



Healthy Lives, Healthy People

Impact Assessments

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Healthy Lives, Healthy People

Impact Assessments

Prepared by Public Health Development Unit

Healthy Lives, Healthy People – Impact Assessments

Overview

1. This suite of impact assessments accompanies the public health White Paper *Healthy Lives, Healthy People*. The impact assessments directly impact the public sector only. They are integrally linked to the impact assessment accompanying the Health and Social Care Bill. The overall policy of setting up the public health service depends on, and is integrally related to, the changes in the health service domain, including the National Health Service (NHS) and (other) providers. This is set out in *Equity and Excellence: Liberating the NHS*. These plans entail disestablishing existing NHS bodies where some public health workforce currently reside, namely Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs).
2. The overarching policy objective is to protect the public, and to improve the healthy life expectancy of the population, improving the health of the poorest fastest, by establishing a public health service incorporating both national and local structures. There are five critical workstreams under this objective. Each workstream has prepared an Impact Assessment:
 - Impact Assessment A on the Structure of Public Health England – relationship to the Department of Health, NHS and workforce issues (ref IA3024);
 - Impact Assessment B on Commissioning within the public health system– how public health interventions will be designed and purchased (ref IA3025);
 - Impact Assessment C on the Ring Fenced Funding of Public Health England – how it will be funded, including local areas (ref IA3026). This is a consultation stage Impact Assessment;
 - Impact Assessment D on Public Health Outcomes – what framework and indicators we could use to monitor and drive improvements (ref IA3027). This is a consultation stage Impact Assessment; and
 - Impact Assessment E on Information and intelligence – how the public health service will collate and disseminate evidence (ref IA3028). This is a consultation stage Impact Assessment.
3. An effective health visiting service is a crucial public health function and there is a need to increase the size of the workforce. The Coalition Agreement set out a commitment to increase the number of health visitors by 4200. *Healthy Lives, Healthy People* sets out more details on this policy. Impact Assessment F is on Health Visitors (ref IA3030).

Introduction

4. As a nation we are living longer, healthier lives than ever before. However, we know that too many of us damage our health through the choices we make in living our lives and we know that we need to be ever-vigilant in protecting people from hazards to health (such as infectious diseases) where individuals cannot readily protect themselves.
5. Public health services need to be organised and generally commissioned and, in some cases (particularly for health protection), provided by the Government. They confer significant population benefits, but there is little incentive for private providers or local communities to provide such services. Particularly in the case of health protection and public health emergencies, there would be a substantial downside if such services were not provided.
6. There is no single accepted definition of what constitutes public health services. In broad terms they are concerned with the health of the population in general, rather than the provision of specific diagnosis or treatment services to individuals. Or to put it another way, generally they involve an assessment of the needs, patterns and demands influencing health improvement and protection requirements for a whole population or group, rather than a physician-level identification of need for treatment in specific individuals. For example, vaccination and screening (e.g. breast cancer screening) are services provided across the whole of the population (or a group within the general

population), where public health experts design an intervention which is then delivered (generally by the NHS) to the members of a defined group.

7. A new national approach to the organisation and delivery of public health service is required, both to ensure that accountability for health protection is clarified and enhanced, and that health improvement is effectively led, in the context of significant structural changes in the health sector, fundamentally affecting parts of existing public health services. Additional efficiencies will be need to be found in the design and organisation of the public health system, given the expected changes in public sector funding in future.
8. At the local level existing arrangements separate the health actions from other determinants of public health i.e. housing, education etc. and this limits flexibility on the approach to improving public health outcomes and reducing health inequalities. A more outcome-focussed approach with more local discretion is needed.
9. It is important to recognise that the healthcare system already provides a significant level of public health type interventions, and will continue to do so in a future, For example, in a consultation with a patient, a clinician may advise him or her about lifestyle factors.

Current public health system

10. At present, activity to improve public health and provide health protection (i.e. protection from infectious disease, contamination and environmental hazards) is generally seen as distinct from the diagnosis and treatment of disease, but is the responsibility of various different bodies within England:
 - a. The Secretary of State for Health (SoS) and various NHS bodies have a role within health improvement as part of the existing healthcare system. For example, PCTs commission various services for their local populations (e.g. stop smoking support; weight management) and GPs may choose to refer people who smoke into these services, or to provide brief interventions themselves as part of general practice. Hospital Trusts may also provide health improvement interventions for their patients, such as helping people who are due to undergo surgery to quit smoking, or to provide weight management support for people undergoing bariatric surgery.
 - b. Various NHS bodies also have a role with respect to health protection, for example, delivering immunisation and vaccination programmes that help to protect the local population from disease, and for preparing for, and responding to emergencies with a health dimension.
 - c. Local authorities have a role in relation to health protection and in practice have responsibility for a number of areas that affect public health (e.g. housing, environmental services).
 - d. The Health Protection Agency (HPA) has significant responsibility for health protection, including an advisory and expert role, with the frontline responsibility for health protection activity divided between the HPA and local authorities.
 - e. The National Treatment Agency for substance misuse has responsibilities with regard to the health improvement issues surrounding drug abuse. They provide advice and support to NHS bodies to develop interventions that are more effective in helping people who are addicted to drugs.

Opportunities to improve public health outcomes

11. Public health outcomes in this country often fall behind those of other countries. Examples of areas for improvement include:
 - **Cancer** is responsible for a half of female deaths under age 65 and incidence is higher than in other countries for both sexes. Recent estimates suggest that over 30% of cancer is preventable.
 - It is estimated that over 50% of **circulatory disease** deaths could be prevented, relevant factors include diet, smoking and physical activity.
 - **Respiratory diseases** are responsible for 14% of all adult deaths and mortality rates are very high compared to other countries - the mortality rate for females under 65 is double the EU15 average.
 - 20% of people suffer from a **musculoskeletal condition** and it is estimated that the high average impact on health makes musculoskeletal conditions responsible for up to half the overall long-term health burden on society, mainly due to pain and loss of mobility.

- A rapid rise in **diabetes** is projected such that by 2030, almost 1 in 10 people are expected to have the condition. Type 2 diabetes is largely avoidable and the rise is associated with rising obesity levels. **Other digestive diseases** and liver disease are also expected to rise: both associated with rising obesity and long term rises in alcohol consumption.
- Almost 1 in 5 adults experience **mental ill health** at any one time and there is evidence that prevalence has been rising over the last 2 decades. Mental ill health can have a very significant impact on overall health and accounts for a considerable share of the overall burden of disease and tends to be concentrated amongst disadvantaged groups including older people, those who are already sick and those who are poor.
- Whilst **infectious diseases** no longer seem a large threat to the health of the nation, there is evidence that this may change. Drug resistance remains a challenge, and cases of some diseases such as tuberculosis have been rising in recent years.
- Although **infant mortality** is at an all-time low, we have the highest rates of infant mortality in the EU15¹. Health inequalities within England are exacerbated by a 70% gap in infant mortality rates between managerial and professional and routine and manual groups.
- As Michael Marmot's Independent Review of Health Inequalities <http://www.marmotreview.org/> has extensively demonstrated, there are large variations in health that are systematically concentrated and persistent within sub groups of the population in England. There are concentrations of both shorter life expectancy and greater disability and these tend to be, although not exclusively, in some of the poorest areas of England. This means that people living in disadvantaged areas are more likely to bear a higher burden of ill health and Marmot describes this as evidence of a social gradient in health. In addition, the impact of poor health and the risk of an early death are not evenly distributed across the population. Rather, they tend to follow a social gradient² with the worst health and earlier deaths concentrated amongst those with the least education, the unemployed, those in manual or routine jobs and those who live in deprived areas.

A fragmented public health system

12. The current public health system has grown up organically and as a result is fragmented not making the most of potential synergies across services. This could lead to inefficiencies due to overlapping responsibilities and activities as well as loss of opportunities to make a more positive impact on public health through the lack of clear accountability.
13. Thus at the national level there is a clear rationale for accountability for health protection to rest with central government, as the nature of various threats to health (ranging from infectious disease to terrorist attacks) are not generally amenable to individual or local action, but require clear "command and control" arrangements, resting on a clear line of sight from the centre of government down to local services. This requires a system which is more integrated and less dispersed than the present one.

A national approach misses localised opportunities

14. With respect to health improvement functions, there is currently little freedom for local communities to design and deliver local solutions for the particular challenges they face, within a rigorous framework of evidence and evaluation. Centrally designed and developed approaches, such as national campaigns, may be ill-suited to meet the needs of particular groups within a population. This may lead to a waste of resources and lack of effective interventions for particular groups, which could exacerbate inequalities.

A healthcare based approach misses opportunities to impact wider determinants

15. Public health expertise can be overlooked in the healthcare dominated NHS organisations, leading to fewer public health specialists, reduced spend on public health overall, and poor understanding of how to use public health evidence to deliver or commission appropriate interventions.
16. Since 2002, the primary responsibility for commissioning NHS and public health services has been led by PCTs. However, there is evidence that combining the responsibility for commissioning health services and public health services under PCTs has meant that only a low priority has been given to public health; thus in 2005-6 when PCT budgets were under pressure, public health

¹ Department of Health (2010) *Health Profile for England 2009*, page 64

² Marmot Review 2010

budgets were severely cut to provide for cutting deficits in acute trusts and PCTs. This argues for ensuring there is a clearer focus locally on public health, undistracted by the demands of commissioning acute and other health care.

17. Last year a report from the King's Fund suggested that "NHS staff may... lack the skills necessary to interpret (data) accurately and use it to develop or adapt behaviour change interventions. As well as drawing on local health professionals' knowledge (whether GPs, health visitors, or other primary and community care staff), PCTs should be making full use of available data on the local population from a wide range of sources. To do so, they should ensure they have the necessary skills to interpret this data and to develop targeted interventions using the insights provided by the data.³
18. Although local authorities have statutory **duties** to work in partnership with PCTs and others to achieve improvements in public health, and do have wider powers of wellbeing in the non-health area, working together with the health sector to tackle public health issues has not always been a priority. However, many of the wider determinants of health (e.g. housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations. Local authorities are in principle well-placed to take a very broad view of what services will impact positively on the public's health, and combine traditional "public health" activities with other activity locally to maximise benefits.

Driving the Solution: rationale for Government intervention

19. Bringing together the existing different public health bodies into a streamlined public health service, and shifting local drivers for public health from NHS bodies to local authorities requires central Government-level leadership and strategic oversight.
20. The Department is aware of the requirement to achieve efficiency savings with respect to central government administration. Any changes to workforce and associated costs relevant to the Health Protection Agency (HPA) and the National Treatment Agency for substance abuse (NTA) will need to be considered along with changes to the Department of Health and other Arms Length Bodies. Further analysis on this point will be required in the context of the whole department, and therefore a reduction in workforce for the HPA and NTA has not been considered in the impact assessments.
21. The Impact Assessments in this document impact directly on the public sector only.

Post implementation Review

22. The policies outlined in this impact assessment will be reviewed as they proceed through the consultation stage to the final policy stage. The intention is to review the final policies after implementation to evaluate whether the changes have delivered the anticipated benefits. A post-implementation review plan is at Appendix 1.

Specific Impact Tests

Equality impact assessment

23. A full screening for equality impacts, and an action plan, is attached at Appendix 2.
24. We believe that the creation of a public health service, Public Health England, has potential to make a positive impact on equality groups through reducing the barriers and inequalities that currently exist. However, more evidence is needed for a detailed assessment.
25. Regarding the transfer of staff from the HPA and the NTA to the Department of Health, we would expect a neutral impact given that at this time, all staff within those organisations as of 31 March 2012 will transfer on 1 April 2012.

³ Boyce, T, Commissioning and behaviour change, Kicking Bad Habits final report, Kings Fund, 2008

26. The proposed ring-fenced budget has the potential to have a positive impact but until policy options are clarified, it is too early to accurately determine the impact.
27. The Public Health Outcomes Framework and indicator set has the potential to contribute to a reduction in barriers and inequalities that currently exist. However, as this work-stream is under development, there is not enough evidence to make this assessment. However, as the Outcomes Framework seeks to contribute to promoting equalities in health for the whole population, a negative impact is unlikely.
28. It is likely that improving collection and dissemination of public health information will have a positive effect on equality as better understanding of the outcomes of different groups help to promote better targeting of effective interventions.
29. We anticipate that the commitment to increase health visitor numbers would have a positive impact on disadvantaged groups. The policy intention is to improve health outcomes by ensuring continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and arrange of interventions for those with greater needs, championing wider health and wellbeing, prevention and public health and building family and community capacity. This is likely to have a particular impact on women (and pregnant woman and socio-economically disadvantaged children
30. By making the proposed changes to social marketing, we would anticipate a positive impact on equality groups by better targeting information campaigns and ensuring there is a meaningful and trusted voice delivering relevant messages.
31. **As we move into the consultation phase of the White Paper and outline the available options, we will be in a better position to make an accurate assessment. Discussions with stakeholders will better equip us to mitigate any potentially negative impacts.**

Health impact assessment

32. The policies on the development of the new public health system and health visitors are likely to contribute to significant positive impacts on health and wellbeing of the population and indeed is the primary purpose of the overarching policy.
- **Will the proposal have a direct impact on health, mental health and wellbeing?**
The overarching policy aim is to protect the public and improve the healthy life expectancy of the population, improving the health of the poorest fastest. It will do this by establishing a new public health system. This should ensure that health protection is clarified and enhanced and that health improvement is effectively led. The Public Health Outcomes Framework should provide a vision for the future of public health and demonstrate a mechanism for how it can be achieved. Spending on public health services will also be safeguarded by the establishment of a ring-fenced budget. Health visitors also provide direct services as well as supporting and encouraging other health professionals to help promote health. The skills of health visitors, working with individuals and communities should maximise health outcomes and reduce inequalities. The policies should therefore have a positive impact on health, mental health and wellbeing.
 - **Will the policy have an impact on social, economic and environmental living conditions that would indirectly affect health?**
The transfer of health improvement functions to local authorities will unlock synergies with the wider role of local authorities in tackling the determinants of ill health and health inequalities. This would address problems with the current arrangements that separate health actions from other determinants of public health. Local authorities will have autonomy to make health improvement initiatives and innovations that encompass social, economic and environmental living conditions, which could have a positive impact on public health. The establishment of health and wellbeing boards in local authorities could also ensure wider determinants of health are considered.
 - **Will the proposal affect an individual's ability to improve their own health and wellbeing?**

Local authorities are well placed to make decisions that take a broad view of the needs of their population. Local authorities can combine public health activities with other activities that could lead to an individual's ability to improve their own health and wellbeing.

- **Will there be a change in demand for, or access to, health and social care services?**
A unified public health system should ensure that protecting and improving health will be provided in an efficient and cost-effective manner. This may lead to an increase in primary care services and a decrease in secondary care services with an overall reduction in demand for health and social care services.
However any changes in demand to access to health and social care services as a result of this policy would need to be considered in the wider context of changing demographics.

Rural Proofing

33. The policies on the development of the new public health system and health visitors are unlikely to have a significant impact on rural areas or people. The transfer of health improvement functions to local authorities will unlock synergies with the wider role of local authorities in areas such as transport or housing and could therefore lead to a positive impact for rural areas. In formulating their policies for public health interventions, local authorities would be expected to consider their impact on rural areas.

Impact Assessment A: Structure of Public Health England

Title: Structure of Public Health England Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 3024
	Date: 30/11/10
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

What is the problem under consideration? Why is government intervention necessary?
 A new national approach to the organisation and delivery of public health services is required to streamline and integrate existing health protection and improvement bodies and functions and thereby improve the health of the population. Existing local arrangements for delivery of public health separate action on health from other determinants of public health, eg. housing, education etc, limiting the scope for improving public health outcomes and reducing health inequalities. At the same time, significant structural changes in the health sector necessitate new arrangements for public health delivery.

What are the policy objectives and the intended effects?
 The over-riding policy objective is to protect the public, and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest, by establishing a new public health service, Public Health England, incorporating both national and local structures. There are two relevant objectives:
 1. At a national level, set up the public health service (Public Health England)
 2. At a local level, transfer the responsibilities for public health and the post of Director of Public Health, from NHS Primary Care Trusts to local authorities
 The intended effects of these changes are to create efficiency and to improve public health outcomes, including addressing health inequalities.

What policy options have been considered? Please justify preferred option (further details in Evidence Base)
 With regard to objective one:
 A. Do nothing
 B. (preferred option) Set up Public Health England as part of the Department of Health and move Directors of Public Health to local authorities

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?	See Annex
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

Ministerial Sign-off

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:  **Date:** 27/11/2010

Summary: Analysis and Evidence

Policy Option B

Description: Set up Public Health England as part of the Department of Health and move Directors of Public Health to local authorities

Price base year 2010	Pv base year 2012	Time period 10 years	Net benefit (present value (pv)) (£m)		
			Low: Redacted	High: Redacted	Best estimate: Redacted

Costs (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total cost (present value)
Low	£ Redacted	£ Redacted	£ Redacted
High	£ Redacted	£ Redacted	£ Redacted
Best estimate	£ Redacted	£ Redacted	£ Redacted

Description and scale of key monetised costs by 'main affected groups'

Transition costs: Transfer of HPA staff to Department of Health – **Redacted**, Transfer of DsPH and some public health PCT staff to local authorities - **Redacted**
 Annual costs: Increased employer pension costs - **Redacted**, Extra funding needed to deliver the same public functions as currently (due to loss of HPA income generation): **Redacted**

We have redacted figures which could compromise the commercial activity of the HPA or prejudice negotiations with staff prior to formal consultation.

Other key non-monetised costs by 'main affected groups'

NA

Benefits (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total benefit (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised benefits by 'main affected groups'

Na

Other key non-monetised benefits by 'main affected groups'

A unified public health service, incorporating both national and local structures, should provide a streamlined and efficient service which will make a positive impact on health and improve health outcomes. These benefits have not been quantified but are discussed in paragraphs 24-41.

Key assumptions/sensitivities/risks

discount rate 3.5

This assessment does not include any costs or benefits arising from the reduction in administration costs across the ALB sector as a whole, DH or the NHS.
 Salaries of staff transferring into DH will not rise at greater than the rate of inflation
 The value of HPA income generation would not have risen faster than the rate of inflation
 The cost of pension liabilities resulting from contractual changes as part of the transition for HPA staff to civil service contracts and the transition of DsPH and other PCT staff to local authority contracts is a key sensitivity. Key risks include the loss of the skilled and specialist workforce and the potential loss of HPA's income generating function.

Direct impact on business (Equivalent Annual) (£m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:		

What is the geographic coverage of the policy/option?		England			
From what date will the policy be implemented?		01/04/12 for HPA			
Which organisation(s) will enforce the policy?		N/A			
What is the annual change in enforcement cost (£m)?		N/A			
Does enforcement comply with Hampton principles?		N/A			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		Traded:		Non-traded:	
Does the proposal have an impact on competition?		No			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs:		Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ⁴ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

⁴ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

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

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

No.	Legislation or publication
1	<i>Equity and Excellence: liberating the NHS</i>
2	
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years). The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices. Redacted text marked by [REDACTED]

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs - low	[REDACTED]									
Transition costs - high	[REDACTED]									
Annual recurring cost -	[REDACTED]									
Annual recurring cost -	[REDACTED]									
Total annual cost - low	[REDACTED]									
Total annual costs -	[REDACTED]									
Transition benefits										
Annual recurring										
Total annual benefits										

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



Microsoft Office
Excel Worksheet

Structure of Public Health England

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health White Paper. Other impact assessments in this suite are:
 - Commissioning within the public health service (IA3025)
 - Ring-fenced funding of public health (IA3026),
 - Public Health Outcomes Framework (IA3027),
 - Information and intelligence for public health (IA3028)
 - Health visitors (IA3030)
2. This Impact Assessment considers the structure of the public health service. It impacts directly on the public sector only.

