proposed policies are supported by appropriate impact assessments.

5. We will look at whether there is a role for Public Health England in supporting health impact assessments, and will work with other government departments to consider the best way of ensuring that they take account of possible health impacts when developing their policies.

The Chief Medical Officer

We welcome the continuing role of the Chief Medical Officer (as the Government's principal medical advisor) in respect of public health, particularly the production of an independent annual report on the nation's health. However, we have concerns about the devolution of the Chief Medical Officer's broader duties relating to healthcare to the NHS Medical Director. The NHS Medical Director is a management role within the NHS; the role of the Chief Medical Officer has traditionally been to provide a professional voice on healthcare issues which is independent of NHS management; the Committee regards this as [an] important function which is not recognized in the new arrangements. (HC 1048, paragraph 34)

6. The Department recognises the need for clarity about the respective roles of the Chief Medical Officer and the NHS Medical Director/Deputy Chief Medical Officer but does not share the Committee's concern on this issue. Aside from the greater independence accorded to the NHS Commissioning Board, within which the NHS Medical Director will be a senior leader, the reforms do not fundamentally change the relationship between the two roles. The Chief Medical Officer will continue to provide an independent voice on all healthcare issues as part of the role of the Government's principal medical advisor, and will provide professional leadership for public health. The NHS Medical Director will

6 HM Government (2011) *Open Public Services White Paper*. www.openpublicservices.cabinetoffice.gov.uk/

continue to have a senior management role as part of the NHS Commissioning Board, and to provide professional leadership for the NHS.

Public Health England

The Government's case for combining within Public Health England a range of public health functions currently carried out by several organisations appears to rest on the perceived need to streamline a system that is currently fragmented. While acknowledging "considerable strengths" in the current system, the Government argues that it can still be made to work better. The Committee does not disagree with this view but sees the main case for change in the need for an independent voice for public health at the heart of government. (HC 1048, paragraph 60)

7. The Government agrees that the provision of impartial advice on public health issues by Public Health England was a key consideration for establishing it as an Executive Agency of the Department of Health. This places it in a position to provide professional and impartial advice on public health issues to the Department of Health and other government departments to support the development of policy. It will also provide independent analysis of the public health of the country to the Chief Medical Officer for her annual report on the nation's public health. At the same time, establishing Public Health England as visibly and operationally independent will help it to gain, and maintain, the essential trust and confidence of the public and public health professionals.

Public Health England must be – and, just as importantly, must be perceived as being – independent of the Government. Only in this way will it maintain the reputation for independence and evidence-based expertise, as well as the important trading activities, of the Health Protection Agency and some of the other bodies which Public Health England will succeed. We, therefore, welcome the Government's decision that Public Health England will not, as originally planned, be constituted as an integral part of the Department of Health. (HC 1048, paragraph 61)

It is important that the Government ensures that the arrangements for the new body provide it with sufficient guarantee of its independence. The Committee believes that the principle that Public Health England must be visibly and operationally independent of Ministers is more important than the precise bureaucratic formulation. (HC 1048, paragraph 62)

8. The Committee makes an important distinction between the legal status of Public Health England and its operational independence. Public Health England will be established as an Executive Agency on 1 April 2013, and ministers will agree its strategic objectives. However, the Agency will have the operational freedom to decide how it will deliver these.

9. A Chief Executive will be appointed through open and fair competition, and will be solely responsible for the day-to-day operation of the Agency. The Chief Executive will receive external advice and challenge from a board which will contain non-executive members from public health, local government and the private sector. Public Health England will receive its own budget to deliver its services and, as set out in its Operating Model,[7] the Chief Executive will instil a culture of openness and transparency (for example, through its scientific committees which will provide rigorous and impartial advice on public health issues).

10. This operational freedom will be supported by a Framework Agreement between the Department of Health and Public Health England, which will set out the roles and responsibilities of both organisations, and will be published on the Department of Health and Agency websites.

We are concerned at the lack of clear plans for Public Health England to be established at the regional level. The idea of "sub-national hubs", in some – as yet undefined – alignment with the sub-national structures of the NHS Commissioning Board and the Department for Communities and Local Government does not seem to us adequate. The Committee believes, in particular in view of the sensitivity of its health protection responsibilities, Public Health England needs a clear structure of regional accountability, along the lines currently provided by the regional structure of the Health Protection Agency. (HC 1048, paragraph 63)

11. The Government set out the structure for Public Health England in its Operating Model, which was published on 20 December 2011. The effective delivery of some Public Health England functions will rely on the leadership and co-ordination of the work of its units with partners in the local public health delivery system, such as Directors of Public Health and their teams and NHS service providers. This will be carried out through four hubs that are coterminous with the four sectors of the NHS Commissioning Board and Department for Communities and Local Government resilience hubs, covering London, the South of England, the Midlands and East of England, and the North of England. The Chief Executive designate will ensure that appropriate arrangements are in place for the delivery of health protection services.

12. One of the next priorities for the organisational design of Public Health England is to describe in detail the role of the hubs. A core role for the hubs will be to ensure that Public Health England's emergency preparedness, resilience and response plans are in place in their area and, in addition, working with the NHS Commissioning Board sectors and Department for Communities and Local Government resilience hubs, leading and co-ordinating the public health response during major incidents.

