



Department  
of Health

Government Response to the  
House of Commons  
Communities and Local  
Government Committee  
Eighth Report of Session  
2012–13: The Role of Local  
Authorities in Health Issues





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Presented to Parliament  
by the Secretary of State for Health  
by Command of Her Majesty

July 2013

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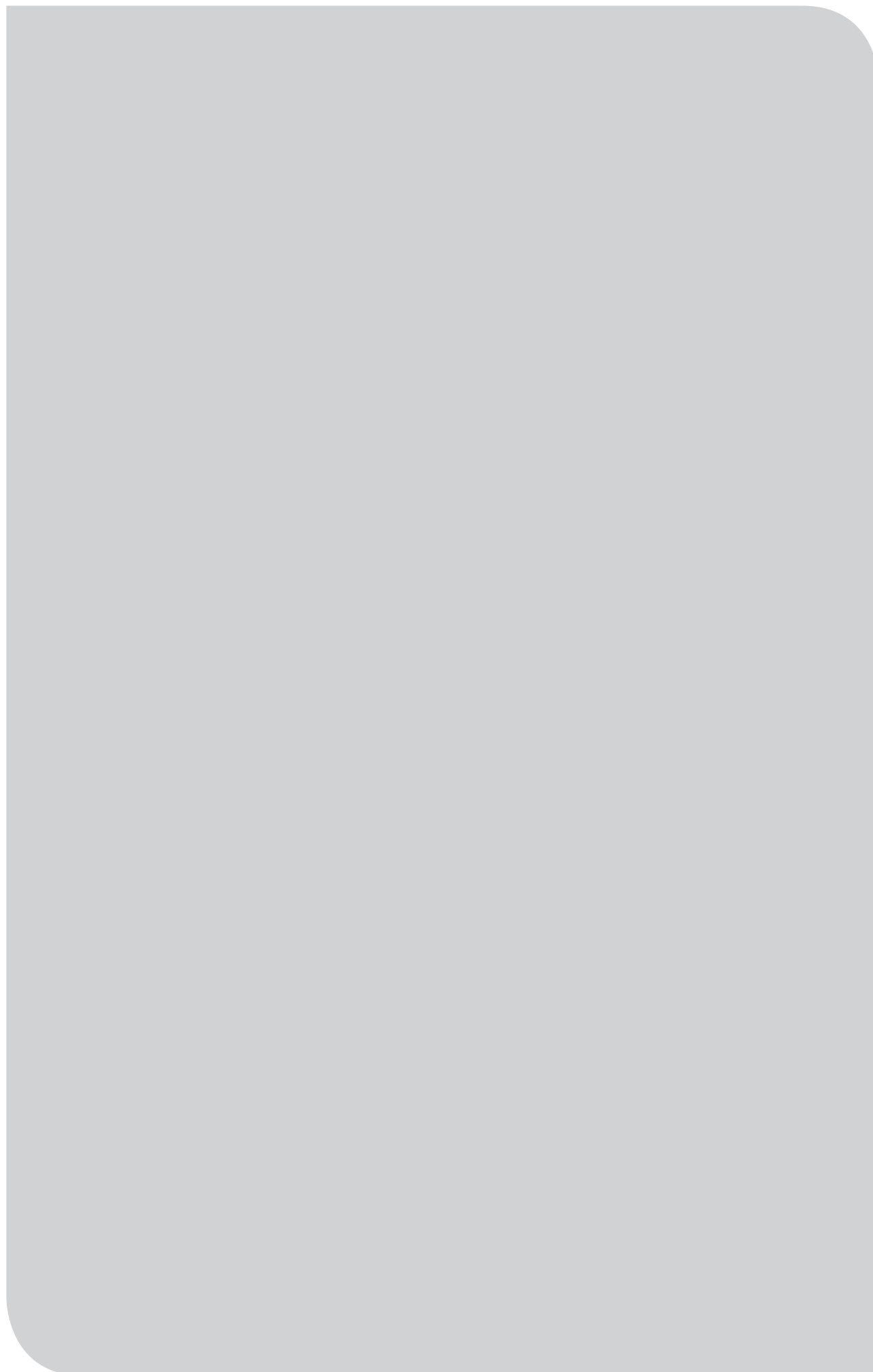
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# Introduction

The Government is grateful to the DCLG Select Committee for its constructive and positive report, and for the opportunity it provides to set out our position and expectations on some key issues in greater depth. This response draws together input from the Departments of Health, Communities and Local Government and Work and Pensions – an indication of the increasingly wide base across government for thinking and action around public health.

After a gap of almost 40 years the Government has returned substantial public health duties to local authorities for a simple, but powerful, reason: we believe firmly that they, not the NHS or central government, are best placed to deliver those duties and improve the health of their residents. Local authorities can now promote public health across the full range of their business and become an influential source of trusted advice and effective scrutiny. We have every confidence in local government's ability to play its part successfully and are encouraged by the enthusiasm and commitment that it continues to show.

The primary public health duty that we have given to local authorities is to do what they believe is appropriate, based on their understanding of their local community and its needs. It is not the job of central government departments to look over their shoulders unnecessarily and make these decisions for them – we are equal partners, each contributing what it is most qualified to contribute. Nevertheless, we accept

entirely the overarching responsibility of the Government – in particular the Secretary of State for Health – for the stewardship of the comprehensive health service as a whole, of which local authorities are now such a significant part. In this response to the Committee we describe how some of the most important components of the reformed system will work in practice.