What are the policy objectives and the intended effects?

3. The overarching policy objective is to streamline existing public health bodies and functions in order to maximise synergies and efficiencies thereby improving public health, increasing efficacy of health protection, and ensuring the system offers value for money.
4. At a national level, this relates to bringing together a number of existing public health organisations into a single public health service, directly accountable to the Secretary of State.
5. At a local level, the objective relates to locating the Director of Public Health in either a local authority or within GP consortia.
6. We would anticipate seeing increased efficiency and efficacy as a result of the system changes, leading ultimately to financial savings and improvements in public health outcomes.
7. The preferred options are not for consultation.

What policy options have been considered?

National structure

8. We have considered two options in relation to the national structure of Public Health England.
 - A. Do Nothing
 - B. Set up the public health service as part of the Department of Health (DH)
- A. Do Nothing
9. Currently, the public health system incorporates a number of organisations, primarily:
 - Department of Health policy and analytical leads
 - NHS
 - Strategic Health Authorities – Regional Directors of Public Health and their teams
 - Primary Care Trusts – Directors of Public Health and their teams
 - Health Protection Agency
 - National Treatment Agency for substance misuse
 - Several information services including public health observatories and various registries
10. This list does not include all those who contribute to public health or who are part of the broader public health system, which would include, for example, clinical staff of the NHS and local authority staff, such as environmental health officers. However, it does include those involved in leading specific aspects of public health, including either or both delivery and commissioning of appropriate interventions. These are the elements of the public health service with which we are concerned in terms of the new public health service.
11. The Do Nothing option is not viable because:

- In light of the disestablishment of SHAs and PCTs, and given the vital nature of their work, there is a requirement to ensure public health expertise and workforce is located elsewhere.
- Maintaining the status quo is unlikely to meet the overall objective of effectively protecting and improving the health of the population, improving the health of the poorest, fastest.
- In view of the need to achieve significant cost efficiencies in order to respond to the financial challenge facing the public sector, we need to maximise use of shared corporate services and minimise duplication in activity across different organisations.

B. Set up Public Health England as part of the Department of Health (DH)

12. This is our preferred option. Alongside the proposals in the White Paper *Equity and excellence: liberating the NHS* it supports a fundamental change in the role of the Department of Health that is intended to unify accountability for the protection and improvement of public health in England, bring it into the heart of national government under the Secretary of State for Health, and sharply reduce government's role in the management of the NHS.
13. The HPA is just one component of a public health system that is currently fragmented and relatively opaque, spread across central government, local government, the NHS and other arms length bodies such as the Food Standards Agency (part of which has been recently integrated into DH) and the National Treatment Agency for substance misuse (which will also be integrated). The objective is a co-ordinated and coherent public health service with clear leadership, accountable to Parliament and the electorate, that can respond quickly and flexibly to threats to public health. The Secretary of State, in his role as chairman of the new Public Health Cabinet Committee, will also be able to bring to bear the combined expertise of the public health service across government. To carry out that oversight and directional role effectively the Secretary of State needs a public health service that he is able to deploy flexibly as needs arise and change, without further potentially costly reorganisations. That realistically can only be delivered by a service which is integrated within the Department of Health.
14. The alternative, such as a public health service housed in an organisation at arms length from the Department might reduce short-term transition costs but would not deliver that integration, flexibility and close oversight of key public health functions which is the essence of the Government's plans. A body which focused on the current HPA functions and did not include the intelligence and analysis functions would perpetuate the current fragmentation. On any arms length model, there would be a real risk that, over time, the body developed its own agenda and became less responsive to the wishes of Ministers, who will be taking personal accountability for the successful operation of the system.
15. At the moment within the UK, there is a very rich range of bodies producing intelligence, information and analysis. However, this has grown up in a piecemeal fashion, resulting in a lack of overall coherence with duplication and gaps within the system. Bringing together these functions offers the opportunity to maintain high quality, streamlined services. This should enhance user accessibility and ease of access which should in turn mean the available data is more likely to be used. In addition, creating Public Health England should ensure gaps in the current evidence base are more readily identified. The decisions to commission research and development will be better informed as the Department will have better access to information which means we will be able to better target resources.
16. Anecdotally the relationship between the Directors of Public Health and HPA colleagues had not always been as effective as it might be. By clarifying the relationships between the local leadership (DsPH), the local public health service (Health Protection Units) and the rest of the public health service is vitally important. The clarification of relationships is essential in ensuring the most effective possible response to health emergencies.
17. In summary, the benefits of a unified public health service should include:
 - clearer, stronger lines of accountability through to the Secretary of State;
 - a more responsive and adaptable service;
 - more effective analysis and application of evidence, intelligence and data;

- wider government engagement with the improvement and protection of health, with more direct access to the experience and advice of front-line health protection staff.

Local structure

18. We have considered three broad options in relation to the local structure of the public health service.

- A. Do Nothing
- B. Move Directors of Public Health to local authorities
- C. Move Directors of Public Health to commissioning consortia

A Do Nothing

19. In light of the disestablishment of SHAs and PCTs, and given the vital nature of their work, there is a requirement to ensure public health expertise and workforce is located elsewhere so the do nothing option is not viable.

B Move Directors of Public Health to local authorities

20. This is our preferred option. Currently, DsPH are employed by NHS Primary Care Trusts, limiting scope for influencing the wider determinants of health, such as housing, education, transport and the built environment. Locating DsPH within local authorities will enable greater synergies with other local government responsibilities, increasing the likelihood that public health outcomes can be improved through effective joint working. For example, a DPH may influence, and potentially support with ring-fenced public health funding, other local authority directors to ensure investment in transport planning took account of the need to increase physical activity of the local population. This would enable local authorities to meet their local community's needs in both reducing congestion and improving public health. DsPH will be jointly appointed by the Secretary of State and local authorities and employed by the local authority.

21. We intend to locate DsPH within upper-tier and unitary authorities. This broadly corresponds to existing provision of public health expertise, with DsPH sitting within PCTs, that are often coterminous with these local authorities. We recognise, though, that many existing public health functions within local authorities take place at the lower-tier, district councils, for example, environmental health officers. We anticipate that local areas will build on existing relationships between the tiers to enable effective public health commissioning at the local level, though this will be subject to local discretion and arrangements. Furthermore, some local authorities may choose to amalgamate DPH roles across boundaries, as some authorities are already considering for other posts within local government. This is a response to the efficiency agenda and will be for local determination to balance cost-effectiveness with the drive for locally-relevant services and strategy.

22. There is a risk associated with moving DsPH to local authorities regarding healthcare public health and the reduced influence and access to information DsPH will have on commissioning and monitoring healthcare services from a population perspective. This could be negative both for local public health in terms of reduced leverage over whole care pathways for DsPH, but also for NHS commissioning in terms of reducing the cost-effectiveness of commissioning. To ameliorate this risk, we are working closely with professional public health organisations, departmental colleagues and stakeholders involved in the design of the NHS commissioning board and supporting development of GP consortia. Collaborative working will enable us to develop a joint solution that meets the need both of public health and healthcare commissioning.

C. Move Directors of Public Health to GP consortia

23. This option would ensure consideration of population health remained within healthcare commissioning. However, it would not enable improved focus on public health within local government, nor would it provide Secretary of State with line-of-sight accountability for the public health service. We anticipate GP consortia will require significant input from public health

expertise, including DsPH. The health and wellbeing board will provide formal opportunities for this to take place, though informal local relationships and arrangements may develop over time.

Preferred Option: Impacts, Costs and Benefits

This policy will not have any direct impact, positive or negative, on the private or civic society sectors.

Discussion of the current strengths and weaknesses

24. As presently constituted, the HPA carries out a good deal of essential work. Some teams within the organisation have hard-won international reputations in their respective fields, and there are good examples of timely coordination with DH to support national policy, involving appropriate and efficient division of labour. To give two examples:
25. The recent volcanic ash incident saw excellent coordination between DH Health Protection and Emergency Preparedness Divisions and the Health Protection Agency's Centre for Radiation, Chemical and Environmental Hazards to produce a consolidated health risk assessment for specific scenarios generated by the Scientific Advisory Group for Emergencies (SAGE) and the COBRA Situation Reports.
26. One of the major successes of the UK response to the 2009 Swine Flu pandemic was the investigation and database which followed a significant numbers of the early cases and their contacts, the so-called 'FF100'. This rested on the close working relationship between the surveillance experts at the HPA and the modellers both in HPA and DH. This meant that the features of the raw data (i.e. reporting delays, laboratory delays) could be properly understood and incorporated into the analysis.
27. However, HPA's status as a separate body makes it more difficult to ensure that its activities match national priorities – that its work is addressing the questions that most need answering. At present, DH funding for HPA activity comes from a mixture of core Grant-in-Aid (GiA), and funding for specific additional projects either through additional GiA or through research projects. (In addition, as stressed elsewhere, HPA generates a significant amount of external funding.) This can lead to loss of clarity in distinguishing between what HPA is doing as part of its core function, and what it is being contracted to do as additional project work. In addition, use of research funding has meant that to comply with EU regulations projects have had to go out to competitive tender even if in reality HPA was the only credible bidder. This can introduce significant delays in getting the required work started. In one instance, DH needed to know whether to continue piloting an intervention against a common infectious disease. A full academic level analysis was not required initially, and HPA had the capacity and expertise to take the work forward quickly. However, the need to treat this as a 'research project' required that the project go out to competitive tender. HPA provided a bid sufficient to meet the DH requirement, but insufficient to meet the requirements of a full academic research proposal. The work eventually proceeded, but only after considerable delay.
28. Most importantly, getting good value from project work is critically dependent on (a) setting up and agreeing contracts against well-defined specifications and (b) active and effective project-management thereafter, taking account of any changes in circumstances or policy needs. The former can be time-consuming to define and negotiate, while any failure to project-manage effectively risks wasted effort and production of work that does not meet policy needs. Although there are again examples of good practice, the current situation can fairly be described as patchy. Success is overly-reliant on individual initiative by staff (in both organisations) rather than stemming naturally from the organisational structure. Such success is consequently vulnerable to changes in key staff. The risk is that there may be little systematic way of holding the parties to key deliverables and timelines, and to reporting of progress and early warning of difficulties or slippage. HPA staff are not directly accountable to DH: they have their own management chain, and business priorities do not *necessarily* match the Department's – for example as to the relative importance of surveillance as compared to other tasks. Potentially, this risks delay in identifying public health problems.

29. The current arrangements for intelligence and analysis involve a wide range of bodies, including the HPA, Public Health Observatories and the Department. Whilst this has delivered rich sources of public health intelligence, there is also scope for duplication - for example, though production and use of separate Situation Reports. This is potentially wasteful, and also risks confusion as to whether, for example, HPA are providing independent information or speaking on behalf of Government. Taking a more systematic approach should also reduce the risk of “partially overlapping” roles leaving significant issues overlooked. At present, rapid sharing of information is also inhibited by lack of IT integration: for example, as a non-Civil Service body, HPA staff do not have gsi (government secure internet) email accounts, which restricts the material that can be sent.
30. In summary, although there are considerable strengths in the current arrangements, the disjoints in the system could make it more difficult to spot emerging public health problems at the earliest possible opportunity and therefore to respond where necessary as early as could be the case.
31. In this respect, the proposed integration of HPA and DH functions complements other steps to improve preparedness. In particular, the NHS Commissioning Board becoming directly responsible for assuring NHS preparedness and resilience, the related assurance and compliance mechanisms being put in place and the obligation to plan jointly with partner agencies (Public Health England itself, local authorities, Police and Fire services etc). This should deliver a more joined-up system with greater strength, clarity and accountability.

Benefits

Enhanced Use of Evidence

32. Effective use of evidence to underpin public health policy involves a number of steps, from research and generation of basic information through to provision of analytical policy advice⁵ The key benefit of the proposed change in structure at national level is to ensure that this “evidential chain” works in its entirety, and in an integrated way. This forms one key strand of the Department’s evolving Public Health Information Intelligence and Research Strategy.
33. Achieving this requires an organisational structure that can combine – and to some extent balance, *integration* of mechanisms to prioritise work and *coherence and cost-effectiveness* in information collection and management - e.g. collecting each given piece of information once and only once then making it available for a wide variety of uses (subject to appropriate safeguards) with *variety* in the types and sources of information and analysis used, allowing cross-checking and “triangulation” using independent sources and methods.

Integration as a Means of Reducing Costs

⁵ Using evidence to inform policy decisions: key Steps

Generation of data. In the Public Health context, this includes the results of laboratory work (on animals, human samples or inanimate materials), surveillance activity (some of which is experimental, e.g. serological testing, some of which is observational). HPA currently generates some of this primary itself, or contracts others to do so.

Interpretation of data into evidence – e.g. testing for statistical significance.

Information Management. As well as generating primary data, HPA is also active in bringing together and organising data from other sources, dissemination activity etc.. This is also reflected in HPA’s role in providing the scientific secretariat for various advisory committees.

Modelling. Although in some areas and for some purposes, information – e.g. statistical indicators – can be used to inform policy without much intervening analysis, there is more usually a need for modelling to provide the bridge between evidence and policy choices. Essentially, modelling may be needed to understand and assess *the potential impact of a given threat to public health, bearing in mind inevitable scientific uncertainties (for communicable diseases, this includes capturing the epidemiology; the likely effect of potential intervention; the effective organisation of interventions (“operational” modelling); cost-effectiveness of alternative choices.* Note that this will only be satisfactory if the previous stages have been adequately covered. (For communicable diseases, health economics needs to build on the epidemiology of transmission.)

Providing policy advice based on all the above, whether to DH policy teams or relevant Advisory Committees.

34. Abolishing various bodies and transferring their functions to Public Health England within the Department of Health will facilitate savings of around 30% to be made from back office and administrative functions during the Spending Review period. There is a process in place to identify the relevant figures for the bodies concerned.
35. It is arguable that 30% savings in non-front-line costs could be made in the bodies concerned without integration. This is potentially true. However, the purpose of integration is **not** simply to make savings, rather it is to develop a streamlined, integrated public health service which can maintain and enhance current performance but at significantly lower cost. Reducing the costs of the bodies without integration will make it challenging to do more than maintain existing performance, let alone make the improvements which can be delivered through integration. In addition, it is arguable that in the case of a smaller organisation reductions of these size would make it unsustainable, further strengthening the case for integration.

Benefits associated with a reduction in duplication of activity and filling in of gaps

36. Bringing the HPA and the NTA into the DH has the potential to reduce duplication in activity and, where appropriate, fill in the gaps that have previously fallen between organisations. This is particularly relevant with respect to information and intelligence, which currently operates across a number of organisations, including particularly the HPA and the existing DH.
37. The opportunity to better integrate intelligence may enhance the ability of the service to deliver what is needed and what works best. For example, we know that there is robust cost-benefit evidence that prevention and early intervention can break down cycles of inequality running through generations of families (Marmot et al, 2009). The economic returns of early childhood interventions exceed cost by an average ratio of six to one (NICE, 2009). A number of studies have demonstrated significant cost benefits from early years interventions, and particularly for long-term outcomes (Karoly et al, 2005). We believe that better alignment of information, analysis and intelligence, would put us in a better position to understand the most appropriate interventions and enable early intervention.

Benefits associated with better responsiveness

38. At the moment, there are many organisations with responsibility for public health functions. At an individual-level these organisations work well but the approach is not as co-ordinated as it could be. The proposed system changes will bring greater accountability for the SofS and a better overview of the whole system. Bringing functions such as the HPA and NTA and other bodies into the DH will ensure better alignment with national strategy.
39. Another potential benefit of drawing different public health bodies together is removing confusion and subsequent delays in responding to public health threats and emergencies. Having a streamlined public health service will improve clarity of accountability and remove the potential for duplication or gaps in activity due to lack of clear roles and responsibilities between different agencies and organisations.

Benefits associated with improved public health outcomes and a reduction in health inequalities

40. Ultimately, the objective of this legislation and the associated policy changes outlined in the public health White Paper is to improve the health of the population, improving the health of the poorest, fastest. In the Department's view, a first step to achieving this is to draw together under the Secretary of State all the different aspects of the public health system that could benefit from being part of a unified, professional public health service. We anticipate improvements in public health outcomes, and this is considered in more detail in Appendix D of this document.
41. We will endeavour to monitor the effectiveness of the public health service once it is in operation both through monitoring progress against the public health outcomes framework and the effectiveness and efficiency of delivering health protection and emergency response functions. This work would be led by the public health service information and intelligence elements, but

overseen by other parts of the Department of Health, who will support Ministerial challenge of the service.

Risks and Mitigation

42. Despite the arguments already set out in favour of the proposed integration at the national level, there is no guarantee that bringing HPA into an integrated public health system will ameliorate the problems outlined above. Rather, the change in status should provide *an opportunity* to do so. Realising the advantages will require appropriate management strategies. For example, if at present good project management is often dependent on the existence of well-defined contracts between the separate organisations, removing this specific mechanism poses obvious risks. Mitigation is likely to require more robust processes for business management within the new structure.
43. Loss of HPA's (relative) independence also carries risks as well as benefits to the system. Risks to current income generation – where perceived lack of independence may be key - have already been noted. In addition, the public health system currently benefits considerably from a cadre of scientists in HPA able to do longer-term work, to publish extensively in peer-reviewed literature and offer advice that may be perceived as more objective. To minimise the potential loss of this resource, engagement with staff during the transition period will be essential, as will effort to ensure that responsiveness to policy needs does not squeeze out longer-term research excessively.
44. Once the new system is in place, it will be important to maintain centres of expertise with separation sufficient to allow analytical staff currently in HPA and DH to peer-review each other's work. On the most important issues, it is highly desirable to have separate and independent analyses available – e.g. modelling using different methods - to ensure robustness of conclusions. This was of great benefit, for example, during the 2009 Swine Flu pandemic. At present, HPA has sufficient independence to provide such input, with academic researchers providing further alternative views. Loss of this role for HPA researchers would necessitate greater reliance on external sources of expertise that might prove more difficult to mobilise in an emergency.
45. These issues will be kept in mind as the more detailed organisational design is considered. It may be that sufficient specialist autonomy can be retained within a fully-integrated system. Alternatively, the provisions set out in the White Paper and Health and Social Care Bill are sufficiently flexible to allow creation of other models for specific functions – e.g. setting up trading companies wholly-owned by Secretary of State.

Summary of Risks and mitigation

- **Risk:** transition to new structures is financially costly in terms of changing people's terms and conditions.
- **Mitigation:** working with HR to develop an appropriate framework for transition, including looking to apply TUPE where appropriate to keep transition costs to a minimum – any decisions as to changing or maintaining terms and conditions will depend on the outcome of an HR framework and consultation.
- **Risk:** moving DsPH to local authorities reduces influence and access to information DsPH will have on commissioning and monitoring healthcare services from a population perspective reducing leverage over whole care pathways for DsPH, but also for NHS commissioning in terms of reducing the cost-effectiveness of commissioning.
- **Mitigation:** working closely with professional public health organisations, departmental colleagues and stakeholders involved in the design of the NHS Commissioning Board and supporting development of GP consortia to enable a joint solution that meets the need both of public health and healthcare commissioning.
- **Risk:** losing workforce during transition due to uncertainty and lack of clarity on their future roles.