7 Department of Health (2011) *Public Health England's Operating Model.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/_DH131882

13. The hubs will also have an important role to play in assuring the quality and consistency of all services delivered by Public Health England units, including their health protection and emergency preparedness, resilience and response responsibilities.

14. The hubs will also support transparency and accountability across the public health system, including managing strategic discussions with partners in relation to achievement of public health outcomes, including in health protection.

15. More detail can be found at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131892.pdf.

Local government and Directors of Public Health

We welcome the new public health role planned for local authorities, leading in health improvement, and the emphasis that this places on tackling the wider determinants of health. We also welcome the new role envisaged for Directors of Public Health, as public health leaders in local communities, located within local authorities. However, several concerns have been raised with us about the details of implementation. (HC 1048, paragraph 92)

16. We welcome the Committee's endorsement of the transfer of new public health functions to local authorities.

The lack of a statutory duty on local authorities to address health inequalities in discharging their public health functions is a serious omission in the Government's plans. We recommend that the Health and Social Care Bill be amended to rectify this. (HC 1048, paragraph 93)

17. We believe that, since local authorities are independent, democratic bodies, we are best able to promote a national focus on tackling health inequalities through non-legislative means such as the Public Health Outcomes Framework. From 2013/14, the Department intends to allocate a ring-fenced public health grant, targeted for health inequalities, to upper-tier and unitary local authorities for improving the health and wellbeing of local populations. We are also developing a health premium that will reward communities for the improvements in health outcomes they achieve and incentivise action to reduce health inequalities. We believe that these non-legislative levers will be at least as effective as any duty, though of course local authorities are already subject to the provisions within the Equality Act 2010.

Some witnesses have argued that local authorities need additional regulatory powers to allow them to achieve public health improvements in their area, including, for example the ability to extend the scope of the ban on smoking in enclosed public places or set a minimum price per unit for alcohol. The Committee recommends that these proposals be the subject of further public consultation. (HC 1048, paragraph 94)

18. On the proposal to hold a consultation to allow local authorities to extend the scope of the ban on smoking in enclosed public places, there are no plans to do this. However, as set out in the Tobacco Control Plan for England, published in March 2011,[8] local authorities and organisations may wish to go further than the requirements of smokefree laws by creating environments free from secondhand smoke, for example in children's playgrounds, outdoor parts of shopping centres and venues associated with sports and leisure facilities.

19. We have no current plans to consult on allowing local areas to adopt minimum unit pricing for alcohol. The evidence base for alcohol pricing interventions is based on national rather than local level interventions.

We endorse the joint appointment of Directors of Public Health by local authorities and the Secretary of State (through Public Health England). We recommend that, in addition, these appointments should be subject to a statutory appointments process, involving an Advisory Appointments Committee, and accredited by the Faculty of Public Health, as is currently the case in respect of Directors of Public Health within the NHS. (HC 1048, paragraph 95)

20. The proposed appointments process will be joint with the Secretary of State, which will allow the Secretary of State to ensure that individuals of the right calibre are appointed. There is, therefore, no need for a statutory process as the Committee recommends.

21. The National Health Service (Appointment of Consultants) Regulations are already optional for consultants in NHS Foundation Trusts. Directors of Public Health will currently be subject to these Regulations because they are NHS appointments at Consultant level in Primary Care Trusts (PCTs). These Regulations will cease to apply after the abolition of PCTs. Directors of Public Health should not be under more strict regulatory requirements than doctors of equivalent status in NHS Foundation Trusts.

The Government argues that the involvement of Public Health England in the appointment of Directors of Public Health will be sufficient to ensure that those appointed are appropriately qualified and trained. The Committee does not agree; it believes that there should be a statutory requirement for Directors of Public Health to be a member of an appropriate professional register. (HC 1048, paragraph 96)

22. The Government agrees, given the critical leadership role that public health consultants play in protecting the public from harm, that it is essential that all public health consultants have in place an appropriate system to ensure the highest quality of decision making. On 23 January 2012, the Secretary of State announced that the Government would legislate to rectify the anomaly which means that non-medical public health consultants fall outside the statutory regulatory system. The Health Professions Council will regulate this group to help ensure consistent standards across the whole profession. The extension

8 HM Government (2011) *Healthy Lives, Healthy People: A Tobacco Control Plan for England* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

of professional regulation is a devolved matter, so it would not be practicable to enact this through an amendment to the current Bill. We will bring forward legislation under Section 60 of the 1999 Health Act, following appropriate periods of consultation and consideration by both the Scottish and the UK Parliaments.

The Committee believes that Directors of Public Health should be appointed at chief officer level, reporting directly to the council Chief Executive. The Government says that it "expects" Directors of Public Health will be appointed at this level, but there will be no sanctions that can be applied if they are not. We recommend that this be laid down as a statutory requirement in the Health and Social Care Bill. (HC 1048, paragraph 97)

23. We promised in *Healthy Lives, Healthy People: Update and way forward*[9] to discuss with stakeholders how best to ensure that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services. We have consulted local government and public health interests, and intend to bring forward amendments to the Health and Social Care Bill to reflect our desired policy position. Subject to agreement by Parliament, we will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989. We will also amend the Bill to give the Secretary of State the power to issue guidance, to which local authorities must have regard, on the appointment, termination of appointment, terms and conditions, and management of the Director of Public Health.

