Department of Health

Commissioning responsibilities

Local authorities will be responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

We have undertaken a further check of where commissioning responsibilities for a range of services might sit in the future. As part of this work we have taken the opportunity to look again at where commissioning of abortion services might most appropriately be placed.

Given the highly clinical, and in most cases surgical, nature of abortion provision we have reconsidered our earlier decision to place these services with local authorities. We have provisionally concluded that abortion should remain within the NHS and be commissioned by clinical commissioning groups. However, we are keen to seek a range of views on this revised commissioning route. A consultation on this revised recommendation will begin in due course.

In *Healthy Lives, Healthy People: Update and way forward*, we said we were still considering where to place responsibility for sexual assault referral centres (SARCs) and for campaigns to promote early diagnosis of, for example, cancer. We have

decided that, subject to resolving some further points of detail, responsibility for sexual assault services, including SARCs, at least in the short to medium term, should rest with the NHS Commissioning Board. This is in our view the best way to ensure the delivery of uniformly high-quality services across the country. On early diagnosis we are committed to giving both Public Health England and the NHS Commissioning Board clear responsibility for delivery, based on a shared set of outcomes.

Only some of the above services are to be mandated. The commissioning of other services will be discretionary, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

There was considerable comment during our consultation on commissioning responsibilities about the split of responsibilities for the public health of children and young people, including the Healthy Child Programme, with pregnancy to five services being commissioned by the NHS Commissioning Board. We accept the many benefits to be had from the integration of public health into the wider commissioning of children's and young people's public health, particularly in terms of the prevention and safeguarding agendas.

As we explained in *Healthy Lives, Healthy People: Update and way forward*, we believe that the NHS Commissioning Board will be best placed to lead the commissioning of public health funded services for children under five in the first instance, including health visiting, the Healthy Child Programme and Family Nurse Partnership, given the commitment to a 50% increase in the health visiting workforce and a transformation in the health visiting service by 2015, and to ensure associated improvements in support for families.

Our medium-term aim is to unify responsibility for these services within local government by 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place. In line with this direction of travel, we are also transferring responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget. This decision will be reviewed in 2015 to determine longer-term plans. We will engage further on the detail of these 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.

In the meantime, Public Health England will retain a close interest in the specification of Child Health Information Systems, to ensure public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.

The list of commissioning responsibilities above is of course not exclusive. Local authorities may choose to commission a wide variety of services under their health improvement duty, and indeed we would hope to see much innovation as local authorities embrace their new duties. This freedom is deliberately wide, to encourage

the kind of locally-driven solutions that lie at the core of localism, underpinned by a robust analysis of the needs and assets of the local population. Public Health England will promote this local innovation through encouraging peer sharing of best practice and learning experiences, and through supporting rigorous evaluation of new approaches to improving and protecting public health.

Sexual health services

Local authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services, for the benefit of all persons of all ages present in the area. Transfer of these services offers great opportunities to integrate sexual health services and to link services to wider services, including alcohol and drugs, for particular target groups, such as young people, vulnerable people and other groups at risk of sexual ill-health.

We are going beyond merely transferring responsibility for sexual health services to local authorities and actually mandating them for two reasons. First, STI testing and treatment services are a central part of protecting health. The Government therefore believes that high-quality services must be available in all areas, although the services provided will be tailored to meet local needs.

Second, the Secretary of State for Health currently has a duty, reiterated in the Health and Social Care Bill, to provide advice on contraception, medical examination of people seeking advice on contraception, the treatment of these people, and the supply of any contraceptive substances and appliances. This duty is currently delegated to primary care trusts, who are required to provide open-access services which are not limited to their own residents. Mandating these services of local authorities in the future will allow the Secretary of State for Health to meet this duty fully, over and above what is provided for via current GP provision.

Health protection plans

At present Directors of Public Health in primary care trusts play a key leadership role in planning for, and responding to, health protection incidents, supported by local Health Protection Agency health protection units. Subject to Parliamentary approval, the Health and Social Care Bill will provide that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. However, we want the Director of Public Health to continue to provide a coordination role to protect the health of the local population when transferred to local authorities. Our vision is that the local authority, and the Director of Public Health acting on its behalf, should have a pivotal place in protecting the health of its population. We therefore propose to use a regulation-making power in the Bill to require local authorities to take steps to ensure that plans are in place to protect the local population.

Under this duty, local authorities (and Directors of Public Health on their behalf) would be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-

scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services including, for instance, coordination of outbreak control, and access to national expert infrastructure as and when necessary. His or her role in delivering these functions will be supported by the transparency in the system that will allow the Director of Public Health and others rapid access to routine monitoring data.

Below we set out in brief how we envisage this health protection role working.

With regard to emergencies, we plan the following. At the Local Resilience Forum (LRF) level, a lead Director of Public Health from a local authority within the LRF area will be agreed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

LHRPs are a formalisation of existing health subgroups found in the majority of LRF areas. They will enable all health partners to input to the LRF and in turn provide the LRF with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats. Further work will be done over the coming months to pilot and plan the resourcing and operation of LHRPs.

The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. Resources will be required to support the LHRP to provide continuous readiness.

More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model.

The NHS lead director will represent the LHRP on the LRF, as now, since most

emergencies require readiness and input of NHS resources. The lead Director of Public Health should also attend, and Public Health England will attend where the emergency requires its presence.