# Government response to the Committee's conclusions and recommendations

1. The transfer of public health responsibilities back to local authorities

*These changes are part of a complex set of reforms across local government and nationally. Local authorities and, in particular, Health and Wellbeing Boards will have to work hard to involve local people in their work, and we expect that the operation of the new arrangements will be reviewed by a select committee in two years' time.* (Report paragraph 13)

We are grateful to the Committee for its appreciation of the principles underpinning the reformed public health system. We would welcome the opportunity to review progress with the Committee in future as the reforms mature and develop.

2, 3. The role of Health and Wellbeing Boards,

*The obvious danger with the new Boards, however, is that the initial optimism surrounding their establishment and first year or two in operation will falter and go the way of previous attempts at partnership working that failed and became no more than expensive talking shops. To succeed, Health and Wellbeing Boards will need to work on the basis of*

*relationships and influence, and this will depend on both people and structures* (report paragraph 22)

*Local authorities should use the limited central prescription on their Health and Wellbeing Board membership in combination with their influence across the local community, to work with a range of people and bodies most closely linked to their areas' health needs and objectives. They might do this either by including them on the main Board or by creating a range of other relationships. These can be informal, through the cultivation of partnerships with, for example, the voluntary sector, or formal, with the development of Health and Wellbeing Board sub-committees, partnership bodies, and community groups.* (Report paragraph 23)

The Government accepts the Committee's assessment. For health and wellbeing boards to be fully effective, local authorities will need to consider whether their boards' membership is diverse enough to reflect the needs of their local communities – so, where appropriate, that could include members of the sort that the Committee suggests, or others such as local employers.



#### 4. The priorities of Health and Wellbeing Boards

***Health and Wellbeing Boards have been given a substantial mandate to encourage integrated working between the NHS and public health and social care services. They also need to maintain a strategic and balanced outlook on their new responsibilities, focusing on promoting the health of their local population, rather than becoming exclusively preoccupied with the detail of health and social care commissioning and integration. Given that people are living longer and the cost of health care is rising, Boards will need to draw on the public health, clinical and social care expertise of their members to promote healthy and independent living among all age groups, young and old, if they are fully to take advantage of the opportunity provided by their creation to embed health promotion and disease prevention in all local services.*** (Report paragraph 27)

The Government agrees. Local authorities will take the lead for improving health and co-ordinating local efforts to protect the public's health and wellbeing, and for ensuring that health services effectively promote population health. Health and wellbeing boards will play a crucial role in building partnerships through the development of Joint Strategic Needs Assessments, and setting a joint health and wellbeing strategy with local commissioners. The Public Health Outcomes Framework, used alongside the NHS and Adult Social Care Outcomes Frameworks, will provide a robust basis for analysis of the health and wellbeing of the local population.

#### 5. Accountability

***We recommend that the Government clarifies the procedures for holding Health and Wellbeing Boards to account, including the role it expects local overview and scrutiny committees to play and the role of the Director of Public Health, given their position as a Board member. Directors of Public Health should also report directly to the local authority's chief executive, and we urge the Government to reassert its understanding of this point, too.*** (Report paragraph 31)

Health and wellbeing boards are committees of local authorities and as such they are subject to overview and scrutiny committees of their local authority. Overview and scrutiny committees are able to review the decisions and actions of health and wellbeing boards, and make reports and recommendations to the authority or its executive. The involvement of local councillors and local Healthwatch on boards will further enhance their transparency and accountability to local people.

The internal management structure of local authorities is a matter for local authorities themselves. In its guidance on the role and responsibilities of the director of public health (DPH) the Department of Health made clear its view that there needs to be a direct line of accountability between the DPH and their chief executive (or other head of paid services) for the exercise of the authority's public health function. This may or may not mean that the DPH should be a standing member of their authority's most senior corporate management team.

The written evidence to the Committee indicated that a large majority of local authorities (85 per cent) had already made arrangements consistent with that position by June 2012. The Government intends to fulfil its commitment to republish its guidance

as 'statutory' – that is, guidance that local authorities must have regard to – and will discuss this with the Local Government Association and others.

## 6. Healthwatch

***We call on Healthwatch England and the Government to work with local authorities to ensure that a Local Healthwatch representative is available to take part in the deliberations of every Health and Wellbeing Board throughout the country by the end of the year.*** (Report paragraph 33)

The Government shares the Committee's recognition of the value of the role of Healthwatch on health and wellbeing boards. The Health and Social Care Act 2012 sets out the statutory minimum membership of the boards, which includes a local Healthwatch representative. As a statutory member the local Healthwatch organisation will be expected to supply a representative to attend each meeting of the health and wellbeing board and participate in the work it undertakes, and we expect that local Healthwatch organisations will want to make full use of their statutory membership. Healthwatch England will also publish guidance on health and wellbeing boards for local Healthwatch organisations.

## 7. The position of national organisations in guiding and advising Health and Wellbeing Boards

***As the reforms bed in, local authorities should seek out support and improvement among themselves, including, for example, through the Local Government***

***Association's Knowledge Hub resource.*** (Report paragraph 36)

The Government agrees. The principle of sector-led improvement is essential to the quality and future development of local authorities' contribution to the comprehensive health service. The Local Government Association played a central role in preparing its membership for the transition of public health responsibilities from the NHS; the Department of Health and the LGA are currently discussing arrangements for the LGA to co-ordinate a partnership with NHS England, Public Health England, Healthwatch England and others that can support local system leaders.

This will include an LGA-led health and wellbeing system improvement programme, funded by the Department of Health, that can help to develop local Healthwatch, health and wellbeing boards and public health functions in local authorities. NHS England is aligning its support to clinical commissioning groups with the LGA's partnership.