24. Subject to Royal Assent, we intend to issue statutory guidance on the responsibilities of Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Social Services. While the organisation and structure of individual local authorities are matters for local leadership, we are clear that these legal responsibilities should translate into the Director of Public Health acting as the lead officer for health in a local authority and championing health across the whole of the authority's business. This means that we would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

We endorse the plan for Directors of Public Health to be, under statute, mandatory members of their local health and wellbeing boards. We also welcome the proposed statutory obligation on Directors of Public Health to prepare an annual report, which the local authority must publish. (HC 1048, paragraph 98)

25. We welcome the Committee's support for these vital functions of the Director of Public Health.

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9 HM Government (2011) *Healthy Lives, Healthy People: Update and way forward*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120

We are concerned that, in fulfilling their role, Directors of Public Health should be free to speak out, if necessary to criticize their local authority, without inhibition or restriction. We, therefore, recommend that any local authority wishing to terminate the appointment of its Director of Public Health must be required by statute to have the Secretary of State's approval. (HC 1048, paragraph 99)

26. The Bill states that, before terminating the appointment of its Director of Public Health, a local authority must consult the Secretary of State. This is not a veto, but represents a significant additional safeguard for the Director of Public Health role. To go further would be to undermine the legitimate role of the local authority as employer.

We are concerned that too little attention is paid in the Government's plans to the role of lower-tier authorities. Given their areas of responsibility, in particular in the commissioning and provision of social housing, there should be a statutory requirement for upper-tier authorities to involve them in the work of the health and wellbeing boards. (HC 1048, paragraph 100)

27. We do recognise the importance of upper-tier authorities working with lower-tier authorities. In many cases, they have the lead on key services impacting health and wellbeing, such as housing and environmental health, and as such have a crucial contribution to make in offering local insight and expertise. We do anticipate that lower-tier authorities will need to be actively involved in the work of health and wellbeing boards. Their knowledge of local people and needs will be a crucial contribution to the Joint Strategic Needs Assessment (JSNA), and they can help to ensure that the joint health and wellbeing strategy tackles the issues that really matter to local people.

28. The draft statutory guidance being developed for health and wellbeing boards on the preparation of JSNAs and joint health and wellbeing strategies places emphasis on working with, and involving, district councils (and other bodies locally) in the preparation of both the JSNA and the joint health and wellbeing strategy – to reach into issues such as housing, planning and leisure services.

29. However, we do not wish to prescribe how this should happen in practice. Local areas will have the flexibility to develop the arrangements that work for them and fit best with local circumstances, whether that is by adding district councils to the health and wellbeing board's membership or via another route.

30. Ultimately, getting this right will depend on leadership, relationships and culture, not on prescription or just legislation. We are working with shadow health and wellbeing boards to explore relevant issues, including how the new arrangements can be most effective in two-tier areas.

31. Local authorities already carry out a number of functions relevant to the protection of health. Thus, district and unitary authorities, for example, provide environmental health services. These duties will be unchanged by the reform of the public health system. The Public Health (Control of Disease) Act 1984,

as amended, and health protection regulations made under it, give local authorities powers and duties to prevent and control risks to human health from infection or contamination, including by chemicals and radiation.

The Public Health Outcomes Framework

We welcome the Government's intention to measure progress in improving the health of the population by reference to outcomes rather than process targets; and we endorse the overall Outcomes Framework that has been outlined for public health. (HC 1048, paragraph 123)

32. We welcome the Committee's strong endorsement of the Government's focus on outcomes, and of the Public Health Outcomes Framework.

There is a good case for having a single, integrated Outcomes Framework for public health, the NHS and adult social care. It is disappointing in this regard that the first NHS and Social Care Outcomes Frameworks have been finalised before the Public Health Outcomes Framework. (HC 1048, paragraph 124)

33. We do not accept that there is a good case for one framework rather than three, as there need to be separate frameworks to ensure clear accountability, recognising separate delivery systems for public health, social care and the NHS. Robust and effective accountability mechanisms require organisations to be held to account for that which they can deliver. There are different delivery systems for the NHS, adult social care and public health services which, while they need to integrate, have their own structures and governance.

34. Therefore, it is necessary to create accountability mechanisms at a national level which take account of the separate delivery systems. However, that is not to say that the three services, and indeed other public services, do not need to join up to deliver integrated services. Our aim continues to be that all three outcomes frameworks align well and tell the 'story' of health from a whole-systems approach.

35. Some of the outcomes that matter most to people hinge on such effective integration. For example, tackling mortality rates requires public health interventions. In December 2011, the Department published a refreshed NHS Outcomes Framework,[10] explaining intentions for better aligning the outcomes frameworks in relation to reducing mortality rates. This Framework now includes an indicator on the under-75 mortality rate from cancer which is shared with the Public Health Outcomes Framework, while retaining the specific NHS Outcomes Framework's indicators on improving cancer survival.