- **Mitigation:** develop a clear transition plan for the workforce, and engage fully following publication of the public health White Paper to manage expectations and formal consultation with those people currently working in the Health Protection Agency, the National Treatment Agency and other constituent parts that may contribute toward the public health service, such as regional tier NHS staff and Public Health Observatories and disease registries staff.
- **Risk:** public health threats are not adequately managed during transition
- **Mitigation:** Business as usual will be maintained throughout this process, with an emphasis on a smooth transition of functions from the HPA and other bodies to Public Health England. The functions of the HPA and other bodies will not be lost in the wake of its abolition. The HPA and other bodies will continue to contribute to the government's response to emergencies and other areas of responsibility, in the run up to integration in DH – after which functions will be subsumed into Public Health England. In order to manage transition planning for emergency preparedness, each SHA will work with local health and social care economies to develop coherent plans, building where possible on existing sub-regional arrangements, for shared commissioning capacity and capability, with leadership and accountability arrangements that can be secured through the transition period. These will include how critical functions (including for example emergency planning) can be sustained through the transition.

Cost

46. The preferred option for the national structure is the highest cost option. The efficiencies in terms of any staffing, resource and duplicative activity reductions will not outweigh the one-off costs outlined below. However, the purpose of streamlining public health organisations within a new public health system is to significantly improve public health outcomes, leading in the long-term to reduced healthcare and social care costs.
47. This policy will have impacts on, and associated with, the workforce of both the HPA and the NTA. These impacts could include:
- Costs associated with changing from NHS-type contracts to civil service contracts; and
 - Costs associated with transferring from one organisation to another.
48. Based on typical reorganisations covered in the National Audit Office (NAO) report "Reorganising central government" (March 2010), we estimate that transferring the HPA into the Department of Health will cost approximately [Redacted] excluding the possibly significant costs associated with moving staff on to a Civil Service Pension scheme and assumes that there will be no redundancies. A higher estimate of [Redacted] if the cost for more complex reorganisations from the NAO report is used. The costs of increased employer contributions from moving HPA staff from NHS to Civil Service pensions is estimated to be [Redacted] (net present value of about [Redacted]).
49. HPA currently supplements its Grant in Aid financing with income from a wide range of activities which utilise its specialist resources. This is currently around £140m per annum. It is assumed, for the purposes of this impact assessment, that when HPA functions transfer to the Secretary of State that there are no barriers, legal or structural, that would prevent the continuation of current income-generating activities. However there are potential risks to the fixed costs which are funded by this income. Assuming that there are no barriers to income generation and Public Health England supports a risk-aware, responsive, cost-focussed approach which supports income generation, the overall net reduction in contribution to the fixed costs has been estimated at [Redacted]. If there are some barriers to income generation, customer perception problems to contracting with a Government department and lack of drive for external income, the overall net reduction has been estimated at [Redacted]. If all income generation ceased, manufacturing stopped and NHS testing services were outsourced the overall net reduction in contribution to the fixed costs has been estimated at [Redacted]. In order to mitigate against this loss to ensure the same level of public health services can be delivered in future it would be necessary to ensure that additional finance were available. However, whilst income generation is a risk, we would not anticipate that all income generation would cease, Consequently, this case has not been

considered in the Analysis & Evidence Summary. The Department of Health will set up any necessary mechanisms to ensure the income generation capacity of the HPA is maintained.

50. Over the past four years, the HPA has grown external income at 12.6%,. However, it is uncertain that this could be sustained under any option. It has been assumed that even without moving HPA into the public health service this external income would remain the same at constant prices.
51. In the long run, cost savings should arise from an overall reduction in corporate services where duplication exists between the merging organisations. Abolishing various bodies and transferring their functions to Public Health England within the Department of Health will facilitate savings of around 30% in non-front-line costs, to be made from back office and administrative functions. There is a process in place to identify the relevant figures for the bodies concerned. These savings will be considered as part of the overall reductions required as part of the Spending Review measures being taken by the department. We have therefore not included an estimate of the savings in this impact assessment.
52. It is arguable that these savings could be made in the bodies concerned without integration. This is potentially true. However, the purpose of integration is **not** simply to make savings, but rather to develop a streamlined, integrated public health service which can maintain and enhance current performance but at significantly lower cost. Reducing the costs of the bodies without integration would make it challenging to do more than maintain existing performance, let alone make the improvements which can be delivered through integration. In addition, in the case of a smaller organisation reductions of these size would arguably make it unsustainable, further strengthening the case for integration.
53. All the organisations relevant to consideration here are already undertaking efficiency programmes as part of their response to the efficiency agenda. This means the level of staffing, resource and programmes ongoing at the time of this impact assessment may be different if and when the organisations are drawn together by Royal Assent of the Health Bill (expected 2011).

SUMMARY AND WEIGHING OF OPTIONS

- i. Present the best estimate of the overall net benefit of each option, by deducting the expected opportunity cost of the intervention (see IA Technical Guidance on how to derive the Opportunity Cost) from the expected benefit.
- ii. Summarise other factors, including equality and that weigh for or against each option, using the criteria cited for this IA in section A.
- iii. Draw conclusions:

Table : Costs and benefits and other factors associated with the short listed options							
OPTIONS (against Option 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	Equality/ Other Impacts	QIPP Compliance
	Central	Worst	Central	Worst			
Option 2:							
Option 3:							
Total							
NPV							
Costs and benefits							

Annex: Post Implementation Review

<p>Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];</p> <p>There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.</p>
<p>Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p> <p>Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.</p>
<p>Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]</p> <p>The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England</p> <p>The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework. Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.</p> <p>DsPH will also need to produce an annual report</p>
<p>Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p>Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p>
<p>Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]</p> <p>Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.</p>
<p>Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]</p>

Impact Assessment B – Commissioning within the public health service

Title: Commissioning within the public health service Lead department or agency: Department of Health Other departments or agencies:	Impact assessment (IA)
	la no: 3025
	Date: 01/01/2010
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Other

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

Local commissioning: Existing local arrangements for commissioning of public health separate action on health improvement from other, wider, determinants of health improvement, eg. housing, education etc, limiting the scope for commissioners to improve public health outcomes and reducing health inequalities.
National commissioning: Existing national arrangements for commissioning of public health separate action on health protection among a number of organisations, with expertise on public health issues fragmented across organisational boundaries, limiting the efficiency and innovation in commissioning and delivering health protections services.

What are the policy objectives and the intended effects?

The policy objectives are to align commissioning activities within those bodies which are most able to i) plan effectively, ii) take account of the needs of their population most effectively, iii) get value for money (e.g. through outsourcing), and iv) take into account the full cost and benefit to society when planning a service. Transferring the local public health commissioning responsibilities to local authorities facilitates joined up approaches across many other areas of local government work and with other important local partners – all of which can have a huge impact on the wider determinants of health wellbeing. Transferring the national public health commissioning responsibilities to one organisation will allow for a more effective use of existing knowledge and expertise currently deployed across several organisations.

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

Local commissioning

Do nothing - Primary Care Trusts remain responsible for commissioning

Preferred option - All local commissioning to be undertaken by local authorities

Alternative option - All local commissioning to be undertaken by GP commissioning consortia

Note that we also consider the impact of assigning commissioning responsibilities to upper tier, as opposed to lower tier, local authorities.

National commissioning

Do nothing – the Department of Health, Health Protection Agency and National Treatment Agency remain responsible for commissioning

Preferred option – All national commissioning to be undertaken by Public Health England

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?

SEE ANNEX

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?

YES

Ministerial Sign-off

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:..... ..... **Date:** 27/11/2010

Summary: Analysis and Evidence

Description: Preferred option – All local commissioning to be undertaken by local authorities

Price Base Year 2010	PV Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	High: N/A	Best Estimate: N/A

COSTS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS	AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL COST (PRESENT VALUE)
LOW	N/A	£1.0M	£9.1M
HIGH	N/A	£1.5M	£14.1MM
BEST	N/A	N/A	N/A

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

We assume that transferring local public health commissioning responsibilities from PCTs to LAs will result in a cost saving to primary care trusts (PCTs) of £348m, and a cost to local authorities (LAs) of, potentially, £348m. Furthermore, we assume an additional cost in joint working between LAs and GP consortia since there are likely to be more GP consortia than there are PCTs (we assume a higher estimate of this joint working for the high cost estimate).

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

We do not monetise the transition costs of transferring staff from PCTs to LAs. This may add significant cost, and will be necessary in order to build capacity within LAs to carry out the new commissioning functions.

BENEFITS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS	AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL BENEFIT (PRESENT VALUE)
LOW	N/A	£0	£0
HIGH	N/A	£140M	£1,164M
BEST	N/A	N/A	N/A

Description and scale of key monetised benefits by 'main affected groups'

We consider (in the high benefit estimate) that local authorities may be able to make cost savings from increasing the diversity of supply through outsourcing and improving efficiency in commissioning.

Other key non-monetised benefits by 'main affected groups'

It would be misleading to monetise the potential impacts on improved health and wellbeing in the population, since it is dependent on commissioning actions taken at the local level, as yet undetermined. However, we have argued that it is plausible to assume, based on some (limited) evidence that transferring commissioning responsibilities for public health services has the potential to improve the health and wellbeing of the population.

Key assumptions/sensitivities/risks

discount rate 3.5%

Firstly, LAs may not have the capacity to commission public health services effectively, which are of their nature challenging. Secondly, commissioning may result in a postcode lottery, as local authorities focus on local needs. This reflects the government's approach to localism, but it could result in what was deemed an unacceptable variation in service access. Finally, local authorities and GP consortia will need to continue to work together to ensure that public health and NHS care services are aligned. This may prove difficult, given different boundaries and different priorities. This may have implications for joint working and commissioning. There is also potential for cost shifting where responsibilities are split between the public health service and NHS (e.g. obesity prevention).

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	By 2013/14				
Which organisation(s) will enforce the policy?	N/A				
What is the annual change in enforcement cost (£m)?	N/A				
Does enforcement comply with Hampton principles?	N/A				
Does implementation go beyond minimum EU requirements?	N/A				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded: N/A		Non-traded: N/A		
Does the proposal have an impact on competition?	Potentially, but indirect				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	Costs:		Benefits:		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ⁶ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

⁶ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Description: Preferred option – All national commissioning to be undertaken by Public Health England

Price Base Year 2010	PV Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	High: N/A	Best Estimate: N/A

Costs (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total cost (present value)
Low	N/a	N/a	N/a
High	N/a	N/a	N/a
Best estimate	n/a	n/a	n/a

Description and scale of key monetised costs by 'main affected groups'

N/A

Other key non-monetised costs by 'main affected groups'

We do not monetise the transition costs of transferring staff to the public health service. This may add significant cost.

Benefits (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total benefit (present value)
Low	N/a	N/a	N/a
High	N/a	N/a	N/a
Best estimate	n/a	n/a	n/a

Description and scale of key monetised benefits by 'main affected groups'

N/a

Other key non-monetised benefits by 'main affected groups'

We assume that there may be improved efficiency and innovation in the commissioning activities currently undertaken by the Department of Health, when the three organisations that provide health protection services at a national level are bought together within Public Health England. These potential savings will have to be large enough to offset the costs of transferring staff to the public health service if we are to conclude that the benefits of the preferred options outweigh the costs.

Key assumptions/sensitivities/risks

As for the local level, there may be potential for cost shifting.

discount rate

N/a

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	NO	NA

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			By 2013/14		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded: N/A	Non-traded: N/A	
Does the proposal have an impact on competition?			Potentially, but indirect		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:	Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ⁷ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

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

Evidence Base (for summary sheets) – Notes

Table 1: References

N O.	LEGISLATION OR PUBLICATION
5	<i>EQUITY AND EXCELLENCE: LIBERATING THE NHS</i>
6	
7	
8	

+ Add another row

Table 2: Annual profile of monetised costs and benefits* for local commissioning arrangements - (£m) constant prices

		Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs		N/A									
Annual recurring cost	LOW	£1M									
	HIGH	£2M	£2M0								
Total annual costs	LOW	£1M									
	HIGH	£2M	£2M0								
Transition benefits		N/A									
Annual recurring	LOW	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	HIGH	£140M									
Total annual benefits	LOW	N/A									
	HIGH	£140M									

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

Table 3: Annual profile of monetised costs and benefits* for national commissioning arrangements - (£m) constant prices

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs	N/A									
Annual recurring cost	N/A									
Total annual costs	N/A									
Transition benefits	N/A									
Annual recurring	N/A									
Total annual benefits	N/A									

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

Commissioning within the public health system

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health White Paper. Other impact assessments in this suite are
 - Structure of Public Health England (3024)
 - Ring-fenced funding of public health (3026),
 - Public Health Outcomes Framework (3027),
 - Information and intelligence for public health (3028),
 - Health visitors (3030)
2. This Impact Assessment considers how public health interventions will be designed and purchased. It directly impacts the public sector only.
3. The policy objective is to align commissioning activities within those bodies which are most able to i) plan effectively, ii) take account of the needs of their population most effectively, iii) get value for money (e.g. through outsourcing), and iv) take into account the full cost and benefit to society when planning a service.

Local level

4. Since 2002, the primary responsibility for commissioning NHS and public health services has been led by Primary Care Trusts (PCTs). Although local authorities have had statutory duties on them to work in partnership with PCTs (e.g. to complete the Joint Strategic Needs Assessment) and others to achieve improvements in public health, they do not have specific funding to do so.
5. Transferring the local public health commissioning responsibilities to local authorities allows for tailored local solutions to meet widely varying local needs, and facilitates joined up approaches across many other areas of local government work (such as housing, planning, social care, and leisure) and with other important local partners (such as the police, business and schools) – all of which can have a huge impact on the wider determinants of health and wellbeing. Local authorities can then take overall responsibility for improving the local area for their populations, including public health services. This has the potential to demonstrate cost savings (as a result of increased outsourcing and/or improved efficiencies) and the potential for improved health of the population (as a result of more joined up services with a focus on public health outcomes). In this Impact Assessment, we consider the costs and benefits of transferring local public health commissioning efforts to local authorities compared to the ‘do nothing’ option (i.e. PCT commissioning). Since PCTs are being abolished under the provisions in the Health and Social Care Bill, we also consider the costs and benefits of our preferred option in relation to transferring commissioning responsibilities at a local level to GP commissioning consortia.

National level

6. Not all public health services can be commissioned at a local level. For example, since surveillance benefits from economies of scale, it is likely that one national provider is more efficient. Immunisations have elements of a national public good, with positive externalities occurring outside the locality of local authority geographical boundaries, suggesting that a national strategy on immunisation is therefore most likely to maximise benefits.
7. At a national level, a number of organisations, including the Department of Health, the Health Protection Agency and the National Treatment Agency, have responsibilities for commissioning and/or delivering public health services under current arrangements. Transferring the national public health commissioning responsibilities to one organisation, the Public Health England, will ensure that one body nationally is able to strategically plan the full range of public health services provided at a national level.

8. This will mean that current service provision, taking place across a number of organisations, is joined up, giving Secretary of State direct oversight and accountability of the full range of health protection activities. The rationale for bringing the commissioning of these various services within one organisation is that there is likely to be improved efficiency and innovation in commissioning arrangements, for example, from sharing expertise and experience to deliver services at lower cost. In this Impact Assessment, we consider the costs and benefits of joining up national commissioning efforts within the Public Health England at a national level, in relation to the do nothing option.

What policy options have been considered?

Local level

9. We have considered three main options for public health commissioning at a local level, along with two sub-options.

Do nothing option – PCTs remain responsible for commissioning

10. The Government has announced that PCTs will be abolished and their commissioning functions moved elsewhere. Given this, the do nothing option is no longer an option.

Preferred policy option – all local commissioning undertaken by local authorities

11. The rationale for this is that public health differs from other healthcare services provided by the NHS and may benefit from inclusion within local authorities for the following reasons:
 - Externalities: the consumption of public health services often produces positive externalities. Vaccinations protect non-immunised individuals by reducing the prevalence and likelihood of infection; healthy dietary habits encourage others to eat healthily as well. Since local authorities are responsible for meeting the needs of their local populations, they are most likely, and able to, take into account these positive externalities when commissioning services.
 - Wider determinants: Local authorities may be more able to facilitate joined up approaches to commissioning public health services across many other areas of local government work (such as housing, planning, social care, and education) and with other important local partners (such as the police, business and schools)
 - Individual versus geographical importance: for many public health services there is an important geographical influence on the provision of the service. For example, in areas where teenage pregnancy is high, outreach programmes may be cost-effective. For immunisations, where there are herd effects to be realised, there may be a geographical importance to maintaining high vaccination rates in order to prevent outbreaks of infectious disease. Emergency preparedness also has important geographical elements. Local authorities are likely to be best placed to undertake local horizon scanning and risk management, health surveillance, and working with local partners to develop plans and mitigation strategies for threats and hazards. As local authorities have distinct geographical boundaries, they are most able to take account of this geographical importance.
12. Note that, under this option, we propose that local authorities will hold the funds, and have overall responsibility for commissioning all public health services that are proposed to be delivered at a local level (i.e. mostly health improvement functions). However, local authorities may decide to change the funding route, subject to contractual and other constraints, if an alternative funding route would provide better outcomes. For example, a more joined up service may be made available if local authorities were to give GP consortia the commissioning responsibilities for some services through, for example, contractual arrangements. Note that, under this arrangement, local authorities would still be responsible for assessing the needs of their populations, and, importantly, would still be held to account through the Public Health Outcomes Framework for services provided.

Alternative option – all local commissioning undertaken by GP consortia

13. The rationale for this is that it is difficult to split off some public health services from non-public health elements of a care pathway (e.g. screening from other parts of a pathway). GP consortia may be better placed than local authorities to commission joined up services for patients, where public health services are part of some wider pathway of care.
14. However, we argue that GP consortia are not well-placed to address the specific characteristics of public health services identified previously. For example:
- Externalities: Since GP consortia will only be responsible for those patients registered with them, they may fail to take into account the positive externalities of the provision of some public health services. This may mean that public health services are under-provided when under the responsibility of GP consortia. For example, GP consortia may be less willing to provide mass information campaigns in their areas, choosing instead to free ride on the efforts of other GP consortia in the area.
 - Wider determinants: GP consortia are responsible only for delivering health services. They may therefore not consider the full substitutability and complementarity of different services that may deliver public health outcomes when commissioning services.
 - Individual versus geographical importance: Since GP consortia will not have distinct geographical boundaries, they unlikely to be able to take account of geographical elements in commissioning public health services.
15. Furthermore, while commissioning consortia will be responsible for commissioning services for the whole of their local population, there is a risk that if consortia rely heavily on GP services to deliver public health interventions, unregistered people (and the people who may benefit the most) may fall through the net. This could have the effect of deepening health inequalities. For example, evidence suggests that homeless people and those sleeping rough tend to be more likely than the general population not to be registered with a general practitioner.⁸ Furthermore, a 1994/95 survey covering 117 GP practices in and around Bristol found that only 27% would permanently register a homeless person, with 24% only treating homeless people on an emergency basis.⁹ This might mean that homeless people would be unlikely to receive preventative treatments.
16. Finally, local authorities are likely to have a wider population base than a consortium, which may allow for greater economies of scale in providing (or commissioning to be provided) public health interventions.

Sub-option under preferred option - lower or upper tier local authority responsibility

17. There are advantages and disadvantages to transferring local commissioning responsibilities for public health services to lower or upper tier local authorities. The current responsibilities by type of local authority are outlined in the table below. Transferring local public health commissioning responsibilities to upper tier local authorities (the preferred option) will mean Metropolitan areas: transferring commissioning responsibilities to district councils, who have responsibilities for most local government commissioned services under current arrangements.