## 8. The relationship between NHS England (the NHS Commissioning Board) and Health and Wellbeing Boards

***We therefore urge Boards to work closely with their NHS Commissioning Board Local Area Teams at all times, not simply when discussing their Joint Assessments, Joint Strategies and the NHS Commissioning Board's own commissioning plans. The best way to address these concerns would be to work face to face with the NHS Commissioning Board on a regular basis.*** (Report paragraph 41)

The Government agrees. We expect local authorities with public health functions

and commissioners of NHS services to co-operate (in line with existing statutory duties of co-operation), and the structures put in place by the 2012 Act are intended to encourage that without imposing an overly detailed national model for day to day local collaboration.

## 9, 10, 11. Local accountability, NHS England's role in holding other bodies to account

***We call on the Government to set out in detail what Health and Wellbeing Boards can do if the NHS Commissioning Board subsequently fails to commission services consistent with these strategies. We also ask the Government to clarify what the duty on the NHSCB to "have regard" to a Joint Health and Wellbeing Strategy means in practice.*** (Report paragraph 43)

***Health and Wellbeing Board meetings should be attended by a representative of the NHS Commissioning Board when Clinical Commissioning Group commissioning is under discussion. Indeed, they should be attended by a representative of the national body, given its prominent role in local health matters, whenever required.*** (Report paragraph 45)

***We ask the Government to clarify what action can be taken if a CCG fails to commission services in accordance with a local Joint Health and Wellbeing Strategy.*** (Report paragraph 46)

There is a clear expectation that JSNAs and JHWSs will provide the basis for health and social care commissioning in relation to the local area. The 2012 Act introduces a new statutory obligation on key health and social care commissioners (CCGs, NHS England and local authorities) to have regard to the relevant JSNA and JHWS in exercising

their functions. This means that in making any decisions to which a JSNA or JHWS is relevant (for example a commissioning decision), the body must take account fully of the relevant provisions of the relevant JSNA and JHWS, and consider them properly and seriously, not dismissively. CCGs, NHS England and local authorities will be expected to develop their commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which are not consistent. In effect JSNAs and JHWSs will lay the foundation for both local authorities and NHS commissioning plans.

CCGs must involve the health and wellbeing board in preparing (or making significant changes to) their commissioning plans. This includes consulting boards on whether the plans take proper account of the JSNAs and JHWSs. When consulted, boards must give a view and the CCG must include a statement of the final opinion of each relevant health and wellbeing board consulted, upon publication of the plan.

If a health and wellbeing board believes that NHS England locally has not taken proper account of the relevant JSNAs and JHWSs, it can raise this directly with NHS England, or – in extreme circumstances – it could escalate this to Secretary of State for Health, who has intervention powers in relation to NHS England where it is not exercising its functions properly or at all, or is at risk of failing to do so.

Similarly, if a health and wellbeing board thinks that a CCG has not taken proper account of the relevant JSNAs and JHWSs it can make this clearly known to the CCG when consulted, and also to NHS England. The CCG must be able to justify any parts of their plans which are not consistent. NHS England can take a range of action if it believes that the plan is out of line with the JHWSs without a good reason.

## 12. The development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

***The Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy must not therefore be viewed as tick-box forms to be produced and filed; they must be living, breathing documents to which all local health partners willingly contribute and adhere. Local authorities should look to innovative approaches, such as we saw in Kent, to use their assessments and strategies as an opportunity to devolve power and to identify local-level activity through which they can improve health and wellbeing in specific places, among certain groups of people and throughout their local area.***  
(Report paragraph 49)

The Government agrees. Public Health England will publish the outcomes that local authorities achieve against the indicators in the Public Health Outcomes Framework, and we believe that the greatest and most sustained progress will be made where local authorities and their partners engage in innovative practice of the sort that the Committee envisions.

## 13. Data sharing and information management

***If strategies are to be based on sound evidence, the Government must involve the Information Commissioner in clarifying what data local authorities and the NHS can share. This should be done by the end of this year, so that authorities have time to use any new guidance in the development of assessments and strategies for 2014–15. We recommend***

***that Public Health England publicise widely guidance on how local authorities can manage their data and information.***  
(Report paragraph 53)

The recently published Information Governance Review, commissioned by the Secretary of State for Health, makes a series of recommendations regarding the public's right of access to information about themselves, as well as how confidential information should be used and safeguarded for a range of purposes. These recommendations apply to information sharing between local authorities and the NHS and include requirements to:

- always justify the reason for using and sharing confidential information;
- not use confidential information unless absolutely necessary, and use the minimum amount where it is;
- ensure that access to confidential information is on a strict need-to-know basis, with all those involved aware of their responsibilities; and
- be clear that the duty to share information can be as important as the duty to protect confidentiality.

Under the Health and Social Care Act 2012, the Health and Social Care Information Centre (HSCIC) has a duty to publish a code of practice on the handling of confidential information. Building on the recommendations of the Information Governance Review, the code is expected to be published shortly and will provide mandatory guidelines on the sharing and use of confidential information across health and social care, which all local authorities must have regard to.

As part of its national leadership role for the new public health system, Public Health England is working directly with local authorities and at a national level with the HSCIC and NHS England, to clarify precisely



what information local authorities need from the NHS to carry out their new health protection and health improvement functions. In September 2012, we published a series of Local Public Health Intelligence factsheets providing local authorities with clear advice on how to manage their public health knowledge and intelligence needs, and detailing the steps they must take to ensure they can safely handle data from the NHS.