36. In terms of the other mortality indicators covering the 'biggest killers', our intention now is to retain shared indicators but to look at developing specific NHS Outcomes Framework indicators that help us to understand the

10 Department of Health (2010) *The NHS Outcomes Framework 2011/12*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

contribution the NHS is making to survival alongside its contribution to overall mortality rates, in the same way as we can for cancer. The Public Health Outcomes Framework adopts a similar approach and includes, as well as the shared outcome indicators, specific Public Health Outcomes Framework outcome indicators aimed at measuring how well the public health system is doing in preventing these diseases altogether.

37. This revised focus will recognise the critical contribution that the NHS can make to reducing 'preventable mortality' – for example through making 'every contact count' – and the important contribution the public health service can make to reducing 'amenable mortality' through its role in supporting earlier diagnosis and raising awareness of signs and symptoms.

38. Additionally, to support integration of the frameworks, high-level impact indicators drawn from each of the frameworks are included in the Department of Health's business plan.

We recognise the need to minimise data collecting burdens. However, outcomes data must be sufficiently localised and detailed to reflect accurately trends and patterns in the health of the public. Datasets must be of an adequate size to be able reliably to detect relevant characteristics of populations at the appropriate level. This must include levels below those of local authorities, so that inequalities within authorities' areas are detected. Data should also, as far as possible, be capable of disaggregation regarding the full range of protected characteristics under the Equality Act 2010. (HC 1048, paragraph 125)

39. Where possible, data for indicators in the Public Health Outcomes Framework will be based on existing data sources so as not to impose any additional data burdens. Where any additional burdens are placed on local authorities, through new or extended data collections, the Department of Health has a duty to fund that burden. Additional burdens will not be placed without consultation with local government.

40. We will work towards having data available at as low a geographical level as possible for indicators in the Public Health Outcomes Framework. The minimum requirement for an indicator to be included in the Framework is that data will (in the future, if not already) be available at national level and upper-tier local authority level but, where possible, we will look to obtain data at lower levels. It is also our intention to publish Outcomes Framework data in line with the protected characteristics set out in the Equality Act 2010, wherever this is feasible.

41. We will be working to try to extend the breakdowns of Public Health Outcomes Framework data that are available throughout the life cycle of the Framework.

The overall public health budget

***Healthy Lives, Healthy People* stated that early estimates suggested that the current spend on services for which Public Health England will be responsible could be over £4 billion. More than 12 months later the Government has been unable to provide any detailed explanation as to how this figure was arrived at, or – more fundamentally – which services will in future be the responsibility of Public Health England. The Committee believes that this policy confusion is undermining confidence in the Government's public health strategy and making service planning impossible.** (HC 1048, paragraph 138)

The Department of Health is currently compiling its definitive baseline public health expenditure, with the intention of publishing it later this year. When it does so, it must show in detail exactly how this figure has been arrived at. The Department must clarify whether it intends to make any adjustments to the baseline, relating to factors such as localised underspending and the impact of the reduction in management and administration costs occurring since the baseline year. (HC 1048, paragraph 139)

42. The figure quoted in *Healthy Lives, Healthy People* was based on a combination of sources: central spending by the Department of Health, research reports and a local survey of spend in one Strategic Health Authority (SHA) projected to national coverage. Since then, we have worked with PCTs and SHAs to improve our understanding, and this is based on the commissioning responsibilities as outlined in that consultation.[11] During January 2012, we announced that we estimate that during 2012/13 spending on these services will be about £5.2 billion. We are publishing full details of the basis of this estimate.

43. Understanding baseline spend is just the first step in establishing future budgets, and further analysis will build on this. The Secretary of State has asked the Advisory Committee on Resource Allocation (ACRA) to continue to advise on the targeting of NHS resources and to develop a formula for the allocation of ring-fenced grants to local authorities for their new public health responsibilities. ACRA's recommendations will be published early in 2012.

The Department of Health must also make clear how the actual level of funding for public health will relate to the historic baseline. We seek reassurance from the Department that, in setting the public health budget, it will take account of objective measures of need. This must apply in respect of both the national budget and allocations to local authorities. (HC 1048, paragraph 140)

11 *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* (2010). www.dh.gov.uk/en/consultations/closedconsultations/DH_122916

44. We have asked the independent ACRA to advise on an appropriate formula for setting target allocations for local authorities, and any such funding should also take account of the needs of more remote local authorities. However, as in the past, we should be mindful of the need to ensure the stability is reflected in the baseline spend.

Although the Department of Health states that, in the current reduction of NHS management and administration costs, frontline public health services are being protected, we have heard evidence to the contrary. Furthermore, the Department has failed to give a convincing account of its distinction between frontline and non-frontline spending in public health services. Unless it can do so, the suspicion will remain that it is an arbitrary distinction and that public health services are suffering, and will suffer, in consequence of the cuts that are being made. (HC 1048, paragraph 141)

45. Administration costs are defined as any cost incurred that is not a direct payment for the provision of healthcare or healthcare-related services. Programme costs are any other cost which is not classified as an administration cost, and includes the costs associated with any staff providing healthcare. As well as including policy advice and business support within administration costs, the guidance specifically mentions scientific and technical work as also falling under the administration heading (unless the work involves directly delivering a service to patients, service users, citizens etc). The 2010 Spending Review announced that the Department of Health's administration costs would fall by a third in real terms between 2010/11 and 2014/15. This does not mean that all parts of the system will necessarily see a one-third reduction in administration costs.