⁸ Anderson et al (2003) Single homeless people, London: HMSO

Allen and Jackson (1994) Health care needs and services in resettlement units, London Policy Studies Institute for the Resettlement Agency and Department of Social Security

⁹ Wood et al (1997) Do homeless people get a fair deal from General Practitioners?, Journal of Royal Society of Health 117(5):292-297

- a. Shire areas: transferring commissioning responsibilities to unitaries and county councils. Whilst unitaries are responsible for commissioning most local government commissioned services, county councils are not. County councils are responsible for commissioning education, transport, social care and libraries. On the other hand, it is district councils who are responsible for commissioning housing, leisure and environmental health.
- b. London area: transferring commissioning responsibilities to the City of London and London boroughs, who are responsible for commissioning many of the local government commissioned services.

18. The preferred option means transferring public health commissioning responsibilities to 152 local authorities.¹⁰

¹⁰ 36 District Councils in Metropolitan areas, 56 Unitaries in Shire areas, 27 Council Councils in Shire areas, 1 City of London and 32 London boroughs

Figure 1 Local authority responsibility for major services in England (taken from Communities and Local Government, *Local Government Financial Statistics England*, No. 20, 2010)

	Metropolitan areas		Shire areas				London area			
	District councils	Single purpose authorities	Unitaries	County councils	District councils	Single purpose authorities	City of London	London boroughs	GLA	Single purpose authorities
Number of authorities	36	20	56	27	201	55	1	32	1	4
Education	✓		✓	✓			✓	✓		
Highways ^(a)	✓		✓	✓			✓	✓	✓	
Transport planning	✓		✓	✓			✓	✓	✓	
Passenger transport		✓	✓	✓					✓	
Social care	✓		✓	✓			✓	✓		
Housing	✓		✓		✓		✓	✓		
Libraries	✓		✓	✓			✓	✓		
Leisure and recreation	✓		✓		✓		✓	✓		
Environmental health	✓		✓		✓		✓	✓		
Waste collection	✓		✓		✓		✓	✓		
Waste disposal ^(b)	✓	✓	✓	✓			✓	✓		✓
Planning applications	✓		✓		✓		✓	✓		
Strategic planning	✓		✓	✓			✓	✓	✓	
Police		✓				✓	✓		✓	
Fire and rescue ^(c)		✓		✓		✓			✓	
Local taxation	✓		✓		✓		✓	✓		

(a) Transport for London (TfL), a body of the Greater London Authority (GLA), is the highways authority for about 5% of London roads.

(b) Waste disposal for some areas of London is carried out by separate waste disposal authorities. The GLA has strategic, but not operational, responsibility for municipal waste.

(c) Combined fire authorities are responsible for fire and rescue services in the shire areas affected by reorganisation from April 1996. Cornwall UA, Isle of Wight, Northumberland, and Isles of Scilly are the only UA authorities with responsibility for fire and rescue services.

The table excludes 10 park authorities in England – for the eight National Parks, The Broads and the Lee Valley Regional Park. These authorities have various powers and aims that straddle some of the normal functions of local government. In particular, park authorities have responsibility for planning and leisure functions.

19. The disadvantages of the preferred option therefore most present themselves in Shire areas, where commissioning responsibilities in local government are most clearly separated between County Councils and District Councils (where the local authority is not a Unitary).

20. Transferring responsibilities to County Councils rather than District Councils may limit the ability of the local authority to take a wide view of public health, using leisure and housing services to improve public health outcomes under the Public Health Outcomes Framework. However, transferring commissioning responsibilities to District Councils instead of County Councils would require assigning an additional 173 Directors of Public Health (DsPH) and their teams, at potential higher cost. District Councils are also substantially smaller than County Councils, with fewer responsibilities for assessing population needs, e.g. for education, social care, transport. This might mean that District Councils would be unable to take advantage of the economies of scope and scale, discussed later.

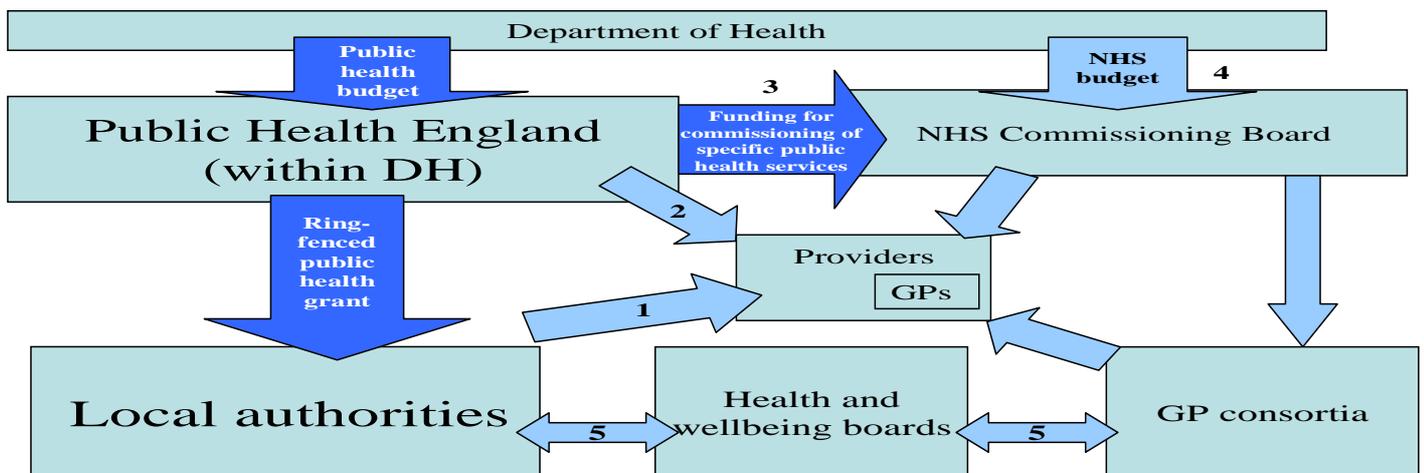
National level

21. We have considered two options for public health commissioning at a national level.
- *Do nothing option* – a number of organisations remain responsible for commissioning at a national level
 - *Preferred option* – Public Health England is responsible for all nationally commissioned public health services
22. At a national level, the public health services that will be commissioned are likely to have either, i) a national public good element (for example, radiation, chemical and environmental hazards and emergency preparedness); or, ii) be subject to significant economies of scale that warrant nationwide commissioning (for example, surveillance of infectious disease and hazards and public health intelligence).
23. Since the majority of public health services commissioned at a national level are likely to be associated with health protection, we assume that there would be potential for greater efficiencies and innovation in joining up commissioning and/or delivery of all services within one national organisation.

Summary of preferred option

24. The following diagram illustrates the preferred option. Public Health England will be responsible for commissioning all public health services that are commissioned at a national level, holding the funds for doing so. For some services, they may choose to provide services in house, for example surveillance of infectious disease. For some other services, they may choose to mandate or contract responsibility to the NHS Commissioning Board, for example cervical screening, which may continue to be delivered via the GP contract. The public health service may choose to contract with providers directly to provide some other national public health services.
25. At a local level, local authorities will be responsible for commissioning all public health services that are commissioned at a local level. However, as with the national level, local authorities may also decide to contract with GP consortia or providers to take on responsibility for the delivery of some services.

Figure 2: Summary of the preferred option



Preferred option: Impacts, Costs and Benefits

Local level

Costs and benefits

26. The preferred option is to have all local commissioning undertaken by upper tier local authorities at the local level. This policy will have a number of impacts, including costs of transferring staff from NHS to LA contracts, costs of transferring commissioning responsibilities from PCTs to LAs, and costs of increasing the diversity of supply of public health services. However, there may also be cost savings that come about as a result of transferring commissioning responsibilities to LAs. Furthermore, we expect there to be benefits in terms of improved health and wellbeing of the population. These impacts are outlined as follows:

- Costs associated with transferring from NHS contracts to LA contracts

27. The costs of transferring employees from NHS contracts (within PCTs) to LA contracts has not yet been estimated.

- Costs of transferring commissioning responsibilities from PCTs to LAs

28. This policy will mean a new burden being placed on local authorities, both in terms of an increased workforce and more responsibilities. The cost to LAs of this transfer of responsibility from PCTs can be estimated using data from the "Operational Efficiency Programme" (OEP). The OEP was a pilot looking at PCTs to determine the potential for efficiencies in the back office function of a PCT.

29. Based on cost estimates from nine PCTs¹¹, the OEP estimated that £23.0m was spent on needs assessment/public health under the commissioning function of the PCTs. Spend on needs assessment/public health include costs of the Public Health Departments and all costs associated with assessing local health needs, analysing available evidence, agreeing local health priorities and outcomes and producing the local Joint Strategic Needs Assessment. Since much of this will currently be done by Directors of Public Health and their teams in PCTs¹² under current arrangements¹³, we assume that much of this cost would transfer to local authorities under the proposals in the White Paper¹⁴.

30. In calculating what proportion of total PCT spend that expenditure on needs assessment/public health contributes, we exclude spend on commissioned services from total expenditure. Commissioned services refer to PCT expenditure on healthcare commissioned from providers. These are cash flows (e.g. expenditure to NHS/Foundation Trusts for secondary care activity) but are not costs incurred by the PCT running the commissioning arm of the organisation, and are therefore excluded for the purpose of calculating costs here. Under this definition, expenditure on needs assessment/public health is 11.6% of PCT operational expenditure under the current system. If we assume that total operational costs of PCTs are currently £3 billion¹⁵, then this means that around £348m of expenditure might transfer to local authorities to carry out their commissioning activities for public health services, under the assumptions made. Under the base case, we therefore assume a cost saving to PCTs of £348m, and a cost to local authorities of £348m.¹⁶

¹¹ Stockton-on-Tees Teaching, Hartlepool, Middlesbrough, Redcar and Cleveland (these four PCTs are confederated into one joint organisations and so presented combined figures), Brighton, North Staffs, Stoke on Trent, West Kent, Surry

¹² For simplicity, we assume no change in the number of DsPH since we assume that there is currently one DPH per PCT (152 in England), and there will one per upper tier local authority (151 in England) in the new system.

¹³ Although, for simplicity we make this assumption, the level to which the assumptions holds will differ across PCTs. Some PCTs will have larger public health teams that are involved in all stages of the commissioning process - analysing population needs, evaluating best practice, designing services, etc as well as more traditional public health provisions/commissioning. In these cases, some of these functions may sit with consortia, some with LAs, and some jointly between the two as the current JSNA (joint strategic needs assessment) does.

¹⁴ The White Paper states that commissioning activities will include public and patient engagement, service specification, prioritisation of services and investment, evaluation and performance management.

¹⁵ This is from analysis of PCT accounts - it is total PCT expenditure minus healthcare purchased from providers minus running costs of the provider arm of the PCT.

¹⁶ Note that local authorities may also face some additional costs of "Management and Strategy", "Patient & Public Engagement", "Market Management / procurement / contracting" and "Performance Management" within their capacity as local commissioner of public health services. However, we assume that the majority of these costs as faced by PCTs under current arrangements will be incurred in commissioning healthcare services (by GP Consortia) rather than public health services (by LAs). For example, management and strategy and patient and

31. This equates to around £2.3m per PCT/LA per year. If we assume that commissioning responsibilities are transferred to 325, rather than 152, local authorities under the option to transfer commissioning responsibilities to lower tier, rather than upper tier local authorities, we might estimate that this would cost around £400m¹⁷. Whilst this may be an over-estimation, since teams working under the DsPH in District Councils would likely be smaller than under County Councils, it illustrates that the cost would be substantial. We suggest that the additional benefit that might come about from lower tier LAs being better able to join up the commissioning of traditional public health services with the services that target the wider determinants of health would be unlikely to offset this significant cost.

32. To counteract the additional burden estimated under the preferred option, the Department of Health is planning to provide ring-fenced public health funding to local authorities. This funding will be taken from the existing health services budget. It will be allocated according to a needs-based formula with a health premium that recognises and rewards improvements in health outcomes made by local areas. The costs and benefits associated with the policy of a ring-fenced local public health budget are considered in Appendix C.

- Costs to local authorities of jointly planning services with GP consortia

33. *Equity and Excellence: Liberating the NHS* states that good public health will rely upon close partnership working between local government DsPH and GP consortia at the local level. Under current arrangements, local authorities have had statutory duties on them to work in partnership with PCTs and others to achieve improvements in public health, by undertaking Joint Strategic Needs Assessments (JSNA). The Department for Communities and Local Government estimate that the total cost of carrying out JSNAs is around £10.9m, of which £4.9m is attributable to local authorities¹⁸. Under the new system, it is plausible to assume that the costs of joint working may increase, as there are likely to be more GP consortia compared to PCTs. To illustrate, we assume that the total cost of carrying out JSNAs (both by local authorities and GP consortia) will increase by 10%-25%, to take account of the potential increase in the number of local GP consortia. This equates to a cost of £1.1m to £2.7m nationally.

- Costs (and cost savings) of increasing the diversity of supply

34. Broader government policy recommends the commissioning of a more diverse supply of services, in particular embracing providers from the private and voluntary sectors. Increasing the diversity of supply alongside the preferred option of transferring all local commissioning responsibilities for public health to local authorities should ensure:

- a. a more effective focus on the needs of disadvantaged groups;
- b. clearer specification of objectives for policies, through the discipline of setting out clearly the requirements of the work;
- c. improved efficiency and quality through competition; and
- d. increased innovation, through opening up services to a wider range of potential suppliers, who can introduce more innovation; this is of particular relevance to public health services, where ill health and inequalities may reflect social and cultural factors; improvements in public health are therefore more likely to require innovative approaches to tackling behaviour change.

35. A review into the public services industry by the then Department for Business Enterprise and Regulatory Reform states that:

public engagement will relate to e.g. design of community services for long term conditions, market management and procurement will relate to e.g. buying secondary/community healthcare from Acute Trusts/Mental Health Trusts/Independent Sector/Third Sector.

¹⁷ 173 additional LAs, multiplied by an average operational cost of £2.3m per year.

¹⁸ See page 75 in Department for Communities and Local Government (2007) "Local government and public involvement in the Health Bill. Regulatory Impact Assessment"

“The evidence shows that there are clear benefits, to both users and taxpayers, in subjecting incumbent service providers to competition. The academic literature typically found the cost savings from competitive tendering to be between 10 per cent and 30 per cent (including when the in-house team won the bid) with no adverse effect, and sometimes an improvement, in service quality.”¹⁹

36. We might predict that local authorities will be able to contract out services more efficiently than GP consortia, firstly because local authorities already have experience of contracting out services, e.g. social services, and secondly, because they may be larger organisations than GP consortia. There is some evidence to suggest that organisations that have experience in contracting are more likely to contract out other services, benefiting from economies of scope.²⁰ There is also evidence that suggests that larger organisations are more likely to contract out for services, suggesting that there are economies of scale in commissioning.²¹
37. Based on this evidence, it might be plausible to assume that local authorities would be able to gain a 10 per cent cost saving over current arrangements (equating to around £35m per year), by increasing the diversity of supply.
38. We might also assume that this saving would be greater than if the commissioning responsibility had transferred to GP consortia, for the reasons previously outlined. However, this argument is limited somewhat by the different regulation arrangements for GP consortia and local authorities. If commissioning for public health services locally had been undertaken by GP consortia, under the alternative option considered in this Impact Assessment, then the commissioning of public health services would be subject to the proactive powers of Monitor, who could enforce competitive tendering where relevant. However, local authorities will not be regulated by Monitor, but will carry out their commissioning role in line with general procurement guidelines. For local authorities, the regulator will have the ability to advise on breaches, but not to take enforcement action. There is therefore a risk that the potential cost savings identified may not be achieved in practice, with local authorities failing to increase the diversity of supply. For the low benefit/high cost scenario, we therefore consider zero savings from increasing the diversity of supply.
39. Note also that increasing the diversity of supply of public health services, and the associated contracting requirements, is likely impose some additional costs on local authorities, such as extra senior staff time, consultancy and legal fees, tendering risks, risk premia for financiers etc. The absence of a centrally determined tariff for public health services also means that commissioners will need to engage in contract negotiations when not providing services in-house; this is likely to have significant transaction costs. Measuring outcomes to compare the performance of providers can be very difficult in health, as measuring health outcomes in general is a very challenging task. This suggests that the potential advantages of contracting services out as opposed to providing them in-house need to be weighed up against these additional costs. Thus, it may not be sensible to contract out all services, despite the potential advantages. For estimating costs and benefits, we therefore assume that local authorities will only contract out services for which the benefits outweigh the costs.
 - Cost savings associated with improved efficiency
40. Some longer-term savings in the operational costs associated with commissioning may be expected from transferring this to local authorities as it seems plausible to expect some efficiencies; for example:
 - Staff reductions: Local authorities already have some staff with a public health focus, perhaps allowing for some reduction in combined staffing levels. For example, under current arrangements, local authorities provide specialist HIV social care services (or contract these services to Non-Governmental Organisations (NGOs)), while PCTs commission primary prevention, secondary prevention/diagnostic and treatment

¹⁹ BERR (2008) Public services industry review, Understanding the public services industry: How big, how good, where next? A review by Dr DeAnne Julius CBE

²⁰ Levin et al. (2008) Contracting for Government Services: Theory and Evidence from U.S. Cities: Consider evidence that suggests that a given service is 15-35% more likely to be privately contracted if a city privatises one additional service (which suggests that writing contracts becomes easier with experience)

²¹ Ibid

services for HIV. There may therefore be some scope to reduce staff responsible for commissioning these services within local authorities under new arrangements, since staff within local authorities may already have some similar competencies that are currently based in PCTs.

- **Complementarity:** Linking the public health focus with control of levers relevant to the wider determinants of health, such as transport, housing and education might enable the joining-up of service design and commissioning across public health (including the determinants of health). For example, the public health services currently commissioned by PCTs to target obesity may be targeting the same groups of people already assessed by local authorities under their education programmes. Similarly, some sexual health services may be more efficiently delivered in school programmes or through libraries, rather than through the more traditional genitourinary medicine (GUM) clinics. More joined-up commissioning may allow for the potential for economies of scope by targeting the same people only once.
- **Substitutability:** Since local authorities have responsibility for commissioning some of the services which feed into the wider social determinants of health, local authorities may be better placed to plan service provision strategically across public health, improving outcomes and reducing cost. This may mean substituting more traditional public health services (e.g. obesity counselling services traditionally provided by the health service, GUM clinics typically based in acute hospitals), for other levers at the disposal of local authorities (e.g. more bicycle lanes, school nurses).

41. To illustrate potential savings, we might therefore assume a cost saving over status quo of £105m (i.e. 30% reduction in costs compared to PCTs). However, since we have proven only the plausibility of this reduction in costs, and not described in any detail how these cost savings may be recovered, for the low cost estimate we assume zero efficiency savings.

- Improved health and wellbeing of the population

42. By moving the role of the Director of Public Health we are seeking to give greater responsibility, backed by dedicated resources as outlined above, to local authorities to enable them to make a major impact on people's health and wellbeing.

43. As has been discussed, linking the public health focus with the control of levers relevant to the wider determinants of health, such as transport and housing, might enable the joining-up of service design and commissioning across public health, potentially offering more joined-up services for the citizen. This could have significant benefits in terms of improving public health outcomes through the commissioning of more effective and locally-tailored interventions at a local level. For example, Cochrane (2005) suggests that interventions to target child obesity are most effective when they use a whole school approach and consider the school environment, and involved families and the wider community. Levers of engagement and enjoyment were also found to be important. These findings suggest that a wider pool of policy levers to influence behaviours may improve the effectiveness of interventions, which would imply improved outcomes.