Further guidance notes have also been published advising local authorities of the legal basis for them to access identifiable health data (for clearly defined purposes and with appropriate safeguards) and providing practical information on what information they can access through the HSCIC and NHS England's Commissioning Support Units.

As part of this year's spending round, and building on the success of community budget pilots to drive transformation in public services, the Government is working to consult on new legislation to remove barriers to data sharing, helping councils, the NHS, the criminal justice system and Job Centre Plus design services around the individuals that need them.

Public Health England is committed to continuing to work with local authorities, and nationally with the HSCIC and NHS England, to ensure that local public health intelligence requirements are clearly understood and being met by appropriate, safe and timely information sharing.

#### 14. Building relationships with other sectors

***We expect that local authorities, the Local Government Association and the Government itself will draw lessons from the four pilot areas establishing the readiness of these sectors. These***

***lessons must be disseminated as soon as possible, so that, first, local government can work out how to create structured arrangements with the potential partners, including through community sector boards, and, second, each has a defined role in the creation of Joint Assessments And Strategies.*** (Report paragraph 57)

The Government agrees that the expertise and experience of the voluntary, community and social enterprise sectors are an invaluable resource for local government in its new role. Local authorities will need to find ways of releasing the potential of that resource in ways that reflect the needs and capabilities of individual organisations.

#### 15. Collecting and analysing information

***We recommend that local authorities and the Government keep under review the role of staff in Commissioning Support Units to ensure they are sufficiently public-health focused and councils have access to an adequate number of public health analysts. They should also consider how staff from Public Health England's local centres might assist in any local analysis.*** (Report paragraph 60)

Under the new health and social care system, local authorities are best placed to understand their own knowledge and intelligence support requirements. The ring-fenced funding allocations to support local authorities in delivering their new public health functions in 2013/14 and 2014/15, announced earlier this year, include funding for the provision of this local support function. To assist with the planning for their new health protection and health improvement functions, we published a series of *Local Public Health Intelligence* factsheets in September 2012 to help local authorities understand

the importance of local health knowledge and intelligence.

The Department of Health, Public Health England and the Local Government Association recently published a public health workforce strategy. This includes a number of actions to develop and support the public health workforce, including knowledge and intelligence staff. These actions include:

- reviewing the scope and definition of public health knowledge and intelligence and the associated competencies;
- developing and updating the current public health knowledge and intelligence training schemes (in partnership with the Faculty of Public Health);
- ensuring relevant continued professional development opportunities are available to all public health knowledge and intelligence staff;
- describing career pathways for public health knowledge and intelligence professionals.

Commissioning Support Units are also providing a range of expert commissioning support services to their customers - including some local authorities where they are buying in this service. 'Developing commissioning support: Towards service excellence' emphasised that commissioning support helps to create the environment for the best decision making and support collaborative arrangements between CCGs and local authorities. It is by working with local authorities that commissioners across the NHS will ensure that the public health needs are reflected in the health and well-being agenda for the local population.

Additionally, at a local level, a key responsibility of the new Public Health England local knowledge and intelligence teams is to provide training, development and network support to public health

knowledge and intelligence staff working in local authorities, the NHS and elsewhere. Where there are gaps in local capacity, the Public Health England local knowledge and intelligence teams are able to provide expert assistance to local authorities to ensure their new public health functions, such as the production of strategic commissioning plans, are based on robust local information. Local authorities will also be able to commission knowledge and intelligence support from other providers.

## 16, 17. Communicating information

***The way in which information from the Joint Strategic Needs Assessment is communicated to people will play an important part in maintaining the momentum gathering behind Health and Wellbeing Boards and in ensuring that they succeed. There will be a significant role for the Director of Public Health, who will be able to present ward-level data to ward-level councillors, and councils will themselves need to instigate training to ensure their councillors take advantage of these new arrangements.*** (Report paragraph 64)

***Local authorities, the Local Government Association, the District Councils' Network and Public Health England should develop the skills required to communicate public health issues and ensure locally elected representatives, Board members and public health staff have access to such training when required. In order to convey to colleagues and residents what their local needs are, and how the Board intends to deal with them, local authorities should seek a Plain English Campaign endorsement of their Joint Strategic Needs Assessments and***

**Joint Health and Wellbeing Strategies.**  
(Report paragraph 65)

The Government agrees. The Department of Health's guidance on the role and responsibilities of directors of public health is clear that DsPH need to be able to work and communicate with elected representatives, colleagues within local government, other partners and their local populations.

To help support this, the NHS Leadership Academy's Aspirant DPH Leadership Programme (which began in January 2013, with 38 participants) includes content focused on using evidence to create compelling messages and sharing these in an accessible way. The second cohort of the programme begins this autumn.

## 18. Engagement of councils and councillors

**County councils might develop a formal compact to devolve some decision making so that districts are recognisably involved in public health matters, or create local HWBs, forums or sub-groups to enable district councils to work more easily with local Clinical Commissioning Groups. We encourage all county councils to develop agreed working arrangements with district councils.** (Report paragraph 70)

The Government acknowledges, and is grateful for, the significant contribution that district authorities already make to public health (for example, through environmental health services). While engagement of this sort is a matter for local discussion and agreement, we expect that contribution to flourish within the reformed system. Many of the indicators set out in the Public Health Outcomes Framework – to which county councils and others with new public health duties must have regard – relate directly

to services that district authorities are responsible for.