Local public health budgets

We are concerned by the government's decision to reduce the weighting for health inequalities in Primary Care Trust allocations for 2011–12 from 15% to 10%. (HC 1048, paragraph 173)

46. As in previous years, and despite a significant research commission, the independent ACRA was unable to find evidence to support the weight of the Disability-Free Life Expectancy (DFLE) adjustment for the 2011/12 allocations, and this was left as a decision for ministers. Despite the weighting for deprivation (a proxy measure) of 15% in the previous formula, there was no evidence that PCTs with higher inequalities spent more on public health and preventative interventions. It was therefore important to adjust the formula more accurately to reflect the relative burden of disease. This led to evidenced weighting for important aspects of health inequalities, eg in relation to children. We feel that an adjustment of 10% strikes the right balance between ensuring that vital work on health inequalities (including public health) continues, on the one hand, and that funding to support access for all to healthcare is sufficient, on the other.

47. The whole formula, not just the DFLE adjustment, contributes to reducing health inequalities. More funding is targeted to areas with the highest need for healthcare services due to age, poor health or deprivation.

We are concerned about the proposed introduction of the Health Premium. We believe there is a significant risk that, by targeting resources away from the areas with the most significant continuing problems, it will undermine their ability to intervene effectively and thereby further widen health inequalities. (HC 1048, paragraph 174)

48. The health premium will be an important tool in addressing inequalities within and between areas. We intend for it to reward those authorities that make the most progress in intervening to tackle health inequalities and for it to reflect the greater challenges faced in some areas.

Although many witnesses welcomed the proposed ring-fencing of public health budgets transferred to local authorities, and the Committee understands the short-term attractions of this approach, it does not believe it represents a desirable long term development. Ring-fencing risks encouraging local authorities to see only spending from the ring-fenced budget as relevant to public health and runs counter to a "place-based" approach, which would allow the wider determinants of health to be more effectively addressed. Furthermore, even with ring-fencing, there is a risk of local authorities "gaming" the system and effectively raiding their public health allocations by "redesignating" as public health spending services that they are already providing from other budgets. (HC 1048, paragraph 17)

The Committee therefore proposes that the ring-fenced public health budget should operate for no more than three years. During that period it should be a statutory duty of Directors of Public Health to certify that the ring-fenced budget is used appropriately for public health purposes. (HC 1048, paragraph 176)

49. We believe that ring-fencing public health allocations is the most effective way to ensure that local authorities embrace their new responsibilities for public health and act creatively to tackle the wider determinants of health in their local areas.

50. We recognise the benefits of pooling budgets, and will be encouraging this. In terms of local authorities 'gaming' the system, we recognise the risk. However, we would stress that there will be significant checks in the system, not least the grant conditions which the Department of Health will produce, and the oversight offered by the health and wellbeing board. The Public Health Outcomes Framework itself will identify the priority areas for public health investment. Decisions about the continuation or otherwise of the ring-fence will be made in due course. Formal responsibility for the ring-fenced grant, and for ensuring that it is spent appropriately, rests with the Chief Executive of the relevant local authority, although we would expect day-to-day responsibility for the grant to rest with the Director of Public Health. We feel that the setting of an arbitrary end date to the ring-fence would be unhelpful.

Public health evidence and intelligence

We welcome the Government's public commitment to evidence and intelligence as fundamental elements of the public health system. The Government's plans for Public Health England do have the potential to improve the public health information and intelligence function, by integrating and streamlining the work currently done by several bodies. We look forward to the results of the Department's Working Group on Information and Intelligence for Public Health in this regard. (HC 1048, paragraph 203)

51. We welcome the Committee's endorsement of our approach to public health intelligence.

The work of the Public Health Observatories is an extremely valuable part of the public health system. While the Government has promised to continue the work of Observatories, there is a great deal of uncertainty, especially following the substantial cuts to their funding that have been made in the current financial year. We are concerned to hear that three of the Observatories, in London, the North East and the North West, face "particular risk of closure". We recommend that Ministers clarify their plans for individual Public Health Observatories as a matter of urgency to ensure that this important resource is not lost before Public Health England is established. (HC 1048, paragraph 204)

52. The Committee recognises our commitment to build on the work of the Public Health Observatories (PHOs) and to incorporate their functions into Public Health England. Following the decision to delay setting up Public Health England until April 2013, we have been in active discussions with the hosts of all the Observatories to clarify the position of individual Observatories in 2012/13. Those discussions have progressed well and we do not consider that any of the Observatories are currently at risk of closure. The core functions of PHOs and the specialist Observatories will be funded in 2012/13 at a broadly similar level to 2011/12. We will set out the allocations for each PHO in more detail by March 2012.

We welcome the decision to create a new School for Public Health Research (within the National Institute for Health Research) and a Policy Research Unit on Behaviour and Health. We also welcome the Government's indication that the National Institute for Health and Clinical Excellence will continue to have a function in respect of evaluating the effectiveness and cost effectiveness of public health interventions. (HC 1048, paragraph 205)

53. We welcome the Committee's endorsement of the Government's decision to create the new National Institute for Health Research (NIHR) School for Public Health Research and Policy Research Unit on Behaviour and Health.