In terms of plans for screening and immunising the local population we envisage a process as follows. The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes in accordance with an agreement between the Secretary of State for Health and the Board which will set out the terms in which the Board will exercise a Secretary of State function. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening.

Directors of Public Health will advise, for example, on whether screening or immunisation programmes in their area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board on issues such as raising uptake of immunisations and screening, and how outcomes might be improved by addressing local factors. They will also have a role in championing screening and immunisation, using their relationships with local clinicians and clinical commissioning groups, and in contributing to the management of serious incidents.

Directors of Public Health will play a role in ensuring that immunisation care pathways for programmes such as neonatal hepatitis B are robust. The Board will remain accountable for responding appropriately to that challenge from local public health teams, and for driving improvement.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. But it will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency.
Thus clinical commissioning groups will have a duty of cooperation with local authorities; NHS-funded providers can be required through contracts to share plans and appropriate information; Directors of Public Health can use their annual report and membership of the health and wellbeing board to raise concerns more formally; and the Secretary of State for Health can use the Mandate and his agreement with the Board to ensure that the NHS Commissioning Board takes appropriate account of the advice of Directors of Public Health.

Finally, there will be a professional relationship between Directors of Public Health and Public Health England, and the Chief Medical Officer as professional lead for public health, which will give directors and their teams a route for contributing to national thinking about what is needed.

The system ensures that accountability is focused where it needs to be. The Director of Public Health will be

responsible as the public health lead in each local authority for advising on plans that are in place and identifying any problems, using his or her public health expertise. NHS and other partner colleagues will be accountable for taking appropriate account of that advice.

This is in line with the design of the new system overall: Public Health England and Directors of Public Health are accountable for the provision of high-quality public health advice; the NHS Commissioning Board, clinical commissioning groups and others are accountable for making the appropriate use of that advice.

The Secretary of State for Health will retain a central interest in health protection even where he has delegated functions to the local level. To this end we will publish further details as we develop policy on the new system. In particular we will develop a statement on how we will promote high performance and support performance improvement.

We also intend to produce operational guidance to support incident management at a local level, which will cover the working relationship between the NHS, Public Health England and the local authority. The guidance will recognise the need for flexibility to enable each area to make plans most appropriate to protect the health of its population.

Population healthcare advice to the NHS

We will also mandate local authorities to provide population healthcare advice to the NHS. Good population health outcomes, including reducing health inequalities, rely not just on health protection and health improvement, but on the quality of healthcare services provided by the NHS. That is why we are preserving a key role for local authority public health teams in providing public health expertise for the NHS commissioners of these services.

The need to secure provision of public health expertise for healthcare commissioners (and to support health and wellbeing boards in producing the joint strategic needs assessment and joint health and wellbeing strategy) was a key theme of the consultation on the public health white paper *Healthy Lives, Healthy People*.

We have consulted a group of public health and other experts who have developed a draft model for what such a public health advice service might look like, building on existing work across the country. Appendix 1 sets out the group's recommendations, aligned against the stages of the commissioning cycle.

Clinical commissioning groups will require a range of information and intelligence support via both the population healthcare advice service based in local authorities and other commissioning support services such as from Public Health England where appropriate. It is important to note that although there are some similarities in the nature of these services (ie public health population healthcare advice and the work of commissioning support organisations (CSOs) in the future), they will have a different focus.

We envisage that public health teams will provide largely a strategic population focus, synthesizing data from a wide variety of sources and applying their public health skills to draw the implications of that data for the local population. CSOs will focus more on commissioning processes and clinical systems, including detailed analysis of referrals and activity, procurement and business processes. Both are essential for driving improvements in services.

There would be nothing to stop local authorities from agreeing locally to offer a wider range of services. Local authorities will also be free to meet this obligation in a variety of ways, for example in relatively small authorities it may make sense to locate a team in a single authority, acting on behalf of several. In addition, Public Health England will have a role through its information and intelligence service to support local authorities on this mandatory duty. This could include, for example, providing baseline data and analysis that local public health teams would need to share with the local NHS to inform discussions about relative needs and priorities.

Given close working and responsiveness between public health teams and clinical commissioners we would expect clinical commissioners to make full use of the expertise of local public health teams (as well as public health expertise in clinical senates). Indeed we are confident that as fully integrated commissioning teams are put in place throughout the country, the nature and extent of such assistance will be an accepted and automatic core element of local commissioning practice. This will be another means of taking forward the underpinning localism ambitions of this policy approach.

Where there are concerns about the quality of the advice received we would expect this to be raised at the local level initially with the local authority. There may be an issue of professional development, in which case we would envisage clinical commissioning groups involving Public Health England in discussions.

We are considering further what role local public health advice may play in supporting the NHS Commissioning Board in its core responsibilities, for example with respect to the quality of local primary care commissioning.

The group of public health experts and GPs who have advised us on the development of the population healthcare advice service are also working with us to consider how best to ensure that the provision of population healthcare advice meets the needs of clinical commissioning groups. This will help ensure that clinical commissioning groups can be confident that they will receive the kind of high-quality, responsive service they need.

DH Department of Health

Produced: December 2011
Gateway reference: 16747

Produced by the Department of Health
www.dh.gov.uk/publications