## 19. Unitary authorities

**We consider that all upper tier councils, including unitary authorities, should set an example to central Government by demonstrating and embedding effective localism themselves. They can do so by devolving certain responsibilities and, where possible, budgets to councillors and committees at ward and area levels. All authorities should look to each other, including through the Local Government Association, for peer support and mentoring. They should also explore the powers and information currently at their disposal, through mechanisms such as the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, to describe the health situation at ward level and to include local councillors and, therefore, communities in decision making.** (Report paragraph 72)

While upper tier and unitary authorities must take the steps that they themselves decide are appropriate, the Government agrees with the principle of the Committee's recommendation.

## 20. Housing

**We acknowledge the importance of housing in determining people's health and wellbeing. It is important that this service is included in the 'voluntary' arrangements we have described. We suggest that councils explore ways to include housing in their work, either by establishing housing sub-groups of their main Health and Wellbeing Board or by addressing housing in their Joint Strategic Needs Assessment, Joint Health and**

***Wellbeing Strategy and when reporting on progress with public health outcomes.***  
(Report paragraph 75)

Again, the Government understands and agrees with the principle behind the Committee's recommendation. Housing is a prime example of services that district authorities may have most influence over, and is a prominent feature of some of the key indicators in the Public Health Outcomes Framework –for example settled accommodation for people with mental illness, or statutory homelessness.

## 21. Councillors and clinical commissioning groups

***We do not intend to press for the inclusion of locally elected representatives on these boards; instead we recommend that they are not specifically excluded. In the spirit of localism, such issues should be left to local resolution.*** (Report paragraph 81)

The National Health Service (Clinical Commissioning Groups) Regulations 2012 preclude elected representatives, including local councillors, from membership of clinical commissioning group governing bodies. CCGs are intended to have a sharp clinical and professional focus. Councillors are able to influence decisions affecting the health service locally through membership of health and wellbeing boards. The Government will listen to representations on the effect of these regulations in practice.

## 22. Local authority initiatives

***Local authorities, if they are to grasp fully the opportunity afforded to them by the return of public health, will need to look beyond those services traditionally considered to be “public health”, such as health protection, health promotion and***

***disease prevention, and tackle the causes of the causes of poor health, working with local partners and using all the powers, personnel and services at their disposal. The evidence we received makes it clear that people, particularly in vulnerable groups, are more likely to exhibit a range of unhealthy behaviours. Single initiatives targeting individual lifestyle choices, such as drinking or smoking, have been shown not to work, especially among people at the lower end of the social gradient of health. Authorities should be willing to take one step back from treatment to look additionally at by-laws, education campaigns and how to involve, for example, GPs, pharmacies or debt management and housing services in a more holistic attempt to deal with the multiple reasons behind complex health problems.*** (Report paragraph 88)

The Government agrees with the need for a new, broader-based approach to tackling public health. Dealing with the excess mortality caused by smoking and obesity as conclusively as the threats of infectious disease were dealt with a century ago requires different ways of thinking and intervening. This was a key factor in the decision to return public health responsibility to local government, and the range of indicators included in the Public Health Outcomes Framework are intended to encourage innovation of the sort that the Committee recommends.

## 23. Early years

***Local authorities will of course wish to base their public health work on their Joint Strategic Needs Assessments, but we note how several councils have placed early years interventions—literacy, readiness for school and childhood obesity programmes—high on their list***



***of priorities. We commend authorities to bear this in mind when making their decisions, given the importance of early years development in people's later health and wellbeing.*** (Report paragraph 90)

Decisions about what is appropriate locally must be made by local authorities themselves, although we expect directors of public health to be well aware of the significance of early intervention.

## 24. Employment

***We note that local authorities already support apprenticeships and back-to-work schemes, but the Government should consider devolving to local government further measures, including elements of the Work Programme, in order to address at a more local level unemployment and, in turn, one reason why people may adopt unhealthy lifestyles.*** (Report paragraph 92)

The Work Programme is the single largest employment programme ever contracted, and replaced more than 20 programmes in an effort to realise greater efficiencies and economies of scale, and to encourage a more joined-up approach focused on the individual and not the benefit being claimed. It is delivered by 18 different prime providers across 40 different regionally-based contracts.

For the Work Programme to be a success the experience, knowledge and specialist skills of local partners must be integral to the delivery of personalised and localised services. This is why prime providers have been given the freedom to design their own delivery models and can work with local authorities, CCGs and any other local groups to deliver joined up, locally tailored services. Work Programme providers are paid on the basis of results – getting people into sustained employment

– so they have a clear economic incentive to work with local partners where that joint working will result in more claimants in sustained work.

We believe that this model is the correct one for the current circumstances. To devolve aspects of a future model of the Work Programme a clear evidence base would be needed for its effectiveness, value for money, quality of service and a clear payment by results model for local authorities.

Public Health England is committed to supporting employers large and small to establish the business case for supporting a healthy workforce. This consists of supporting the adoption of health and wellbeing approaches at work, supporting employees with health problems to return to work, making adjustments in the workplace and improving the understanding of good health and wellbeing amongst employees. The evidence is clear that employers who adopt these approaches benefit from greater productivity, increased morale, and lower rates of absenteeism and there is some evidence to show that they are better at attracting people into the workplace.

## 25. Local authorities working with Government

***Some public health issues, such as alcohol misuse and obesity, may require central Government leadership and action, including legislation, if a big difference is to be made to the health of local people. Central Government action will not be a panacea, but to effect change local authorities may require the support of complementary national-level initiatives to make the most of their own strategies, powers and influence.*** (Report paragraph 97)

The Government agrees that central leadership and action should continue to complement and support local strategies in key areas of health improvement, including actions set out in national strategies on tobacco, obesity, alcohol, drugs, and sexual health. This will include legislation where appropriate; national-level initiatives and guidance, and the ongoing support of Public Health England at national, regional, and local levels.