Against that background the Committee was surprised to learn that the Institute's [NICE's] Public Health Interventions Advisory Committee has yet to meet this year, having previously met on a monthly basis. The Committee believes that Ministers should make clear as soon as possible exactly what role the Institute will play in future in respect of public health and how that role will be fulfilled. (HC 1048, paragraph 206)

54. We agree with the Committee's recommendation that the detail of the National Institute for Health and Clinical Excellence's (NICE's) future public health role needs to be clearly set out. This depends to a considerable degree on the development of the system as a whole, and the Department of Health is currently working with NICE to clearly define its roles and responsibilities relative to Public Health England. We expect that there will be greater clarity on NICE's specific future public health role by spring 2012.

55. The Committee may also be interested to note that NICE is currently consulting on proposed changes to its public health guidance methods and processes. As part of the changes, NICE is proposing to stand down its Public Health Interventions Advisory Committee (PHIAC). Under NICE's proposals, PHIAC would be replaced by up to five Public Health Advisory Committees (PHACs) that would each maintain a broad topic focus. Further information on NICE's proposed changes is available at www.nice.org.uk.

Public health and NHS commissioning

Public health expertise is an indispensable part of commissioning NHS services. With the NHS facing major financial challenges, these functions are more important than ever. Yet *Healthy Lives, Healthy People* was widely seen as downgrading the role of public health in the commissioning of healthcare services. In its response to the Future Forum and in the consultation response the Government outlines changes to its plans intended to provide reassurance on this count, but we do not believe these are enough. (HC 1048, paragraph 217)

56. We agree that public health expertise is an essential part of commissioning NHS services. At the national level, Public Health England will provide public health advice to the NHS Commissioning Board, not least in supporting it in delivering those public health services it will commission on behalf of the Secretary of State. Locally, we will require local authorities to provide NHS commissioners with public health advice, to be delivered through local public health teams led by Directors of Public Health. We will also ensure, through the Health and Social Care Bill, that NHS commissioners have a duty to obtain appropriate advice on the protection and improvement of public health. One of the public health updates published by the Department in December 2011[12] set out draft proposals for population health advice to CCGs.

12 Department of Health (2011) *Public Health Advice to NHS Commissioners*. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131902.pdf

In its earlier report on commissioning the Committee recommended that the local Director of Public Health should be a member of the Board of each local commissioning body (now Clinical Commissioning Group). This remains our view. (HC 1048, paragraph 218)

57. The Future Forum's[13] report stated that it would be unhelpful for CCGs' governing bodies to be representative of every health and care professional group. We agree. The prime purpose of a governing body should be to take key decisions and to make sure that CCGs have the right systems in place to do their job well. It is these systems which will ensure that they involve the full range of health and care professionals in commissioning. Requiring a very large group of professionals on the governing body itself would not mean that a broader range are involved in designing patient services. Of course, there is nothing to prevent a CCG governing body from including people with expertise in specialist services or public health, should the CCG wish this.

The Committee also believes there should be a qualified public health professional on the NHS National Commissioning Board, and that the Commissioning Board should routinely take advice from qualified public health professionals when commissioning decisions are being taken. (HC 1048, paragraph 219)

58. The NHS Commissioning Board will be under a clear duty to obtain public health advice and will be working closely with Public Health England and other stakeholders to ensure public health input into commissioning decisions, capturing the needs of both urban and rural areas.

59. It will be key to the effectiveness of the Board to ensure that it obtains sufficient input from, and the involvement of, clinicians, other professionals and those with relevant experience of the NHS, patients and the public. It also needs to have effective working arrangements with local government. The Board will be required to obtain clinical advice from a broad range of professionals, including those in public health, and we have stated our intention that there should be clinical and professional leadership on the Board.

60. However, it is an important principle that it should have autonomy of decision making on matters such as its own membership, structures and procedures, as far as possible, to determine how best to exercise its functions.

61. The Board will have the freedom to appoint committees and sub-committees as it considers appropriate, and it may well prove useful to the Board to bring in various interested parties on specific issues.

Commissioning public health services

There is a danger that the involvement of local authorities, Public Health England and the NHS Commissioning Board in various facets of public health commissioning will produce a lack of coordination and

13 NHS Future Forum (2011). www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

cohesion in public health services. This danger is compounded by the definition of the mandated services which will be the responsibility of local government which, for example in sexual health services and child health services, creates a dysfunctional division between services which need to be coordinated. The Committee recommends that these distinctions be reviewed. (HC 1048, paragraph 236)

62. We recognise the risks, but believe that the mechanisms which will be in place will help to ensure that services are appropriately integrated locally, at both urban and rural level. These mechanisms include, in particular, the JSNA, the joint health and wellbeing strategy and the health and wellbeing board itself as a new statutory committee of the local authority with a duty to promote integration. With regard to public health services for 0–5-year-olds, including health visiting, the Government's consistent position has been that this is a time-limited approach to ensure that the necessary steps are taken to meet the Government's commitment to increased health visitor numbers.