44. It would be misleading to monetise the potential impacts on improved health and wellbeing in the population, since it is dependent on commissioning actions taken at the local level, as yet undetermined. However, we have argued that it is plausible to assume, based on some (limited) evidence that transferring commissioning responsibilities for public health services has the potential to improve the health and wellbeing of the population.

- Indirect impacts

45. There is unlikely to be any direct impact on either the private or civic society sectors as a result of these changes. There may be indirect impacts if organisations in these sectors are commissioned by local authorities in the future to deliver specific public health interventions or support functions.

- Summary

Table 4: Summary of costs and benefits of the preferred option at the local level

	Low (central) estimate	High estimate	Notes/caveats
Costs			
Costs associated with transferring from NHS contracts to la contracts	Non-monetised	Non-monetised	These costs are currently unknown.
Costs of transferring commissioning responsibilities from PCTs to LAs	£348m to LAs	N/a	There is some uncertainty as to how much PCTs spend on commissioning public health services; estimate is based on assumptions made on results from a pilot.
	-£348M TO PCTS	N/A	
Costs to local authorities of jointly planning services with GP consortia	£1.1m	£1.7m	Assumes a 10-25% increase above the current costs of carrying out JSNAs.
Benefits			
Cost savings of increasing the diversity of supply	£0	£35m	Dependent on the level to which local authorities increase the diversity of supply and outsource services.
Cost savings associated with improved efficiency	£0	£105m	
Improved health and wellbeing of the population	Non-monetised	Non-monetised	Although plausible, subject to local decision-making in commissioning arrangements
Net benefit	-£1m	£139m	

Risks

46. There are a number of potential risks to the preferred option of transferring existing responsibilities to commission public health interventions from PCTs to local authorities at a local level. These include:

- Capacity: Local authorities may not have the capacity to commission public health services effectively, which are of their nature challenging.
- Postcode lottery: commissioning may result in a postcode lottery, as local authorities focus on local needs. This reflects the Government's approach to localism, but it could result in what was deemed an unacceptable variation in service access. It should be noted, though, that PCTs already commission services, to a lesser extent, based on local needs, so this is already part of the fabric of public health commissioning.
- Fragmentation: Local authorities and GP consortia will need to continue to work together to ensure that public health and NHS care services are aligned. For example, for HIV, there may be links to other blood-borne viruses, especially hepatitis C, hepatitis B and TB for African communities. There may also be links with mental health services. This will necessitate close working with GP consortia. However, this may prove difficult, given different boundaries and different priorities. This may have implications for joint working and commissioning.
- Cost shifting: where services could be delivered through the NHS or via local authorities, there are incentives for cost-shifting. Thus to take the example of obesity services, we expect local authorities to take the lead, but we would want GPs to provide brief interventions around weight management as well. To manage this risk, we will need to prioritise QOF public health payments to ensure primary care continues to deliver public health interventions. DsPH will also need to develop good relationships with GP consortia to manage any problems locally.

National level

Costs and benefits

- Costs associated with transferring staff to Department of Health contracts

47. The costs of transferring employees to Department of Health contracts has not been estimated.

- Cost savings associated with improved efficiency Public Health England will commission, for the most part, health protection services. These services aim to protect the population from infectious disease, chemical hazards and pandemic flu, for example. The different ways in which this aim is delivered will currently vary depending on the specific expertise within the organisation (e.g. the microbiologist specialist expertise within the Health Protection Agency (HPA) and the more policy-based expertise within the Department of Health). By bringing this expertise within one organisation, we might suggest that different specialists will develop a greater understanding of each other's knowledge and expertise, and be able to draw on these specialisms more successfully, leading to improved efficiency in commissioning/delivering services. We suggest that it is plausible to assume that this benefit will go beyond the benefit of working in partnership across organisational boundaries, as is the case under status quo.

48. This is supported, to some extent, by the literature on networking. Buchel and Raub (2002)²² suggest that networks can deliver three distinct benefits. These benefits are discussed below with reference to commissioning by Public Health England

- a. *Strengthening employee satisfaction and loyalty through network activity.* Buchel and Raub (2002) argue that participating in an exchange of ideas with like-minded colleagues with a common interest may boost employees' motivation and satisfaction at work. To provide some illustration of this potential benefit, we consider commissioning of services in preparation for some future pandemic flu. If modellers, currently sitting within the Health Protection Agency, were working more directly with policy makers, currently sitting within the Department of Health, they may be able to better share what their expertise can bring to effective commissioning. This may have the potential to not only improve policy making, better motivating DH employees, but may also mean that modelling was, potentially, better used to inform commissioning arrangements, thereby potentially motivating HPA employees.
- b. *Improving efficiency through reuse of knowledge.* Buchel and Raub (2002) also argue that networks can deliver value by reusing existing company knowledge. Existing company knowledge is currently split between the three organisations that operate on a national level with the objective of health protection. By bringing these various experts together into one organisation, there may be better reuse of knowledge across the organisation. For example, the analytical capabilities within the DH and HPA may both be strengthened by better sharing knowledge on analytical techniques used to inform commissioning arrangements. If this allowed evidence to be better deployed in commissioning activity, this may lead to better value for money in commissioning arrangements.
- c. *Fostering innovation through leverage of knowledge.* Finally, Buchel and Raub (2002) suggest that, since networks are composed of organisational members who share a strong interest in a particular topic and frequently work at the cutting edge of current knowledge, their interaction may lead to the creation of entirely new knowledge. For example, policy and analytical colleagues within DH work on developing policy to reduce the number of healthcare-associated infections (HCAIs), developing substantial expertise on the topic as a result. In addition, employees of the HPA work on collecting data from surveillance of HCAIs analysing this data for trends in risk factors, for example. Bringing together this different expertise on a day-to-day level, and without organisational boundaries, may foster greater shared knowledge and more innovative ways of commissioning services to reduce the number of HCAIs.

49. These illustrative examples suggest that there may be scope for increased efficiency and more innovation in commissioning public health services at a national level from bringing all health protection activities within one organisation. In addition, it suggests better employee loyalty and motivation as a result.

50. However, these results are not guaranteed, and depend on how closely employees currently working across the three organisations will work together within the Public Health England. Additional benefits of bringing the different organisations together into one organisation may also depend on how well benefits of networking are already taken advantage of under current cross-organisational working.

Risks

51. There are a number of potential risks to the preferred option of transferring existing responsibilities to commission public health interventions from the HPA and NTA to Public Health England at the national level. These include:

²² Buchel and Raub (2002) "Building knowledge – creating Value Networks" European Management Journal 20(6): 587-596

- Cost shifting: as for local commissioning arrangements, where services could be delivered through the NHS or via Public Health England, there are incentives for cost shifting.

SUMMARY AND WEIGHING OF OPTIONS

Local level

52. The following table summarises the costs, benefits and impacts of the preferred commissioning option at the local level, to transfer all public health commissioning responsibilities at the local level to upper tier local authorities.
53. We argue that, at worse, the transferring of commissioning responsibilities will lead to higher costs of joint working between local authorities and GP consortia, with limited benefits. At best, this policy option may lead to improved efficiencies in commissioning services, and better health outcomes for the population.
54. However, the costs of transferring local commissioning arrangements to local authorities do not yet take account of the transitional costs of transferring staff from PCTs to local authorities, building the necessary capacity within local authorities. Under the low cost scenario, this cost could be as high as £1.2billion and we would estimate that the benefits of the transfer of commissioning responsibilities over a 10 year period would outweigh this costs. However, the high cost scenario suggests the benefits of transferring commissioning responsibilities to local authorities are unlikely to outweigh the costs.
55. Note, however, that the abolition of PCTs necessitates that the commissioning for public health services be transferred to some other organisation at a local level (i.e. the do nothing option is not an option in reality). We have provided a number of justifications in this Impact Assessment as to why we believe that local authorities are the 'best' organisation to commission public health services.

Table 5: Costs and benefits and other factors associated with the preferred option for commissioning at the local level

OPTIONS (against Option 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	Equality/ Other Impacts
	Low	High	Low	High	Central	
Option 2:	£1m p.a.	£1.7m p.a.	£0 p.a.	£140m p.a.	N/A	None
Total	£1m over 10 yrs	£17m over 10 yrs	£0 over 10 yrs	£1.4bn over 10 yrs	N/A	
NPV	£9.1m over 10 yrs	£14.1m over 10 yrs	£0 over 10 yrs	£1.2bn over 10 yrs	N/A	
Costs and benefits	This assumes that the cost of commissioning in PCTs will be exactly equal to the cost of commissioning in LAs	Assumes that LAs cannot make cost savings compared to PCTs. Net cost is a result of increased costs of joint working with GP consortia.	The high benefit estimate assumes that LAs can make cost savings compared to PCT commissioning. In addition, although it is plausible to predict that there would be improvements to the populations health and wellbeing, it would be inappropriate to provide an estimate, since decisions taken by LAs will be taken at a local level		Since we do not monetise benefits, we have not provided an estimate of net benefit; however, since the costs are neutral under the high cost estimate, we could expect the net benefit to be positive	LAs are already well-versed in their responsibilities under equality and human rights legislation

National level

56. The following table summarises the costs, benefits and impacts of the preferred commissioning option at the national level, to transfer all public health commissioning responsibilities at the national level to Public Health England.
57. We argue that, at worse, there will also be transitional costs of transferring staff, with limited benefits. At best, this policy option may lead to improved efficiencies and innovation in commissioning services, with better use made of sharing knowledge and expertise among those working in the commissioning of public health services. However, the cost of transferring staff to carry out commissioning activities within Public Health England is likely to require that significant efficiencies and innovations are made to ensure that the benefits of the preferred option outweigh the costs

Table 6: Costs and benefits and other factors associated with the preferred option for commissioning at the national level

OPTIONS (against Option 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	Equality/ Other Impacts
	Low	High	Low	High	Central	
Option 2:	N/A	N/A	N/A	N/A	N/A	None
Total	N/A	N/A	N/A	N/A	N/A	
NPV	N/A	N/A	N/A	N/A	N/A	
Costs and benefits	<p>We assume that there may be improved efficiency and innovation in the commissioning of public health services from joining up commissioning activities at a national level. These potential savings from increased efficiencies and innovation will have to be large enough to offset the costs of transferring staff to the Public Health Service if we are to conclude that the benefits of the preferred options outweigh the costs. We do not consider any benefits of transferring commissioning responsibilities to the PHS.</p>					<p>DH is already well-versed in its responsibilities under equality and human rights legislation</p>

Annex: Post Implementation Review

<p>Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];</p> <p>There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.</p>
<p>Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p> <p>Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.</p>
<p>Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]</p> <p>The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England</p> <p>The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework. Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.</p> <p>DsPH will also need to produce an annual report</p>
<p>Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p>Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p>
<p>Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]</p> <p>Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.</p>
<p>Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]</p>

Impact Assessment C: Ring-fenced Funding for Public Health England

Title: Ring-fenced funding of the public health service Lead department or agency: Department of Health Other departments or agencies:	Impact assessment (IA)
	IA no: 3026
	Date: 30.10.10
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Other

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

There is evidence that insufficient priority has been given to public health services in recent years. This could lead to lower improvements in health of the population over the medium to long term and a higher need for NHS treatment services.

Over 80% of NHS funding is allocated to Primary Care Trusts (PCTs) and the Department of Health has not broken down PCT allocations by policies, at either the national or local level. It has been for PCTs to decide their priorities for investment taking into account both local priorities and the NHS Operating Framework. The incentives faced by PCTs and DH central budgets have not led to sufficient priority being given to public health.

What are the policy objectives and the intended effects?

The main policy objective is to safeguard spending on public health services by establishing a ring-fenced public health budget and thereby help to improve public health and overall health outcomes. Investment in public health services is a cost-effective way to improve population health and reduce the need for NHS treatment services.

A second objective is to ensure that the funding for public health work is provided according to the baseline need and that public health funding allocations act to reduce inequalities.

A third objective is to ensure that local areas which achieve improvements in public health outcomes are rewarded for their achievement. This will encourage local areas to improve their performance.

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

1. Do nothing
 2. Transfer existing PCT public health budgets to local authorities without a ring-fence
 3. Establish a national public health budget and transfer some of this funding to local authorities with a ring fence
 4. Establish a national public health budget and transfer some of this funding to local authorities with a ring fence with higher funding for areas with poorer health to help reduce health inequalities, and a "health premium" to incentivise progress and reward success
- Option 4 is the preferred option.

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?	SEE ANNEX
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	YES

Ministerial Sign-off For consultation stage Impact Assessments:

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

Signed by the responsible Minister:  **Date:** 27/11/2010

Description: Do Nothing

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

The Coalition Agreement said that the Government would give local communities control over public health budgets, including payments by outcomes. In the White Paper 'Equity and excellence' the Government proposed a ring-fence for budgets. The impact assessment therefore focuses on this option, but includes others for illustrative purposes and to inform the consultation exercise that begins shortly with the publication of detailed proposals. We will develop the costings as we finalise the system in the light of consultation responses.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Key assumptions/sensitivities/risks

Discount rate

With the disestablishment of Strategic Health Authorities and Primary Care Trusts, funding for public health interventions needs to move to whoever has responsibility for commissioning them. The “do nothing” option is therefore not viable.

Direct impact on business (Equivalent Annual) (£m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?					
Which organisation(s) will enforce the policy?			N/A		
What is the annual change in enforcement cost (£m)?			N/A		
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ²³ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

²³ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 2

Description: Transfer existing PCT public health budgets to local authorities without a ring-fence

Price **PV** **Time**
Base **Base** **Period**
Year **Year** **Years**

Net Benefit (Present Value (PV)) (£m)		
Low: Optional	High: Optional	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

The Coalition Agreement said that the Government would give local communities control over public health budgets, including payments by outcomes. In the White Paper 'Equity and excellence' the Government proposed a ring-fence for budgets. The impact assessment therefore focuses on this option, but includes others for illustrative purposes and to inform the consultation exercise that begins shortly with the publication of detailed proposals. We will develop the costings as we finalise the system in the light of consultation responses.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Public health spend will be separated from healthcare spend. This option should lead to better co-operation with other wider local authority mentioned interventions.

Key assumptions/sensitivities/risks

Discount rate

This option cannot ensure that the money will be spent on public health activities so it does not achieve the objective of protecting public health spend.

Direct impact on business (Equivalent Annual) (£m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?			England			
From what date will the policy be implemented?						
Which organisation(s) will enforce the policy?			N/A			
What is the annual change in enforcement cost (£m)?			N/A			
Does enforcement comply with Hampton principles?			N/A			
Does implementation go beyond minimum EU requirements?			N/A			
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:	Non-traded:		
Does the proposal have an impact on competition?			No			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:	Benefits:		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)		Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?		N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ²⁴ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

²⁴ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 3

Description: Establish a national public health budget and transfer some of this funding to local authorities with a ring fence

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

The Coalition Agreement said that the Government would give local communities control over public health budgets, including payments by outcomes. In the White Paper 'Equity and excellence' the Government proposed a ring-fence for budgets. The impact assessment therefore focuses on this option, but includes others for illustrative purposes and to inform the consultation exercise that begins shortly with the publication of detailed proposals. We will develop the costings as we finalise the system in the light of consultation responses.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

The option will protect public health funding and promote synergies within current local authority activities.

Key assumptions/sensitivities/risks

Discount rate

Without ensuring higher funding for areas with poorer health, there is a risk that funding is not matched to need and therefore does not promote action on health inequalities. This option does not ensure that local areas which achieve improvements in outcomes are rewarded.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?					
Which organisation(s) will enforce the policy?			N/A		
What is the annual change in enforcement cost (£m)?			N/A		
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ²⁵ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

²⁵ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 4

Description: Preferred Option - Establish a national public health budget and transfer some of this funding to local authorities with a ring fence with higher funding for areas with poorer health to help reduce health inequalities, and a “health premium” to incentivise progress and reward success

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

Costs (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total cost (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised costs by ‘main affected groups’

The additional costs will be those of developing a separate allocation formula for public health rather than the current single PCT formula. These costs will be low. There will also be costs associated with the process of issuing allocations for the public health service. Costings are being developed and will be finalised at a later stage.

Other key non-monetised costs by ‘main affected groups’

Benefits (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total benefit (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Ring-fencing the public health budget will protect public health spend in the forthcoming years of spending cuts or when the demands on the NHS are increasing at a faster pace than resources. This should lead to higher population health than would otherwise be the case
The funding mechanism includes a health premium, designed to promote action to reduce health inequalities (and reward success), will ensure higher funding for areas with poor health outcomes,

Key assumptions/sensitivities/risks

discount rate

There is a risk that once the ring-fence budget is set at a particular level, this cements spend, even if it is not enough or too high and thus could lead to less than optimal health outcomes.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?			Options		
From what date will the policy be implemented?			2013		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ²⁶ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

²⁶ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

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

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

N O.	LEGISLATION OR PUBLICATION
9	<i>EQUITY AND EXCELLENCE: LIBERATING THE NHS</i>
10	
11	
12	

+ Add another row

Evidence Base

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

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

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
TRANSITION COSTS										
ANNUAL RECURRING										
TOTAL ANNUAL										
TRANSITION										
ANNUAL RECURRING										
TOTAL ANNUAL										

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



Microsoft Office
Excel Worksheet

What are the policy objectives and the intended effects?

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health White Paper. Other impact assessments in this suite are
 - Structure of Public Health England (IA3024)
 - Commissioning in the public health service (IA3025)
 - Public Health Outcomes Framework (IA3027)
 - Information and intelligence for public health (IA3028)
 - Health visitors (IA3030)
2. This Impact Assessment considers how the public health service will be funded. It directly impacts the public sector only.
3. In the context of the historically insufficient priority given to public health services and public health spend within the total resources available to the NHS, the policy objective is to safeguard spending on public health services and thereby help to improve public health and overall health outcomes. Investment in public health services is a cost-effective way to improve population health and reduce the need for NHS treatment services.
 - The Independent Advisory Group on Sexual Health and HIV has said that a substantial part of the £300 million set aside for improving sexual health has been absorbed by primary care trusts (PCTs)²⁷.
 - The British Heart Foundation have argued that funds intended for public health have been used to offset deficits in acute care budgets²⁸.
 - As one newspaper investigation revealed: “NHS trusts across England have siphoned off almost £100 million from government funds intended to combat obesity, alcohol abuse and sexually transmitted infections as a panic measure to escape financial crisis. Data provided by 103 PCTs showed that half axed almost all the projects promised by the government in the Choosing Health White Paper in 2004. Less than 10% of PCTs used the full public health allocation for the intended purpose²⁹.”
4. As a justification for ring-fencing it is worth noting that the cost per quality-adjusted life year (QALY) for preventive interventions is often better than for treatment services. The median cost per QALY of public health interventions examined by NICE is £365 while the cost per QALY (strictly, cost per life year) for five broad treatment services at the margin has been estimated to be of the order of £10,000 (CHE Research Paper 32³⁰). The evidence available inevitably does not cover many interventions or treatments, but it gives an indication of the health loss from potential cuts to public health budgets.
5. The same data on cost per QALY indicates the potential impact on health inequalities from a distribution of resources towards areas with poorer health.
6. A second objective is to ensure that the funding for public health work is distributed according to each area’s relative baseline need and that public health funding allocations act to reduce inequalities.
7. A third objective is to ensure that local areas which achieve improvements in public health outcomes are rewarded for their achievement. This will encourage local areas to improve their performance.

What policy options have been considered?