The Secretary of State for Health has a goal of reducing the rates of premature mortality in England to be among the best in Europe. On 6 March 2013 the Department of Health published 'Living well for longer: a call to action to reduce avoidable premature mortality', challenging and inspiring the health and care system local and nationally to take action to reduce the number of people dying prematurely. Alcohol misuse and obesity are some of the underlying factors of premature mortality.

## 26. Joined-up government

***We note also plans within the Department of Health to engage with the Home Affairs policy committee, and the discussions that the Department has already had with the Department for Education, which should be encouraged elsewhere in government***

***In the spirit of close working throughout government, both centrally and locally, we recommend that the Department of Health and the Department for Communities and Local Government set up a single point of ministerial contact to which local authorities can turn for support in their new health care role.***

(Report paragraph 99)

The Parliamentary Under Secretary of State for Public Health, within the Department of

Health, represents the single co-ordinating point of Ministerial contact in government for public health issues. Ministers from DH, DCLG and other departments will continue to work together closely on cross-cutting matters.

## 27, 28. Measuring success, assessment bodies

***The transfer of functions from central to local government during the relocation of responsibilities for public health must not become an end in itself. Local authorities will need to provide within an agreed period evidence of an improvement in the health and wellbeing of their population. With these new powers comes the responsibility to deliver results, and local authorities will need to balance local and national objectives and short-term and long-term aims. Given the complex, multifaceted nature of the social determinants of health, however, determining the success of general—population-wide—or specific initiatives will be difficult, time-consuming and may ultimately distract those working on them from making progress. Short term success can be demonstrated relatively quickly, and without distracting from longer-term objectives, by, for example, improvement in readiness for school rates, the number of NEETs (those not in education, employment or training) in a local area and by all Health and Wellbeing Board members working to increase patient registration with GPs in order to identify those with long-term conditions and to prescribe treatment for them.***

(Report paragraph 104)

***Good local authorities may already be tackling the difficult challenges posed by unhealthy people and communities,***

***so in the short term at least it would be unfair and possibly counter-productive to start “naming and shaming” councils without taking into account historical and demographical factors. With Public Health England in its infancy it makes sense to restrict its role to that of critical friend. On matters of scrutiny and regulation, local authorities should not hide behind a national body such as Public Health England. We encourage them, in the spirit of localism, to take responsibility for these issues themselves, through overview and scrutiny committees and Local Healthwatch.*** (Report paragraph 106)

The Government agrees. Public Health England will publish annual data in respect of each local authority against each of the indicators in the Public Health Outcomes Framework. PHE has already launched a new web site (Longer Lives) showing variations in early death rates. It is designed to provide local authorities and the NHS with an insight into the top causes of avoidable early death in their areas - such as heart disease, stroke and cancer - and how they compare to other areas with a similar social and economic profile. Local authorities themselves are required to publish annual reports prepared by their directors of public health on the health of their local population.

## 29. Self assessment

***Surveys—self-assessments—are a useful measure of wellbeing: they quantify the less specific but no less important objectives of independence and social participation, and they engage individuals in the development of their own wellbeing. Councils might make such surveys one aspect of agreeing their contracts with voluntary groups.*** (Report paragraph 108)

The Government agrees that this is a potentially valuable measure that local authorities might find helpful.

## 30, 32. Front line health protection, revised responsibilities

***We therefore recommend that the Government sets out clearly and unambiguously the lines of responsibility, from Public Health England down to public health staff in local authorities, and confirms that Public Health England will have sufficient staff throughout the country to assist in the local and regional, as well as national, responses, in the event of a health emergency. We note that four contingency exercises have been planned before April 2013 but, to ensure that local authorities throughout the country are not only aware of, but practised in, the new procedures, we call on the Government to work with them to organise a continuing programme of such exercises.*** (Report paragraph 114)

***We acknowledge the legal issues, raised by the Department of Health, which might arise from giving local Directors of Public Health a similar duty to the Secretary of State to protect the health of the population, but our main concern is with the practicalities. Given the importance that the Government has attached to the role of the Director of Public Health, it must make sense to include them as fully as possible in ensuring, rather than simply advising on and promoting, adequate preparation for local health protection arrangements. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 risk diminishing the authority of the Director of Public Health and creating delays***

***while concerns about local preparedness are taken to Public Health England. We therefore recommend that the Government review these regulations, in order to enhance with identifiable authority the power, respect and status that the Government suggest should be accorded to Directors of Public Health.***  
(Report paragraph 120)

The Government recognises the vital importance of front line health protection and expects the reformed system to strengthen the effectiveness of local arrangements. The response to any particular incident will depend on the nature of the incident, and the Government remains of the view that prescribing a national template for responses would not be helpful.

The Department of Health has published revised guidance on the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, agreed with the Faculty of Public Health, the Association of Directors of Public Health, Public Health England and the Local Government Association. This clarifies the crucial and influential role that directors of public health, on behalf of local authorities, and PHE will play in protecting the health of their local populations. Directors of public health will provide information, advice, challenge and advocacy on behalf of their local authority, to promote preparation of effective health protection arrangements by relevant organisations, such as NHS bodies, operating in their local authority area.

PHE should agree with local authorities the specialist health protection support, advice and services that it will provide; this agreement should build on existing arrangements between the NHS, local authorities and the PHE centres. Experienced staff are in place to ensure that PHE can

assist in the local, regional and national responses, in the event of a health emergency. We will keep under review how these regulations work in practice.