63. However, we are also committed to engaging further on the detail of the proposals, particularly in respect of transition arrangements and the best way to begin to involve local authorities in local commissioning of these services in partnership with the NHS. With regard to other mandated services such as sexual health services, we set out our view in *Healthy Lives, Healthy People: Update and way forward*,[14] that some services ought to be mandated because they should be provided in a universal fashion if they are to be provided at all. We remain of that view.

Emergency preparedness, response and resilience

We welcome the updated and enhanced powers that the Bill gives to the Secretary of State in the event of an emergency. We also welcome the Government's decision to delay the implementation of its new arrangements for health protection until April 2013, lessening the potentially disruptive impact on preparations surrounding the 2012 Olympics and allowing further transition time. (HC 1048, paragraph 249)

We further welcome the clarification given in *Healthy Lives, Healthy People: Update and way forward* about the role that Directors of Public Health will play in emergency preparedness, response and resilience. The Government must specify which bodies will be designated as Category 1 responders under the Civil Contingencies Act 2004. (HC 1048, paragraph 250)

64. Subject to parliamentary approval, the Health and Social Care Bill will make consequential amendments to the Civil Contingencies Act, establishing Public Health England and the NHS Commissioning Board as Category 1 responders and CCGs as Category 2 responders.

14 HM Government (2011) *Healthy Lives, Healthy People: Update and way forward*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120

Public Health England will need a clear leadership and coordination role when public health emergencies cross local boundaries – which they will often do. (HC 1048, paragraph 251)

There is an important need for "surge capacity" at the supra-local level in the event of an emergency; the Committee recommends that PHE take responsibility for ensuring that this capacity exists through coordination of local authority structures. (HC 1048, paragraph 252)

65. Effective leadership and collaboration are essential in planning for and responding to public health emergencies, and Public Health England, the NHS Commissioning Board and local government will need to work closely together.

66. Local authority Directors of Public Health, supported by Public Health England, will be responsible for ensuring that plans are in place to protect the health of their geographical population.

67. Public Health England will work in partnership with local government and the NHS to provide a comprehensive range of health protection services, including assessing risks and responding to infectious disease outbreaks and other health threats, and identifying trends and patterns that may result in significant events or outbreaks. Public Health England will have robust processes for emergencies and to ensure that 'surge capacity' is available, co-ordinating its activities closely with the NHS and Directors of Public Health in local authorities. During major, national public health emergencies, Public Health England and other key partners will work with the Department of Health to provide national co-ordination of the health response.

68. At the 'supra-local' Local Resilience Forum level, Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations, including Public Health England, that are involved in emergency preparedness and response across the Local Resilience Forum area. LHRPs will ensure effective planning, co-ordination, testing and response for emergencies across the area. A lead Director appointed by the NHS Commissioning Board, and a lead Director of Public Health, will act as co-chairs of the LHRP.

Regulation of public health professionals

There is widespread support for the recommendation in Dr Gabriel Scally's report that non-medically qualified public health specialists should be subject to statutory regulation. In view of the rising proportion of public health specialists that do not have a medical or dental background, the Committee recommends that the Government review its opposition to this proposal. (HC 1048, paragraph 258)

69. The Government agrees that statutory regulation of non-medical public health consultants will help to ensure more consistent standards across the profession. On 23 January 2012, the Secretary of State announced that the Government would legislate to give the Health Professions Council responsibility for regulating this group.

The future of the public health workforce

The uncertainty caused by the transition to the new public health system is inevitably having an unsettling effect on the workforce, which is undermining morale and causing people with valuable skills to leave the profession. The structures will rely for their effectiveness on the availability of motivated and committed professional staff; it is therefore important that uncertainties around staffing issues are resolved as quickly as possible. (HC 1048, paragraph 267)

It is also important that the public health specialty is fully integrated into its forthcoming proposals for healthcare workforce planning, education and training. (HC 1048, paragraph 268)

Finally, we attach importance to the future role in the workforce of public health academics, particularly in their role in the Public Health Observatories. The importance of academia as a career option within public health should not be ignored. (HC 1048, paragraph 269)

70. We agree that it is important to ensure that staff working in the public health system have full and timely information to help them to understand how the changes affect them. All transfers will be carried out in line with the Department of Health HR Transition Framework published in July 2011.[15]

71. For those staff transferring to local authorities, we issued a 'public health HR Concordat' in November 2011. Developed in partnership with NHS and local government employers and trade unions, the Concordat provides a best practice framework for organisational changes affecting staff as part of the transition between the NHS and local government, and a range of agreed principles and HR standards.

72. It is vital that the appropriate and necessary skills are retained, wherever possible, during this transition, and the publication of the Concordat will support this. In early January 2012, further, more detailed HR transition guidance was issued by the Local Government Association alongside the Transition Planning Framework[16] that has been issued to PCTs.

73. Guidance on Directors of Public Health appointments and transfers was issued jointly by the Chief Medical Officer and Local Government Association Chief Executive on 4 January 2012. This guidance covers appointments to vacant posts and transfers to local government.

74. The Department will also develop a specific people transition policy for Public Health England. We are working in partnership with trade unions to explore how we can best develop a tailored set of terms and conditions for Public

15 Department of Health (2011) *Human Resources (HR) Transition Framework*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126234

16 Department of Health and Local Government Association (2012) *Public Health Transition Planning Support for Primary Care Trust and Local Authorities*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132178

Health England which can support the retention and recruitment of the specialist staff that Public Health England will need.