We have assessed the impact of four options:

1. Do nothing

²⁷ The Times, Sexual health funds used to cut trust debts, August 2006, <http://www.timesonline.co.uk/tol/news/uk/article697093.ece>

²⁸ BHF submission to Conservative Public Health Consultation

²⁹ 71 The Guardian, Trusts raided public health cash in panic over funding, October 2007, <http://www.guardian.co.uk/uk/2007/oct/19/health.politics>

³⁰ <http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHE%20Research%20Paper%2032.pdf>

2. Transfer existing PCT public health budgets to local authorities without a ring-fence.
3. Establish a national public health budget and transfer some of this funding to local authorities with a ring-fence.
4. Establish a national public health budget and transfer some public health funding to local authorities with a ring-fence, with higher funding for areas with poorer health to help reduce health inequalities and a 'health premium' to incentivise progress and reward success.

Option 1 – do nothing

8. The 'do nothing' option is not viable because in light of the disestablishment of Strategic Health Authorities (SHAs) and PCTs, funding for public health interventions will need to move to wherever the responsibility for commissioning them transfers.

Alternative: option 2 – transfer existing PCT public health budgets to local authorities without a ring-fence

9. Although transferring local public health budgets to local authorities would separate public health spending from healthcare spending it would not ensure that the money was spent on public health activities as opposed to other local authority priorities and would therefore not achieve the objectives of protecting public health spend. This is particularly true in the light of the pressure which is likely to be placed on local authority budgets after the 2010 Spending Review.
10. This option might, however, allow better co-ordination with other, wider, local authority managed interventions affecting public health, such as housing and support for sport and cycling.
11. One disadvantage of separating public health funding from healthcare funding could be a consequential lack of integration between commissioning of public health and health care interventions. This can be reduced by ensuring robust mechanisms for co-operation across the system, for example pooling of budgets.
12. It would not be appropriate for the budget and commissioning role to transfer to GP consortia as they will be responsible for patients from across a number of different areas under patient choice of GP. They will therefore lack sufficient geographic focus for public health initiatives which are most effective within whole geographic areas.

Alternative: option 3 – establish a national public health budget and transfer some of this funding to local authorities with a ring-fence

13. This option would protect public health funding and promote synergies with current local authority activities.
14. The disadvantage of a ring-fence is that it will reduce, to some extent, the flexibility with which local authorities will be able to use their resources locally, and risks resources being used inefficiently. However, this risk can be mitigated. Although the Department will set national outcomes, it will not prescribe exactly how the budget is spent. Rather, the budget will be devolved to local authorities who are best placed to make decisions about the services needed locally, within a framework of national outcomes. They will be able to use the ring-fenced budget widely to improve public health in their local area, including jointly with other local authority budgets such as those for children's service, schools, housing, transport and environmental health. The ring-fence itself ensures delivery of the policy objective of protecting spending on improving public health.
15. As noted above, one disadvantage of separating public health funding from healthcare funding could be a consequential lack of integration between commissioning of public health and healthcare interventions. In order to mitigate this risk we will seek to design a system that allows the NHS and public health bodies to work together closely. Thus local authorities will also be able to commission from public health providers and Public Health England will be able to fund the commissioning of a wide variety of services by the NHS, either via the NHS Commissioning Board at the national level, or GP consortia at the local level.

Preferred: option 4 - establish a national public health budget and transfer some public health funding to local authorities with a ring-fence and a 'health premium' to incentivise progress and reward success

16. In the preferred option, in addition to the ring-fenced local public health budgets being transferred to local authorities we will also ensure higher funding for areas with poorer health and introduce a health premium, designed to promote action to reduce health inequalities and reward success.
17. The split between what funding is retained nationally and what is passed to local authorities will be based on what is best done at each level.
18. The additional benefit of this option is that funding is matched to need and it promotes action on health inequalities. The purpose of success payments will be to ensure that no area that has succeeded in delivering health improvements in its local population will have funding taken away on the basis of its new health outcomes, rather it will incentivise and reward success.
19. This is not a ring-fence which will determine how the money should be spent, but rather what its overall purpose should be. The budget will be devolved to local authorities and local Directors of Public Health who are best placed to make decisions about the services needed locally. They will be able to use the ring-fenced budget widely to improve public health in their local area, including jointly with other local authority budgets such as those for children's service, schools, housing, transport and environmental health.
20. The public health White Paper sets out to estimate current spend on those services that would in future be funded from the public health budget. This is the first step in determining the size of the public health budget. Final decisions on the size of the budget will depend on a number of factors, including the cost effectiveness of public health interventions. The full remit of Public Health England and commissioning responsibilities in the new system will be subject to consultation.
21. The baseline allocation of resources is expected to be based on a formula, the development of which will be overseen by the Advisory Committee on Resource Allocation. We are also developing the health premium that will promote action to reduce health inequalities. The details of the health premium will be subject to consultation.
22. The approach to allocating resources will depend on the detailed design of the local authorities' responsibilities for public health. In particular, it will depend on the services and outcomes that fall to the local authorities. For this reason, we cannot yet specify the design of the allocation methodology, but we expect to be considering relative health outcomes, cost effectiveness of population interventions and population characteristics as possible drivers of the target allocation.
23. In due course, the Secretary of State for Health will ask the Advisory Committee on Resource Allocation to give him recommendations on the design of the allocation, taking account of responses to the consultation on funding and commissioning routes for public health.

Option Impacts, Costs and Benefits

Costs and benefits

24. We have considered the costs and benefits of the three features of the preferred option, namely: the ring-fence; funding recognising deprivation; and the reward element.

Ring-fencing public health funds

25. A benefit is gained from ring-fencing the public health budget over not doing so, as it will protect public health spend in the forthcoming years of spending cuts or when the demands on the NHS are increasing at a faster pace than resources. The ring-fence will lead to higher population health than would otherwise be the case. It is however not possible to quantify this benefit in monetary terms or in terms of health gains as we are not able to predict how much lower public health spend would be without the ring-fence, see paragraph 2 above.
26. There is a risk that once the ring-fence budget is set at a particular level, this cements spend, even if it is not enough or too high and thus could lead to less than optimal health outcomes. The balance of funding between public health and the NHS would be reassessed regularly to avoid this risk.

27. The government will ring-fence public health funds from within the overall NHS budget to ensure that it is prioritised. The additional costs will be those of:

- developing a separate allocation formula for public health rather than the current single PCT formula. The cost of this will be low;
- the process of issuing allocations for the public health service. [Cannot determine these until details are developed]

E. SUMMARY AND WEIGHING OF OPTIONS

i. Present the best estimate of the overall net benefit of each option, by deducting the expected opportunity cost of the intervention (see IA Technical Guidance on how to derive the Opportunity Cost) from the expected benefit.

ii. Summarise other factors, including equality and that weigh for or against each option, using the criteria cited for this IA in section A.

iii. Draw conclusions:

- Which options are QIPP compliant (ie without compromising quality they yield net cash savings by 2014. (See DH IAs Made Easy Guide.)
- Identify the preferred option and briefly state why it is the preferred option?

TABLE : COSTS AND BENEFITS AND OTHER FACTORS ASSOCIATED WITH THE SHORT LISTED OPTIONS							
OPTIONS (AGAINST OPTION 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	EQUALITY/ OTHER IMPACTS	QIPP COMPLIANCE
	CENTRAL	WORST	CENTRAL	WORST			
OPTION 2:							
OPTION 3:							
TOTAL							
NPV							
COSTS AND BENEFITS							

Annex: Post Implementation Review

Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];

There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.

Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]

Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.

Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]

The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England

The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework.

Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.

DsPH will also need to produce an annual report

Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]

Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]

Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]

Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.

Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]

Impact Assessment D: Public Health Outcomes Framework

Title: Public Health Outcomes Framework Lead department or agency: Department of Health Other departments or agencies:	Impact assessment (IA)
	IA no: 3027
	Date: 27/10/10
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Other

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

What are the policy objectives and the intended effects?
 The Outcomes Framework provides a vision for the future of public health, and demonstrates a mechanism by which this vision can be achieved. This vision is 'To Protect and Improve the Nation's Health and Well Being'. As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes Framework. The consultation will also invite suggestions on the structure of the framework itself. Public Health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.

What policy options have been considered? Please justify preferred option (further details in Evidence Base)
 1. Do nothing
 2. Develop a public health outcomes framework

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved? See Annex

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review? Yes

Ministerial Sign-off For consultation stage Impact Assessments:

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

Signed by the responsible Minister:  Date: 27/11/2010

Summary: Analysis and Evidence

Policy Option 1

Description: Do Nothing

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Key assumptions/sensitivities/risks

Discount rate

Without the introduction of an Outcomes Framework, there would be no robust system in place that is able to monitor the extent of health protection or emergency preparedness measures. Addressing this issue is of vital importance if we are to consider resilience or preparation for emergency events. In addition to a lack of monitoring of public health outcomes, there is an implicit lack of accountability at the local and national level that would drive forward improvements in health protection, health improvement and well-being.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?					
Which organisation(s) will enforce the policy?			N/A		
What is the annual change in enforcement cost (£m)?			N/A		
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ³¹ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³¹ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Description: Develop a public health outcomes framework

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

Costs (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total cost (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised costs by ‘main affected groups’

As the development of the new outcomes framework is still in its early stages (with consultation questions detailed in a separate document to be published shortly) the final approach taken, as well as the individual outcome indicators selected, will be determined post-consultation, costs cannot be estimated at this stage.

Other key non-monetised costs by ‘main affected groups’

Benefits (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total benefit (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

There should be refocusing and strengthening of public health outcomes and their delivery at local and National levels. Outcome measures may incentivise cost-effective interventions
Resources should be saved from reducing the burden of current top-down performance management
Structures and streamlining as a result of synergy across the adults social care and NHS outcomes Framework.

Key assumptions/sensitivities/risks	discount rate
--	----------------------

Direct impact on business (Equivalent Annual) £m):			In scope of OIO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?	England
---	---------

From what date will the policy be implemented?			01/04/2013		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:	Non-traded:	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:	Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

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Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³² Race, disability and gender impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

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

References

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

No.	Legislation Or Publication
13	Outcomes Not Targets, Conservative Party (2008). Http://Www.Conservatives.Com/~Media/Files/Green%20papers/Health Policy Paper.Ashx?DI=TRUE
14	<i>Equity And Excellence: Liberating The Nhs</i>
15	
16	

+ Add another row

Evidence Base

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

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

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
TRANSITION COSTS										
ANNUAL RECURRING										
TOTAL ANNUAL										
TRANSITION										
ANNUAL RECURRING										
TOTAL ANNUAL										

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



Microsoft Office
Excel Worksheet

Public health outcomes framework

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health white paper. Other impact assessments in this suite are
 - Structure of Public Health England (IA3024)
 - Commissioning in the public health service (IA3025)
 - Ring-fenced funding of public health (IA3026)
 - Information and intelligence for public health (IA3028)
 - Health visitors (IA3030)
2. This Impact Assessment considers what framework and indicators could be used to monitor and drive improvements in the public health service. It directly impacts the public sector only.
3. The Outcomes Framework provides a vision for the future of public health, and demonstrates a mechanism by which this vision can be achieved. This vision is 'To Protect and Improve the Nation's Health and Well Being'. As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes as well as suggestions on the structure of the framework itself. Public health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.
4. The current Government, elected in May 2010, abolished the Public Service Agreement (PSA) system, and the system of Local Area Agreements. Whilst the NHS Outcomes Framework will be able to monitor and drive forward improvements in NHS services, there are no equivalent arrangements in place for the delivery and monitoring of improvements in public health yet. This impact assessment is concerned with the potential costs and benefits of the proposed Public Health Outcomes Framework, though no actual costs and benefits can yet be estimated.

What policy options have been considered?

5. We have assessed the impact of two options:
 1. Do nothing
 2. Develop a public health outcomes framework

Option 1 – do nothing

6. As mentioned above, currently there is no single system in place that specifically measures public health outcomes. The Health and Social Care Bill, building on *Equity and excellence: liberating the NHS*, published in July 2010 has put forward proposals to abolish Vital Signs and the National Indicator Set which currently report on selected public health indicators.
7. Current inefficiencies include:
 - a. Top-down bureaucratic focus on processes rather than outcomes.
 - b. Vital Signs tiers do not allow local decisions to be made about priorities for health improvement.
 - c. Duplication of performance management processes.
 - d. Lack of prioritisation of public health and wellbeing outcomes at the expense of NHS process and treatment focused delivery.
8. Without the introduction of an Outcomes Framework, there would be no robust system in place that is able to monitor the extent of health protection or emergency preparedness measures. Addressing this issue is of vital importance if we are to consider resilience or preparation for emergency events.

9. In addition to a lack of monitoring of public health outcomes, there is an implicit lack of accountability at the local and national level that would drive forward improvements in health protection, health improvement and well-being.
10. Without a performance framework that addresses delivery and impact on different groups, it will not be possible to continue to assess the impact of services on core public health outcomes for these groups. Doing nothing does not further develop our approach to tackle the gender, age, geographical, or socioeconomic health inequalities that currently exist.

Preferred: option 2 – develop a public health outcomes framework

11. In line with the approach taken by the NHS Outcomes Framework and the Social Care Outcomes Framework, the current proposal for the Public Health Outcomes Framework includes selected indicators in five domains. These domains currently include (subject to change):
 - a. Enhanced Healthy Life Expectancy and Preventable Mortality;
 - b. Health Inequalities;
 - c. Health Improvement;
 - d. Prevention of Ill-Health; and
 - e. Protection and Resilience.
12. The indicators in this Outcomes Framework will be selected because they provide the most robust mechanism by which progress towards the overarching public health outcomes can be monitored
13. In addition, this framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account.
14. Regarding the development of candidate indicators pre-consultation, the following criteria were used:
 - a. HM Treasury Transparency Framework criteria
 - b. Are there evidence-based interventions to support this indicator?
 - c. Does this indicator reflect a major cause of premature mortality or avoidable ill health?
 - d. By improving on this indicator, can you help to reduce inequalities in health?
 - e. Do you think this indicator will be meaningful to the broader public health workforce?
 - f. Is this indicator likely to have a negative / adverse impact on any particular groups? (If yes, can this be mitigated?)
 - g. Is it possible to set measures, SMART objectives and targets against the indicator to monitor progress in both the short and medium term?
 - h. Are there existing systems to collect the data required to monitor this indicator and;
 - i. Is it available at the appropriate spatial level (e.g. local authority)?
 - j. Is the time lag for data less than one year?
 - k. Can data be reported quarterly in order to report progress?
15. Post consultation on the candidate indicators, additional criteria will be applied prior to final publication incorporating the following three principles/analytical tasks:
 - Risk-adjustment. Underlying characteristics (e.g. socio-economic profile) could impact on achievement at a local level. This will pose challenges for comparing indicators between areas and negotiating local contributions to national ambitions. It is anticipated that a process of risk adjustment will be developed and applied where feasible and based on data broken down by agreed characteristics. This process might be applied differently to differentiate between those health improvement indicators where a financial incentive might be applied and those indicators used for monitoring purposes.
 - Calibration. Where feasible, the analytical, research and development functions of Public Health England will review the incremental contribution of indicators in terms of their relative importance to contributing to the overarching public health outcomes of 1) improving healthy life expectancy and 2) reducing the healthy life expectancy gap between the least deprived and most deprived communities. This will enable Health and Wellbeing Boards to formulate their priorities. It is important to note that for indicators which focus on the broader determinants of health, requiring cross-cabinet collaboration, the analytical and Research & Development support might sit outside of Public Health England.

- **Comprehensiveness:** A broad set of candidate indicators will be circulated as part of the consultation process including those that focus on the broader determinants that impact on the public's health. The consultation should expose any gaps and ensure that the list remains comprehensive, reflecting the areas of public health activity most likely to impact on the aforementioned overarching outcomes. Comprehensiveness will be considered prior to publication of the final indicator set alongside the need to be representative and balanced.
16. It is important to note that these principles will pose significant challenges with regards to their translation into practice, (e.g. data availability) which will be fully considered post the initial consultation period.
 17. Achievement of public health outcomes requires a cross-government approach and this must be supported by the alignment of the outcome framework across the NHS, public health and adult social care, taking a life-course approach. The Secretary of State for health has made clear the value of evaluation and we will continue to build proposals and options based on strong evidence where it is available.
 18. Consultation will include:
 - departmental stakeholder events;
 - engagement with the public health community (Directors of Public Health Advisory Group) and Black and minority ethnic communities;
 - engagement across Government, and wider public health workforce, including regional teams (Public Health Observatories, Regional Public Health Groups); and
 - a formal 12 week consultation.
 19. Secretary of State has made clear his intention that an Outcomes Framework which will drive forward improvements in public health will be fully implemented by 2013/14. He has also made clear his intention that the Public Health Outcomes Framework will have strong links with the Outcomes Frameworks for both the NHS and Adult Social Care.

Impacts, Costs and Benefits of preferred option

Costs and benefits

20. Identifying impacts as a result of achieving different outcomes would be the subject of a further Impact Assessment after the consultation period. Local level contribution to the outcome indicators will be driven by local need, dependent on the outcomes chosen and any associated level of ambition agreed regarding outcome indicators.
21. Regarding the Outcomes Framework under development, anticipated positive impacts are:
 - an overall reduction in the performance monitoring burden at a local level;
 - refocusing and strengthening of public health outcomes and their delivery at local and national levels;
 - synergy / alignment between the NHS Outcomes Framework/ Adult Social Care Framework and Public Health Outcomes Framework; and
 - prioritisation of health indicators with the greatest potential to impact on the public's health (and health inequalities), supported by an evidence base of intervention to improve health outcomes.
22. Regarding the Outcomes Framework under development, possible negative impacts are:
 - Current proposal for the Public Health Outcomes Framework may be seen by local authorities, and others as regressive because of its top-down nature.
 - Continuity may be difficult to achieve between existing frameworks (e.g. Vital Signs / National Indicator Set) and the new outcomes framework.
 - The prioritisation process to develop top-level indicators could result in unintended consequences e.g. they become the focus for local action over and above local need / priorities.
 - There may be limitations in the evidence base underpinning the interventions required to improve selected outcome indicators.

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

Anticipated costs

- If new data collections are needed to monitor outcomes, then these will have cost implications for the public health service. In most cases, data underpinning outcome indicators may already be collected. However, the frequency and timeliness of existing indicators may have to be improved in order to be suitable for accountability purposes.
- In other cases, based on the final indicator set, new data collection systems may need to be established incurring additional costs including as appropriate, the setting up and evaluation of pilots.
- To be determined at a local level, additional costs may be as a result of diverting public health expenditure to meet locally agreed ambitions resulting in opportunity costs.

Anticipated benefits

- Outcome measures may incentivise cost-effective interventions. It is not possible to quantify these at this stage.
- Resources saved from reducing the burden of current top-down performance management structures and streamlining as a result of synergy across the Social Care and NHS Outcomes frameworks.
- Until the framework is fully developed and indicator set agreed following consultation, it will not be possible to quantify or evaluate the net benefit of this approach.

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

SUMMARY AND WEIGHING OF OPTIONS

1. Option 2, representing the setting up of an Outcomes Framework, is the preferred option.
2. Provided the outcome indicators and levels of ambition selected are appropriate, and fulfil the conditions explained above and in the consultation document, we would expect benefits to outweigh costs.
3. However, the full costs and benefits of establishing an Outcomes Framework cannot be estimated at this stage, with considerable uncertainties about the likely shape and content of the framework.

Annex: Post Implementation Review

Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];

There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.

Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]

Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.

Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]

The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England

The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework.

Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.

DsPH will also need to produce an annual report

Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]

Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]

Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]

Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.

Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]

Impact Assessment E: Information and intelligence for public health

Title: Information and intelligence for public health Lead department or agency: Department of Health Other departments or agencies:	Impact assessment (IA)
	la no: 3028
	Date: 14/10/10 (draft)
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Other

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

The nation has a wealth of information on public health, collected in a variety of ways, and used by different people and organisations for many purposes. The range of information and number of agencies involved means that there is some complexity in current arrangements, leading to gaps and overlaps in the provision of information and intelligence. The new public health system offers a unique opportunity to review these complex functions and draw together those which make a difference into a more coherent form. This should reduce duplication and fill critical gaps. We will harness the information revolution to deliver information-led, knowledge-driven public health.

What are the policy objectives and the intended effects?

Information and intelligence supports and is generated through the underpinning public health functions of surveillance and epidemiology, and provides the rational basis for public health decision-making at individual, local and strategic level. The policy objective is to consider and weigh options for ensuring provision of issue- and locality-specific public health evidence functions, in line with changes happening across the public health system.

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

1. Do nothing
 2. In-house provision of all issue- and locality-specific public health functions
 3. Public Health England commissions all such functions from outside organisations
 4. Public Health England commissions such functions where possible and performs in-house where necessary
- Option 4 is the preferred option because it offers the most flexible solution enabling functions to be provided in the most appropriate and cost effective way, in keeping with the requirements, documented elsewhere, of an information revolution. Further recommendations will be made by the public health Information and Intelligence Strategic Working Group on which functions are provided by Public Health England and which are commissioned and on ballpark costs

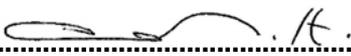
When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?

See annex

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?

Ministerial Sign-off For consultation stage Impact Assessments:

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

Signed by the responsible Minister:.......... Date: 27/11/2010

Summary: Analysis and Evidence

Policy Option 1

Description: Do Nothing

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

Description and scale of key monetised costs by ‘main affected groups’ PH I&I strategic working group are in the process of recommending which information and intelligence functions are to be secured for the future and which are to be provided in-house by the public health service and which are to be commissioned. Costings for these functions are being developed and will be finalised in light of the responses to the consultation exercise that begins shortly with the publication of detailed proposals.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Key assumptions/sensitivities/risks

Discount rate

There is complexity in the current arrangements with gaps and overlaps in the provision of information and intelligence.
There have been commitments given to an Information Revolution as part of Big Society.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:		
			No	NA

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?					
Which organisation(s) will enforce the policy?			N/A		
What is the annual change in enforcement cost (£m)?			N/A		
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ³³ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts Competition Competition Assessment Impact Test guidance Small firms Small Firms Impact Test guidance	No	
	No	
Environmental impacts Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
	No	
Social impacts Health and well-being Health and Well-being Impact Test guidance Human rights Human Rights Impact Test guidance Justice system Justice Impact Test guidance Rural proofing Rural Proofing Impact Test guidance	Yes	8
	No	
	No	
	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³³ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 2

Description: In-house provision of all issue- and locality-specific public health functions

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

Description and scale of key monetised costs by ‘main affected groups’ PH I&I strategic working group are in the process of recommending which information and intelligence functions are to be secured for the future and which are to be provided in-house by the public health service and which are to be commissioned. Costings for these functions are being developed and will be finalised in light of the responses to the consultation exercise that begins shortly with the publication of detailed proposals.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

If elements of Public Health England could be retained in different physical locations around the country, this would enable greater collaboration and innovation with academic and/or NHS colleagues and would increase impact through personal relationships on locality-specific functions.

Key assumptions/sensitivities/risks

Discount rate

There is a risk of losing face to face contact with local areas and disrupting existing issue-specific teams

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:		
			No	NA

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	2012				
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?	N/A				
Does implementation go beyond minimum EU requirements?	N/A				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded:		Non-traded:		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	Costs:		Benefits:		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ³⁴ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³⁴ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Description: Public Health England commissions all such functions from outside organisations

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

Description and scale of key monetised costs by ‘main affected groups’

Description and scale of key monetised costs by ‘main affected groups’ PH I&I strategic working group are in the process of recommending which information and intelligence functions are to be secured for the future and which are to be provided in-house by the public health service and which are to be commissioned. Costings for these functions are being developed and will be finalised in light of the responses to the consultation exercise that begins shortly with the publication of detailed proposals.

Other key non-monetised costs by ‘main affected groups’

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

Where appropriate skills are available, this option could increase value for money and drive innovation through market competition.

Key assumptions/sensitivities/risks

Discount rate

This option would have a lower level of control than direct provision by the public health service with particular risks during emergencies. At the moment the requisite level of skill to perform issue or locality specific functions is not present in other organisations.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?					
Which organisation(s) will enforce the policy?	N/A				
What is the annual change in enforcement cost (£m)?	N/A				
Does enforcement comply with Hampton principles?	N/A				
Does implementation go beyond minimum EU requirements?	N/A				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded:		Non-traded:		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	Costs:		Benefits:		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ³⁵ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³⁵ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Description: Public Health England commissions information and intelligence functions where possible and performs in-house where necessary

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

Costs (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total cost (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised costs by ‘main affected groups’

Description and scale of key monetised costs by ‘main affected groups’ PH I&I strategic working group are in the process of recommending which information and intelligence functions are to be secured for the future and which are to be provided in-house by the public health service and which are to be commissioned. Costings for these functions are being developed and will be finalised in light of the responses to the consultation exercise that begins shortly with the publication of detailed proposals.

Other key non-monetised costs by ‘main affected groups’

Benefits (£m)	Total transition (constant price) years	Average annual (excl. Transition) (constant price)	Total benefit (present value)
Low	optional	optional	optional
High	optional	optional	optional
Best estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Other key non-monetised benefits by ‘main affected groups’

The preferred option should reduce gaps and overlaps in the provision of information and intelligence. The option will allow information and intelligence to be provided in the most appropriate and cost effective way, in keeping with the requirements of an information revolution.

Key assumptions/sensitivities/risks

Evidence functions need to be introduced into the public health system without vital health protection measures being interrupted.

discount rate

Direct impact on business (Equivalent Annual) (£m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:		
			No	NA

What is the geographic coverage of the policy/option?			Options		
From what date will the policy be implemented?			2012		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:		Benefits:
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	NA	NA	NA	NA	NA

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

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

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Sustainable development Sustainable Development Impact Test guidance	No	

³⁶ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

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

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment). Evidence Base

N O.	LEGISLATION OR PUBLICATION
17	<i>EQUITY AND EXCELLENCE: LIBERATING THE NHS</i>
18	
19	
20	

+ Add another row

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

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

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
TRANSITION COSTS										
ANNUAL RECURRING										
TOTAL ANNUAL										
TRANSITION										
ANNUAL RECURRING										
TOTAL ANNUAL										

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



Microsoft Office
Excel Worksheet

Information and intelligence for public health

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health white paper. Other impact assessments in this suite are:
 - structure of Public Health England (IA3024);
 - Commissioning in the public health service (IA3025);
 - Ring-fenced funding of Public Health England (IA3026);
 - Public Health Outcomes Framework (IA3027); and
 - health visitors (IA3030).
2. This Impact Assessment considers how the public health service will collate and disseminate evidence. It directly impacts the public sector only.
3. Information and intelligence supports and is generated through the underpinning public health functions of surveillance and epidemiology, and provides the rational basis for public health decision-making at individual, local and strategic level. The importance of information and intelligence functions to the effectiveness of a public health system cannot be over-emphasised.
4. The objective of this workstream is to consider and weigh options for ensuring provision of issue- and locality-specific public health evidence functions, in line with changes happening across the public health system. Examples of these functions are: Health Profiles, Hospital Episodes Statistics, support for Joint Strategic Needs Assessments, syndromic surveillance, investigation of outbreaks, the work of the specialist observatories.

What policy options have been considered?

5. We have considered four options:
 - 1) Do nothing
 - 2) In-house provision of all issue- and locality-specific public health functions
 - 3) Public Health England commissions all such functions from outside organisations
 - 4) Public Health England commissions such functions where possible and performs in-house where necessary

Option 1: Do nothing

6. The needs of a public health evidence function are wide ranging. Information is required from many sources and crossing many service provision sectors, including:
 - population - demography, resident population numbers and characteristics
 - health status - general surveys, also registration and surveillance of particular groups
 - disease - all types of epidemiology
 - services - provision of health and social care services, usage, outcome, effectiveness, efficiency, drug prescriptions, safety
 - people - life style, risk-factors, views, experience of services, comparisons between groups
 - social and environmental - information about the wider determinants of health, also information relating to occupational health
 - mortality - causes, trends
7. In addition, this information needs to be available at several levels of aggregation, including neighbourhoods, communities, administrative boundaries, regional and national. As a result, many agencies are involved in providing this information and intelligence, including the Public Health Observatories, the Office of National Statistics and the NHS Information Centre.
8. Given the range of information and the number of agencies involved, there is some complexity in current arrangements, leading to gaps and overlaps in the provision of information and intelligence. For example, a workshop in 2008 on surveillance in the NHS, hosted by Informing Healthier Choices, identified over 70 information systems producing surveillance information. Also there are currently at least 35 national clinical audit schemes in the NHS.

9. The development of a new public health system provides the opportunity to draw together a variety of existing public health organisations and structures into a unified professional service that maximises synergies across functions and minimises duplications and gaps. This extends to information functions, and the Impact Assessment focused on the architecture of the public health system examines the impact of bringing different information organisations into Public Health England, including the Health Protection Agency surveillance functions, Public Health Observatories and existing public health registries.
10. In light of the above and the commitments, as part of Big Society, to an Information Revolution in which information is accessible to all, relevant and well structured, the Do Nothing option is not an option. This is further supported by the overarching efficiency imperative across the public sector and the important fact that the rest of the information system is changing (e.g. bringing in the Health Protection Agency) requiring significant and affirmative action.

Alternative: option 2 – in-house provision of all issue- and locality-specific public health functions

11. This approach could be enacted either through a large centralised team delivering efficiencies of approach, though this risks losing face to face contact with local areas and would disrupt existing issue-specific teams (e.g. the Oxford based obesity observatory or York-based health economics function) leading to unnecessary loss of effectiveness. Alternatively, elements of Public Health England could be retained in different physical locations around the country, e.g. with embedded teams working alongside academic institutions and/or NHS Commissioning Board outposts. This would enable greater collaboration and innovation with academic and/or NHS colleagues and would increase impact through personal relationships on locality-specific functions.

Alternative: option 3 – Public Health England commissions all such functions from outside organisations

12. This could include organisations such as the NHS Information Centre or academic groups, or it could be purely commercial companies. There would be a lower level of control than direct provision, which could present risks especially during an emergency. Furthermore, the required level of skill to perform these issue- or locality-specific functions is not currently consistently present in other organisations. This is particularly true for specialist health protection information functions, where other bodies do not have the capacity, skills or necessary understanding. On the other hand, commissioning some specific services, where appropriate skills were available outside Public Health England, could increase value for money and drive innovation through market competition, but only if sufficient purchaser-skill were present.

Preferred: option 4 – Public Health England commissions such functions where possible and performs in-house where necessary

13. This approach would see Public Health England perform some issue- and locality-specific functions in-house while commissioning others to outside organisations.
14. This is our preferred option because it offers the most flexible solution enabling functions to be provided in the most appropriate and cost effective way, in keeping with the requirements, documented elsewhere, of an information revolution
15. The PH I&I Strategic Working Group will share/test recommendations for the future I&I system and a process is in place to deliver this, with ballpark costs, during November. Namely:
 - a. an audit on public health information and intelligence functions is being conducted by the working group, by end of the week commencing 22 November 2010;
 - b. the working group will then recommend which information and intelligence functions are to be secured for the future, with ballpark costs, and which are to be provided in-house by Public Health England and which are to be commissioned, week commencing 29 November 2010;
 - c. the criteria for deciding whether information and intelligence functions are commissioned out or performed in-house are being examined by the working group;
 - d. these recommendations and criteria will be submitted, along with a draft submission, to a senior review group (David Harper, Sally Davies and Richard Murray) for clearance during week commencing 29 November 2010;

- e. the revised submission, with appropriate clearances, will be sent to Ministers week commencing 6 December 2010, after which, following feedback, future plans for information and intelligence and the required budgets can be tightened up; and
- f. it is acknowledged that there needs to be an assessment of the appropriate level of spending and how it is deployed, taking account of the risk to other policies. Also it is agreed that interdependencies exist between the information and intelligence arrangements, the outcomes framework and the ring-fenced budget.

Option 4 Impacts, Costs and Benefits

16. The successful implementation of the preferred option will require alignment on those information and intelligence functions which are to remain within the public health service and those which can safely and cost effectively be commissioned from outside organisations.
17. We are working with critical partners in order to develop the policy required to introduce the evidence functions into the Public Health Service successfully and without vital health protection measures being interrupted. Once policy has been further developed, we will be in a position to update the Impact Assessment.

SUMMARY AND WEIGHING OF OPTIONS

- i. Present the best estimate of the overall net benefit of each option, by deducting the expected opportunity cost of the intervention (see IA Technical Guidance on how to derive the Opportunity Cost) from the expected benefit.
- ii. Summarise other factors, including equality and that weigh for or against each option, using the criteria cited for this IA in section A.
- iii. Draw conclusions:
 - Which options are QIPP compliant (ie without compromising quality they yield net cash savings by 2014. (See DH IAs Made Easy Guide.)
 - Identify the preferred option and briefly state why it is the preferred option?

TABLE : COSTS AND BENEFITS AND OTHER FACTORS ASSOCIATED WITH THE SHORT LISTED OPTIONS							
OPTIONS (AGAINST OPTION 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	EQUALITY/ OTHER IMPACTS	QIPP COMPLIANCE
	CENTRAL	WORST	CENTRAL	WORST			
OPTION 2:							
OPTION 3:							
TOTAL							
NPV							
COSTS AND BENEFITS							

Annex: Post Implementation Review

Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];

There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.

Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]

Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.

Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]

The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England

The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework. Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.

DsPH will also need to produce an annual report

Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]

Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]

Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]

Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.

Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]

Impact Assessment F: Health Visitors

Title: Commitment to fund 4,200 additional health visitors in England Lead department or agency: Other departments or agencies:	Impact Assessment (IA)
	IA No: 3030
	Date: 09/10/2010
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Other

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

The Public Health White Paper and the supporting evidence document "The Health of the Nation" set out the importance of pregnancy and the early years of life for children's physical, mental and emotional development and cite the supporting evidence. The Marmot Review Fair Society, Healthy Lives (2010) also points to the importance of support at the start of life for remedying health inequalities. These sources also indicate that outcomes fall substantially short of what is plausibly achievable with well focused interventions. Yet, one channel of support of families in particular, health visiting, has been in decline and the age profile of the workforce suggests this could continue. In some areas, this has meant insufficient capacity to deliver a universal service offer to all families.

What are the policy objectives and the intended effects?

To improve the social environment in which children, particularly from disadvantaged homes, spend their early years. The intended result is to secure better physical, mental and emotional developmental outcomes.

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

1. Do nothing
2. To increase the health visitor workforce by 4,200 by May 2015 (from a baseline of April 2010) and improve health outcomes by:
 - ensuring continuation of universal health visiting provision.
 - offering family health services with more extended contacts to support new families and a range of care interventions for those with greater needs,
 - championing wider health and wellbeing, prevention and public health, and building family and community capacity,
 - extra capacity for health visitors to lead teams to improve health outcomes for children.

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?

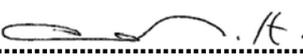
It will be reviewed
10/2014

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?

Yes

SELECT SIGNATORY Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:..... ..... **Date:** 27/11/2010

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	231m	148m	525m

Description and scale of key monetised costs by ‘main affected groups’

HV training costs: qualified nurses to health visitors: £101m
 : backfilling qualified nurses: £130m
 Running costs: Pay etc: £272m (£9m rising to £142m in 2014/15)

Other key non-monetised costs by ‘main affected groups’

Maximum of 5 lines

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by ‘main affected groups’

Maximum of 5 lines

Other key non-monetised benefits by ‘main affected groups’

The main benefits of increasing the number of health visitors will be to children and families. There are likely to be positive effects for children from earlier identification of development needs (the 2.5 year checks), but the main benefits are likely to be over the lifetime of the child.

Key assumptions/sensitivities/risks

Discount rate

Increase in HV numbers occurs in a phased manner : 25%, 25%, 50% over 2011/12-2013/14
 Attrition rate assumed each year = 22%; unit costs based on PSSRU figures.
 Risks relate to benefit realisation and will be mitigated by monitoring, evaluation and feedback to modify the programme as appropriate .

Direct impact on business (Equivalent Annual) (£m):			In scope of OIOO?	Measure classified as
Costs:	Benefits:	Net:	No	NA

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	01/05/2015				
Which organisation(s) will enforce the policy?	DH				
What is the annual change in enforcement cost (£m)?	0				
Does enforcement comply with Hampton principles?	Yes				
Does implementation go beyond minimum EU requirements?	No				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded: n/k		Non-traded: n/k		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	Costs: 0		Benefits: 0		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	Yes	Yes	Yes	Yes	Yes

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

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

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties ³⁷ Statutory Equality Duties Impact Test guidance	Yes	107
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	8
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	9
Sustainable development Sustainable Development Impact Test guidance	No	

³⁷ Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

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

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment). Evidence Base

No.	Legislation or publication
21	Impact Assessment on the CHPP (now the Healthy Child Programme - http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_084076.pdf
22	
23	
24	

+ Add another row

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

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

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs										
Annual recurring										
Total annual costs		£88m	£127	£190	£172					
Transition benefits										
Annual recurring										
Total annual benefits										

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

Health Visitors

1. This Impact Assessment is part of a suite of impact assessments that accompany the public health white paper. Other impact assessments in this suite are:
 - structure of Public Health England (IA3024)
 - commissioning in the public health service (IA3025)
 - ring-fenced funding of public health (IA3026)
 - Public Health Outcomes Framework (IA3027)
 - Information and intelligence for public health (IA3028)
2. This Impact Assessment directly impacts the public sector only.

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

3. The Public Health White Paper and the supporting evidence document “The Health of the Nation” set out the importance of pregnancy and the early years of life for children’s physical, mental and emotional development and cited the supporting evidence.
4. The Marmot Review *Fair Society, Healthy Lives* (2010) also points to the importance of support at the start of life for remedying health inequalities.
5. These sources also indicate that outcomes fall substantially short of what is plausibly achievable with well focused interventions. Yet, one channel of support of families in particular, health visiting, has been in decline and the age profile of the workforce suggests this could continue. In some areas, this has meant insufficient capacity to deliver a universal service offer to all families. Without timely government intervention, fewer families would be able to benefit from the universal offer.

What are the underlying causes of the problem?

Two underlying causes seem likely to be responsible for the problem.

- There is some evidence that commissioners have not seen health visiting and delivery of the Healthy Child Programme as a priority. Although there have been recent steps to strengthen health visiting capacity to safeguard children, the NHS has not generally accorded a high priority to investment in early years support. The commissioning of public health has often been displaced by more urgent calls on the commissioning skills and funds available to PCTs. The related reforms in public health should, in due course, ensure that adequate funding is available and that an adequate focus upon public health interventions is given at a local level.
 - The second problem is that the supply of health visitors has fallen short of demand in some areas.
6. Strategic Health Authority workforce leads have identified that the main reasons for declining numbers of recruits and for difficulties in retained health visitors are:

It is an ageing workforce, many of whom have nurse retirement option to retire at 55 years. In areas where workforce numbers have fallen, those remaining have had to focus support on the most vulnerable children and on safeguarding responsibilities, at the expense of the wider public health professional role originally envisaged.

Practice teacher numbers have also declined and thus system capacity to train new health visitors is reduced and flexibilities to change the pattern of practice education have not yet been widely adopted.