The revised guidance is also clear that ultimately, if the Secretary of State considers that (for any reason, and in any location) the local arrangements are inadequate, or that they are failing in practice, then he must take the action that he believes is appropriate to protect the health of the people in that area.

A series of four regional workshops and four ‘table top’ exercises involving multi-agency partners, including local authorities, are being jointly planned by NHS England, local authorities and PHE for 2013-14. These will build on the outcomes and the lessons identified in the four exercises that were conducted by the Health Protection Agency prior to April 2013, in which 157 organisations participated from across health, emergency responders, local authorities and other government departments.

## 31. The role of NHS England

***The inclusion of the NHS Commissioning Board and its 27 local area teams in the health protection system, with its role in mobilising the NHS in the event of an emergency, and combined with the 39 Local Resilience Forums and 15 local Public Health England centres, adds a further layer of complexity and introduces potential variation to the new arrangements, with all the attendant risks. Local authorities will need to be completely clear about whom they speak to in the NHS locally in the event of an emergency, so we reiterate our recommendation that the Government and the NHS Commissioning Board ensure that these relationships are made***



***unequivocally clear to public health staff in local government.*** (Report paragraph 116)

NHS England has clear objectives set by the Secretary of State for health through the mandate. The Health and Social Care Act 2012 makes clear the boundaries in the new health and care system. Public Health England and NHS England need to work effectively together in order to deliver against all of their objectives.

The Act introduced new arrangements for local health emergency preparedness, resilience and response. Local Health Resilience Partnerships are intended to provide a strategic forum for joint planning and preparedness for emergencies for the new health system and to support the health sector's contribution to multi-agency planning and preparation for response through Local Resilience Fora (LRF). They build on approaches already adopted in many parts of the country. They are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations, in line with their respective statutory duties.

We believe the new system will offer considerable benefits, including:

- a more consistent approach across England, permitting better understanding of health preparedness at LRF level and nationally;
- leadership of planning and resilience at a senior level with a focus on cross-agency preparedness; and
- opportunity for better integration between health and local government emergency planning for the protection of each community.

The Department of Health published detailed information about these new arrangements in April 2013, addressed to local authority chief

executives and directors of public health as well as to NHS bodies.

### 33. Screening, immunisation and NHS England

***We urge the Government and the NHS Commissioning Board to listen to local authorities, to respond to their calls for reassurance and we recommend that the Government reviews the arrangements with a view to devolving these services to public health staff within local government.*** (Report paragraph 125)

National screening and immunisation programmes are essential public health interventions. Each of the key partners in the new system has its own responsibilities for which it is accountable. This includes PHE's responsibility for providing the system leadership and specialist public health advice and information to ensure consistency in efficacy and safety across the country. Under the terms of the 'section 7A' agreement between the Department of Health and NHS England, and national service specifications that support it, NHS England is responsible for routine commissioning of national screening and immunisation (as well as children's public health services from pregnancy to age five, child health information systems, public health services for people in custody and sexual assault referral centres) and the collection of information on disease and coverage.

Local authority directors of public health have a defined role, particularly in the oversight of screening and immunisation services, to ensure that the needs of the population, including equitable access are met. We believe that organising services in this way will mean a consistent and effective approach to commissioning and rigorous programme governance at all levels, with clear oversight

of performance and outcomes and action on any quality concerns.

## 34. Childhood services

***Given the importance of early years interventions, and the reach that local authorities have into their communities, the Government should work with councils on devolving further responsibilities for children's public health, such as the Healthy Child programme, to local government—and guarantee at least that responsibility for health visiting will be transferred to local authorities in 2015, or when the target for increasing health visitors has been met, whichever is earlier. The Government should, as part of a general move to locate children's public health services in local government, also agree to a timescale for placing childhood immunisation services under the control of Directors of Public Health, in acknowledgement of their previous responsibility for this area and of the pivotal position that they now occupy in local public health provision.*** (Report paragraph 128)

The Government remains committed to transferring commissioning of children's public health services from pregnancy to 5, including the Healthy Child Programme, to local authorities from 2015. It is essential to get this important transition right, and we have started a process of engagement with the key parties across the NHS and local government to ensure that commissioning responsibilities are transferred safely.

Local authorities, through their directors of public health have duties to offer advice to clinical commissioning groups on public health matters and to advise NHS England, Public Health England and providers about protecting the health of the local population,

which can include immunisation plans. Local authorities can challenge those plans where necessary. PHE will support DsPH through the provision of data and information on performance against standards.

## 35, 36. The final funding allocation

***Given that local authority public health budgets have now been set for 2013–14 and 2014–15, the Government has time to plan with local government a managed approach to allocating the budgets for 2015–16. We therefore recommend that the Government puts in place a timetable for publishing and consulting on the 2015–16 allocations with a view to finalising them by October 2014, so that commissioners and providers have at least six months in which to plan strategically the services that will contribute most effectively to local people's health and wellbeing in 2015–16.*** (Report paragraphs 137, 138)

The Department of Health appreciates that local authorities need as much certainty as possible for future planning purposes, which is why in January 2013 we made allocations for both 2013-14 and 2014-15. However, local authority allocations are just one of a set of complex and interrelated financial decisions the Departments must take. These decisions will be based on the conclusion of the 2015/16 spending round led by the Treasury. As such, the Department is unable to commit to a timetable at this stage.