75. On 10 January 2012, the Department of Health published *Liberating the NHS: Developing the healthcare workforce – from design to delivery,*[17] the policy framework for a new approach to workforce planning and the education and training of the health workforce. It puts employers and professionals in the driving seat and gives them the national support they need to identify and anticipate the key workforce challenges, and to be flexible and responsive in planning and developing their workforce.

76. The Department of Health believes that these provider-led arrangements offer the best assurance for future-proofing the way in which the health and public health workforce is developed.

77. Workforce planning, education and training for those professional and clinical workforces that will move from the NHS and form part of the new public health system will remain integrated within the new system, informed by the new employers and the public health professional workforce. This will ensure that, regardless of sector or employer, all public health staff that are currently the responsibility of the NHS education and training system will have continuing oversight through Health Education England and delivery via Local Education and Training Boards.

78. We are committed to the full integration of the public health workforce within the education and training system. We also attach importance to the role of public health academics and their role in supporting the public health system as a whole. This includes the need for strong relationships between service and academic public health in all settings and across all areas of practice, including health protection, health improvement and public health information and intelligence (including Observatories).

79. The consultation on the Public Health Workforce Strategy will explore further the importance of a strengthened capability, explicit standards and multidisciplinary team capacity in the workforce across all domains of public health. These workforces will continue to need to be supported by an academic infrastructure and robust information and intelligence functions.

80. The Department of Health can confirm that the specialty of public health will remain fully integrated within the healthcare workforce planning, education and training system. Under our proposals, the specialty of public health will come within the remit of Health Education England. The Department expects that Public Health England and local authorities will have active and leading roles nationally and locally in providing quality-assured education and training placements for the specialty of public health.

17 Department of Health (2012) *Liberating the NHS: Developing the healthcare workforce – from design to delivery.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076

The national policy dimension

We welcome the Government's acceptance of the Marmot Review principles of "proportionate universalism" and the "life course approach". However, we are unclear why the Government only endorsed five of the six policy objectives outlined by Marmot. Ministers have recognized the importance of the social determinants of health, and committed themselves to address health inequalities, so it is not obvious why *Healthy Lives, Healthy People* did not explicitly endorse the importance to public health of securing a healthy standard of living for all. (HC 1048, paragraph 285)

81. We believe that no change in policy is necessary here. We support all of the policy objectives set out in the Marmot Review. We have focused on the positive principles from the Review such as 'proportionate universalism', and the life course approach, and are now engaging the whole of government in the social determinants of health approach. In particular, we are working with the Department for Work and Pensions and HM Treasury on issues such as child poverty and benefit reform to secure a 'healthy standard of living' for all.

We regard the idea of the "ladder of intervention" as no more than a restatement of a principle that is fundamental to a free society. (HC 1048, paragraph 286)

82. The Government recognises that approaches to public health, for example those that depend on changing people's behaviour, have to be multi-faceted. Non-regulatory approaches are only part of our approach. The ladder of intervention (developed by the Nuffield Council on Bioethics) shows the range of potential approaches and, at every step of the ladder, we should consider the insights that behavioural science can provide.

Against this background we do not oppose the exploration of innovative techniques such as "nudging", where it can be shown, following proper evaluation, to be an effective way of delivering policy objectives. The Committee were, however, unconvinced that the new Responsibility Deal will be effective in resolving issues such as obesity and alcohol abuse and expect the Department of Health to set out clearly how progress will be monitored and tougher regulation applied if necessary. Partnership with commercial organisations has a place in health improvement. However, those with a financial interest must not be allowed to set the agenda for health improvement. The Government cannot avoid its responsibility for constantly reassessing the effectiveness of its policy in delivering its public health objectives. (HC 1048, paragraph 287)

83. The Government agrees that the Public Health Responsibility Deal will be unable to resolve complex issues such as obesity and alcohol misuse on its own. It is one approach which is intended to complement other government actions and policy tools. *Healthy Lives, Healthy People: A call to action on obesity in England*,[18] published in October 2011, sets out how the Government, working with others, plans to tackle obesity, including through combining population-wide measures with steps to help support individuals. Similarly, with alcohol, we need to take a whole-person view – which tackles the demand side and responds to the role alcohol plays alongside other factors in people's lives. The forthcoming alcohol strategy will bring together the Government's approach to this complex issue.

84. The Government is committed to assessing the effectiveness of its public health policies in delivering its public health objectives. Robust and transparent monitoring arrangements are in place to track partners' progress on delivering Responsibility Deal pledges. The first set of delivery plans will be available on the Responsibility Deal website early in the new year. At the end of April each year, partners will report on their progress in delivering their pledges using a series of agreed quantitative measures. This information will also be published on the Responsibility Deal website.

85. Regarding evaluation, the Department of Health's Research and Development Directorate is commissioning an independent evaluation of the impact of key elements of the Responsibility Deal. A team of researchers, commissioned by the Department, are currently assessing evaluation options and will recommend approaches likely to deliver robust findings.

18 HM Government (2011) *Healthy Lives, Healthy People: A call to action on obesity in England.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130401

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