37, 38, 41, 42, 43. The revised funding formula, demand-led services, re-charging for non-residents' use of services, funding in the long term

***We recommend that the Government not only ensures the Advisory Committee on Resource Allocation (ACRA) makes good on its commitment to review the allocation formula, but clarifies the timetable for revising it—and whether this means a revised formula in time for the 2015–16 allocations. Just as local authorities need to know well in advance when budgets will be published, they require also some certainty about the formula that will be used to calculate them.*** (Report paragraphs 141, 142)

***We recommend that the Government and the advisory committee, as part of their commitment to keep this area under review, consider alternative formulas for calculating the overall ring-fenced grant, such as the index of multiple deprivation, and how such allocations might take better account of local circumstances.*** (Report paragraph 150)

***We call on ACRA and the Government to work with local authorities on the issue of non-residents' use of demand-led services. Given that many people work or go out in one borough and live in another, people's use of services in this way should not be underestimated. Attempting to resolve that either by pooling resources or by recharging has the potential to become complicated and contentious.*** (Report paragraph 151)

***We urge local authorities and the Government to explore innovative approaches to funding public health services. One route might be to determine***

***the actual cost locally of demand-led services and to separate funding for them from the rest of the public health budget. The remaining public health provision could then be determined using a formula, such as the standard mortality ratio, and either continue to be ring fenced or stand apart from the rest of the authority's budget. Alternatively, the remainder might, as witnesses suggested, correspond to the remainder of the local authority's overall budget and become in all but name a community budget.*** (Report paragraph 154)

We will ensure transparency in our approach to finance allocation for 2015/16 and beyond. The Advisory Committee on Resource Allocation (ACRA) has already begun work on reviewing the allocations formula and is in the process of gathering evidence to inform the revision on the allocations formula.

ACRA only recommends the relative distribution of resources. The final allocation to each local authority will be based on the total quantum available after the 2015/16 spending round led by HMT and internal allocations decisions based on ministerial commitments. To ensure fairness and transparency, the work in progress subject to final decisions being taken will be published. When announcing the final allocations the Department will publish all relevant documents on external facing websites as it did for the 2013/14 and 2014/15 allocations.

In general, it is for local authorities themselves to decide the extent to which it is appropriate for them to offer services to people who normally live outside their area, taking into account factors such as the availability of funding and other services. Clearly, though, a level of cross-boundary service provision will be appropriate or – in the case of sexual health services – required.

In the case of sexual health, when public health resources allocations for local government were published on 10 January 2013 ACRA also published its view that cross-charging is the best way to handle service use by non-residents. We expect this to be an issue that ACRA keeps under review as it considers the allocations formula.

### 39, 40. The Health Premium

***The Government's approach to public health funding leading up to and after 2015–16 seems confused and should be clarified. It says it has no timetable for modifying the current funding formula, but accepts that, given the impact of the Health Premium, the formula will need to be developed in 2015–16. Local authorities will need to know, first, when they can start planning their budgets for 2015–16, second, when the Government intends to redevelop the funding formula, and, third, that any system of reward will complement their main source of funding.***  
(Report paragraph 145)

***The Government has acknowledged that the perverse incentive in the current funding formula would be particularly marked if it were still in place when the Health Premium was introduced. This suggests that the current funding formula and possibly the Premium need to be revised. A funding system which at the same time disadvantages and rewards improvements in public health cannot be fit for purpose. The Government has said that 2015–16 will be a key year in the development of the formula. We recommend that a parallel system of reward should not be implemented in the same year. It should be delayed until the funding formula has been redesigned.***  
(Report paragraph 146)

As part of the 2013/14 funding allocation process, local authorities' baseline expenditure for 2013/14 has been established. 2015/16 falls into the next spending round period, and it is not helpful to speculate at this stage on how this money will be spent.

The health premium incentive will reward communities for improvements in health outcomes they achieve, and incentivise action to reduce health inequalities. The indicators to measure outcomes will be based on the Public Health Outcomes Framework. This work commenced in April and the Health Premium Incentive Advisory Group is currently looking at the PHOF indicators to select indicators that would lend itself to health premium incentive measure. We plan to publish the health premium local and national indicators in the autumn and roll out to local authorities in 2014/15 and make the first payment in 2015/16.

### 44, 45. Community budgets

***We urge the Department of Health to work with the Department for Communities and Local Government and to share that learning as soon as possible, in order to clarify what funding mechanism will be proposed for the financial year 2015–16 and beyond—with a view to removing the ring fence and moving to community budgets. In addition, we urge the Government and, in particular, the Department of Health to recognise that if public health is to become an overarching priority for all local authority departments, it will require an overarching budget which reflects that approach. If the evidence from the completed Total Place and ongoing Community Budgets pilots continues to point to their effectiveness, we recommend the Government provides local authorities with community,***



***place-based, budgets for the direction of resources at people and places rather than at organisations.*** (Report paragraph 161)

***There is also a role for Health and Wellbeing Boards to play, given their duty to encourage integrated working, by devising joint strategies that allow local authorities to use existing levers in the final funding settlement to pool public health budgets with those of other departments and across authorities, thereby demonstrating to central Government how shared resources can improve outcomes. In this endeavour, Directors of Public Health will remain central to the budgeting process if and when the ring fence is removed.*** (Report paragraph 162)

No decisions have yet been made on local authority funding in 2015/16. We are, though, encouraged by the modelling that has been done by the four community budget pilot sites and their estimated improvements in efficiency and outcomes. To build on this, a national partnership of agencies involved in health, care and support has invited expressions of interest from local areas in becoming 'pioneers' in integrated services. These pioneers will help to drive forward change across the country, with support from the national partnership. We agree that health and wellbeing boards have an important part to play in encouraging and facilitating integration.







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