The training requirements - a year's full time training on top of a nursing qualification - can prove a disincentive to entry, especially if this involves leaving a higher paid nursing post, which may have included 'unsocial hours' payments. Many training programmes now pay salary at band 5 whereas historically nurses were seconded on their current grade.

What policy options have been considered?

7. Although the evidence firmly establishes the importance of early years' environment in determining outcomes, the evidence of the cost-effectiveness of different interventions to secure the needed early support is less robust. Consequently, given the urgency of securing results, it makes sense to pursue a range of complementary interventions to expand the health visitor workforce and health visiting service, and ensure best fit with Sure Start Children's Centres and other early years services, whilst evaluating cost-effectiveness through the implementation period.

Option 1: Do Nothing

8. The Do Nothing option (Option 1), against which the other options are compared, would involve allowing the new arrangements for public health commissioning to bed down, and leave it to the discretion of individual local authorities and Directors of Public Health in due course to determine the balance between health promotional interventions. However, such a strategy would involve considerable delay and a widening gap in health visitors workforce capacity. As discussed earlier, this would lead to fewer families being able to benefit from the universal service offer.

Option 2: Increase health visitor workforce capacity by 4200 by May 2014

9. Hence, it is proposed to build on the central role that health visitors already play and the trust families place in them. They lead delivery of an evidence-based programme of support – the Healthy Child Programme - through both directly providing services and managing the skill-mix health visiting team to support families. The Healthy Child Programme covers parenting support, developmental checks, vaccinations and immunisations, health advice; offering additional support and therapeutic interventions for families with particular needs; and helping families to access wider community or specialised support as appropriate. The Impact Assessment carried out in respect of the Programme in 2008, sets out in more detail its policy intention and impact.
10. This option would seek to ensure there is sufficient HV capacity to deliver this core programme of support to all families, with additional help for those who need it; to enhance the offer of support during pregnancy and the early weeks of life; to strengthen relationships between the health visiting team and Sure Start Children's Centres; and to develop the health visitors' public health role in promoting wider community response to families and their needs.
11. The Government has estimated that an increase in capacity of the order of 4200 is required in order to lead and deliver the intended support to families, to help ensure that all children get the best possible start in life and that any problems are identified and addressed as soon as possible.
12. In the first instance, to achieve change it is proposed that DH and then the NHS Commissioning Board should commission these developments. In time, the intention is that responsibility should pass to local authority commissioners arrangements set out in the Public Health White Paper.

Impacts, Costs and Benefits of Option 2

13. The workforce context: Numbers of health visitors in England have been declining over several years. The annual workforce census shows that in April 2010, there were 10,124 health visitors in post, the 2009 return shows 10,859 in post and the 2004 figure is 13,303. This reduction in numbers has coincided with an increase in birth rates. The birthrate in England has risen since 2001, despite falling for several years beforehand. In 2008, 672,809 children were born in England of which 54% were born in the South compared to 46% in the North. Further, the age profile of health visitors shows that the majority are between 45-54 years old, which has a negative impact on the overall supply chain of the workforce. Annex A shows recent provisional monthly data demonstrating a continuation of the downward trend.
14. The Department has completed some projection analysis of the workforce that would suggest that health visitor numbers will continue to fall unless there is direct intervention to reverse the trend. Annex B illustrates that in September 2009 there were 10,859 (headcount) health visitors employed in the NHS in England. If the historic trend in the number of health visitors were to continue we would expect there to be around 8,400 staff (headcount) in 2014. These figures are based on models fitted to the 2005-09 workforce data by age group and are unadjusted for new trainees joining the workforce or for any other factors that may affect the trend e.g. improved retention rates.
15. Against this background it is clear that the “do nothing” option would involve further decline in health visitor numbers and detriment to children and families before local public health commissioning could reverse this trend.
16. A 4,200 increase in the workforce would take account of these trends, based upon several research sources including work conducted by Professor Sarah Cowley³⁸ who first began charting resource and estimating future need.
17. The evidence that a substantial increase in health visitor numbers would have an impact upon welfare includes a YouGov poll³⁹ in which 76% of parents asked wanted support and advice on child health and development specifically from a health visitor with up to date health care knowledge. This was as compared to 58% looking to support from family members, 33% to a qualified nurse and 16% to a child care worker. This material is set out in *Helping new families – support in the early years through universal health visiting* (Conservative Research Department 2008).
18. An increase of 4,200 in the HV workforce is the best current estimate of the scale of expansion needed to secure an improved, universal health visitor led service to children and families at the start of life, consistent with the case advanced by Marmot (Marmot Review *Fair Society, Healthy Lives* (2010)) and others for focusing investment and support at this crucial stage.

Set out the costs of delivering the impacts listed in section

19. A comprehensive programme of action is planned, to address the factors that lie behind the workforce decline and to ensure the expanded workforce is delivered as cost-effectively as possible, generating maximum benefit to children and families.

³⁸ Prof. Cowley, 'The contribution of the NHS to reducing health inequalities', submission to the Health Select Committee's Inquiry into health inequalities, November 2007 and Prof. Cowley, 'A Funding Model for Health Visiting: Baseline Requirements', *Community Practitioner*, 2007 80(11) pp.18-24.

³⁹ YouGov survey on behalf of Family and Parenting Institute 'Parents of Under 5s, 12 March 2007.

Reversing the workforce trends

20. Provisional work has been conducted mapping current health visitor numbers to weighted populations of under 5s. This model is being further refined. Initial work showed a weak, although just statistically significant positive, correlation between numbers of health visitors and deprivation but significant areas of deficit in metropolitan areas and London particularly.

The implementation programme (An implementation programme will shortly follow publication of the Public Health White Paper)

21. This covers a comprehensive programme, including:
- communication of the importance of the first years of life, and the refreshed and expanded vision of the HV contribution, to the NHS and local authorities, the professions and NMC, partners in SSCCs and other early years services, the higher education institutes, and all who will have a part to play in securing implementation, to maximise their engagement
 - a national recruitment drive, linked to action to develop more flexible and cost effective training routes which meet the Nursing Midwifery Council standards for entry to the nursing and midwifery register as a specialist community public health nurse.
 - return to practice initiatives and exploration of flexible retirement and other retention initiatives, to maximise the contribution from trained health visitors and provide practice education in new ways.
 - a new training module for the existing workforce on building community capacity, so that they can refresh and update their skills.
22. The implementation programme also addresses future commissioning arrangements. Under the new arrangements set out in the Public Health White Paper, it is proposed that health visiting and delivery of the Healthy Child Programme will be funded through the new Public Health Service. In due course, it is envisaged that the funds will form part of the local public health budget, with opportunities for local Health and Wellbeing Boards to oversee the best fit with other local early years services, including Sure Start Children's Centres
23. However in the first instance the Department of Health and then the NHS Commissioning Board will lead commissioning of the health visiting service on behalf of Public Health England, working closely with PCTs, GP consortia and other local partners. This reflects the need for swift and focused action to address the particular challenges associated with securing an increase of some 50% in this workforce and ensuring alignment between commissioning, workforce planning and training plans and funding through a period of transition. In the longer term responsibility for commissioning health visiting is expected to transfer to local commissioning.
24. The implementation plan includes further work to ensure best fit with developing plans for Sure Start Children's Centres and their services, and to promote effective joint working between the health visiting service, Sure Start Children's Centres, midwives and general practice to ensure most cost-effective use of the total workforce.

Policy implementation costs

25. In order to increase the total number of health visitors by an extra 4200 by 2014/15, a model was constructed to estimate the gaps in the annual number of health visitors, and cost estimates were applied to the gap to estimate the total costs of this commitment. This is described further below.

Estimating the number of health visitors required each year

26. The April 2010 workforce census shows a total of 10,124 health visitors. Using this as the base figure and considering a target of 14,324 health visitors (4,200 higher than the April 2010

census figure), the model estimates the annual increase required, given assumptions of the attrition rate, the number of training commissions already in place, and the assumed return to practice of retired health visitors. These assumptions are described further below and the modelling results are illustrated in the table below.

Year	Modelled estimates of workforce numbers							Extra HVs trained to make up shortfall against 2014-15 target ⁸		Expected HVs incl. extra QN conversions ⁹
	Modelled w'force based on attrition 2005-09 ²	Assumed new HVs joining after 1 yr conversion training ³	Cumulative total of new HVs joining after 1 yr training ⁴	Assumed return to practice recruits ⁵	Cumulative total of assumed return to practice recruits ⁶	Modelled w'force based on attrition and assumed training and return to practice recruits ⁷	Shortfall against 2014-15 target	Extra QN conversions	Cumulative total of extra QN conversions	
2010-11	10,265	514	514	-	-	10,779	3,545	-	-	10,779
2011-12	9,789	642	1,156	153	153	11,098	3,226	662	662	11,098
2012-13	9,313	640	1,796	49	202	11,311	3,013	662	1,324	11,973
2013-14	8,837	640	2,436	24	226	11,499	2,825	1,324	2,648	12,823
2014-15	8,361	640	3,076	12	239	11,675	2,649	-	-	14,324

Notes:

1. Source: provisional workforce census data, NHS Information Centre for health and social care
2. Forecast based on continuation of historic trend in attrition, 2005-2009.
3. Training commissions for 1 year health visitor qualification for trained nurses. 2010 figure (514) is actual commissions for 2009-10, 20011 figure is planned commissions for 2010-11. Figures for 2012-14(640) are assumed to be at 2011 level.
4. Cumulative total of new trainees joining the workforce during 2010-2014 using NMET data.
5. Estimates based on information from DH return to practice pilots policy team, based on London and E.Midlands pilots.
6. Cumulative total of return to practice recruits during 2011-14.
7. Sum of modelled workforce based on attrition, and cumulative total of trainees and return to practice recruits.
8. The expansion is phased as 25%, 25%, 50%.
9. In 2010-11 and 2011-12 this is the modelled workforce based on attrition and training and return to practice. In 2012-13 and 2013-14, this also includes the additional qualified nurses who have completed their conversion course.

Estimating the costs of the additional health visitors

Fixed or one-off costs

The fixed costs of additional health visitors comprises the costs of training nurses to become health visitors and the costs of backfilling the nurses posts.

This cost, based is based on the PSSRU (Public Social Service Research Unit, University of Kent) unit costs of health and social care and internal DH information on training course costs and the paybill for health visitors and nurses. These costs include the backfill costs and the return to practice costs.

These costs accrue over the first three years based on the expansion rate of 25%, 25% and 50%.

Ongoing costs:

These costs include

- (a) the salary and other costs incurred by staff activity: home visits, other contacts with clients in clinics, the associated administration work for home visits and contacts, in-service training, supervision of staff etc. (£9m in the first year, then rising to £142m in the last year as the target of 4200 additional health visitors is met)
- (b) travel and associated costs (around £10m over the four years)
- (c) costs for running a recruitment campaign (assumed to be £1m annually)
- (d) the additional costs of growing the wider child health nursing pool in parallel to expansion of the health visiting workforce, to increase support for families whilst the health visiting workforce is expanded and to create a pipeline from which future HV trainees could be added (£60m over the four years).

The following table illustrates the cost profile of the expansion of the HV workforce.

Estimated costs¹ (£m) of achieving 4,200 (headcount) increase in health visitors by 2014-15

Year	Start-up costs for extra qualified nurses (QN) converting to health visitors (£m) ²			Ongoing paybill costs (£m) ⁵			Total workforce costs ⁸	Communications costs (£m) ⁹	Costs of additional child health nurse w'force (500 head count) (£m) ¹⁰	Total costs (£m) ¹¹
	Training for conversion from QN	QN backfill costs ³	Total start-up costs ⁴	Travel to home visits costs	Other ongoing costs ⁶	Total ongoing costs ⁷				
2011-12	25	47	72	0.3	9	9.3	81	1	6	88
2012-13	25	43	68	2	44	46	114	1	12	127
2013-14	51	40	91	3	77	80	171	1	18	190
2014-15	-	-	-	5	142	147	147	1	24	172
Total costs 2011-12 to 2014-15	101	130	231	10.3	272	282.3	513	4	60	577

Notes:

- Costs are presented in 2011-12 prices. Costs are based on PSSRU unit costs of health and social care and internal DH training course costs, paybill costs etc. Unit costs for paybill (around £40,000 per annum) and health visitor training (around £6500 per annum) err on the larger side, to reflect the fact that such a large workforce expansion may accrue larger unit costs than the trend.
- The expansion is phased as 25%, 25% 50%, i.e, the total number of new conversion courses is 662 in 2011/12 and 2012/13 and 1324 in 2013/14. This leads to the expansion being realised in 2014-15.
- All of the qualified nurses who convert to health visitor roles are backfilled. Due to the 3-year lead time for qualified nurses, all of the required new trainees enter the system in 2011-12 so that they exit training in 2014-15. The attrition rate for nursing undergraduate courses is assumed to be the same as the recent trend, at 22% in aggregate.
- Total start-up costs are the sum of training and backfill costs.
- These costs include the assumed return to practice of 239 health visitors by 2014/15. The return to practice numbers at the national level was modelled on information available from two pilot sites, by considering the ratio of return to practice recruits in the pilot sites to the total workforce in those sites and extrapolating to obtain a national figure.
- These salary and oncosts will cover all other costs incurred by all other staff activity: home visits, associated administration work, other contacts with clients in clinics, in-service training, supervision of other staff, management meetings etc.
- These are the total travel and other ongoing costs.
- These are the total of workforce start-up and ongoing costs.
- These costs are for the running of a recruitment campaign to include return to practice recruitment and new entrants to the profession.
- These are the additional costs of growing the wider child health nursing pool in parallel to the expansion of the health visitor workforce to provide support.

11. *These are the total of all workforce costs (start-up, ongoing and additional health nurses) and communication costs.*

The total costs over the first four years are discounted at 3.5% to result in a PV cost figure of £525m. To take into account the opportunity cost of such investment, we use the multiplier of 2.4, which brings the total cost to £1260m.

Consider the plausible range of benefits arising from Option 2

Public health outcomes, cost benefit analysis and Programme evaluation

27. Whilst we have been able to apply an estimated cost to a four-year health visitor implementation programme (based on certain assumptions about training, attrition rates, salary costs, etc), it is not possible to conduct a thorough cost benefit analysis based on improved public health outcomes at this stage.
28. However, we are confident that the benefits of adding 4,200 extra health visitors will outweigh the costs of doing so. As discussed earlier, we believe that this number is required to provide the core programme of support to all families, with additional help for those who need it; to enhance the offer of support during pregnancy and the early weeks of life. Health visitors can therefore potentially benefit families and children through a number of ways.
29. Evidence tells us that poverty and failure to initiate breastfeeding both contribute to 1% of all infant deaths⁴⁰. 22% of women do not initiate breastfeeding and the UK ranks as one of the lowest countries in Europe on the proportion of babies receiving any breast milk.⁴¹ Breastfeeding has clear health gains for both mother and baby, improving life chances, health and well being. Benefits of breastfeeding for the infant include protection against gastrointestinal, urinary, respiratory and middle ear infection. For the woman, breastfeeding can reduce the risk of certain forms of cancer, including all breast cancer.
30. Health visitors have the potential to help women to continue breastfeeding beyond the early days if they are working in settings which are implementing the UNICEF UK Baby Friendly Initiative, which is an evidence-based approach to supporting women who wish to breastfeed, in hospitals and at home.
31. The average breastfeeding prevalence at 6-8 weeks for England in the last quarter of 2009/10 was 45.2%⁴². Rates are lowest in the most vulnerable groups in society, with half the number of babies in routine and manual groups being breastfed at 6 weeks, compared to those in managerial and professional groups. We estimate that every additional infant breastfed will lead to cost savings from avoiding hospital admissions, of the following type:

Cost saving per additional infant breastfed in one year:

otitis media	£ 8.40
gastroenteritis	£ 43.20
asthma	£ 35.63
LRTI	£ 4.30
breast cancer	<u>£ 15.32</u>
	<u>£106.85</u>

⁴⁰ Infant mortality statistics from DH analysis – percentages relate to population attributable fractions

⁴¹ OECD Family database; CO1.5: Breastfeeding rates, www.oecd.org/dataoecd/30/56/43136964.pdf

⁴² Q4 2009-10: DH Vital Signs Monitoring Returns

32. Based on number of infants breastfed in 2009 (303,318 children, based on the 2009 births (ONS) and a 45.2% prevalence rate), we estimate that a 10 per cent increase in breastfeeding prevalence at six months would lead to a cost savings of £3.22m per year for the additional infants that are breastfed. Assuming a similar cohort that is breastfed each year, the overall cost savings discounted over 10 years would result in a PV of £30m. Clearly these are only the financial cost savings and take no account of the benefits to the quality of life of each cohort over several years and the quality of life of the mother, particularly the benefit of reduced probability of breast cancer over a 30 year period. Were these to be considered, the benefits would be significantly higher.
33. In addition to direct benefits to the child's health and development, the right support in the early years
34. affects readiness to learn at age 5 and longer term development, with benefits to the individual, the
35. economy and wider society. For example, a key element in the Healthy Child Programme is the 2.5 year check of all children to be able to assess the health and emotional development of the child and be able to identify at an early stage any concerns regarding slow development. Shortage of health visitors mean this is not currently being offered to all families. It is estimated that approximately 7% of children in the UK suffer from specific and primary speech and language impairments (Tomblin, J.B. et al 1997). A study called "The Cost to the Nation of Children's Poor Communication (2006) estimated that 10% of all children have a long term persistent SLCN (Speech, Language, Communication Needs), whereas over 50% of children at school entry age experience more transient difficulties which could be overcome through appropriate support. There is also evidence which points to the important role, that Allied Health Professionals play in addressing speech, language and communication needs, ensuring children have optimum levels of communication in order to access education and avoid behavioural problems with devastating consequences later on (e.g. 60% of the prison population experience communication problems).
36. If this problem is picked up early by the health visitor during the 2.5 year check, and appropriate support is provided, it could potentially enable the child to start with normal school life. Based on the population of 2 year olds and assuming 5% of these could have a SLCN that may be possible to be overcome through early intervention, we estimate that there would be 32,000 children at least who could benefit from early detection. We are not able to quantify current rates of detection of SLCN at the 2.5 year check by the existing workforce. However, a conservative assumption is that, at a minimum, at least 10% more of such children may be detected, as a result of the additional health visitors at the 2.5 year check. There is no evidence available on how much improvement there would be in the quality of life of a child detected and treated early. However, assuming that there is a minimum 0.05 increase in the QALY per child (a very conservative estimate) and applying a monetised value of £60,000 per QALY gained, we estimate that the present value of benefits over a 10 year period would be equal to **£476m** (applying a discount rate of 1.5%). The benefits over the school years of the child or indeed lifetime of the child would be significantly higher.
37. Health visiting interventions also benefits new mothers and families. One such example of health visitors being able to help mothers with post natal depression. Women with post-natal depression are likely to experience persistent feelings of inadequacy and hopelessness, an increased propensity to terminate breastfeeding early and to have difficulty with dealing with infant feeding and crying. These problems in the early mother–infant relationship arising in the context of post-natal depression can lead to suboptimal cognitive and emotional development of the child.

38. A study on the clinical effectiveness of health visitor training to address depression postnatal women⁴³ examined the effects from using health visitors trained to identify depressive symptoms at six to eight weeks postnatally by using the Edinburgh postnatal depression scale (EPDS) and clinical assessment, and also trained in providing psychologically informed sessions based on cognitive behavioural principles for an hour a week for eight weeks. The trial found that 12% more women in the intervention group showed reduced EPDS scores (reduced level of depression) than those in the control group.
39. Moderate to severe post-natal depression is a common condition that affects approximately 13% of women in the early months following childbirth (Petrou et al 2002⁴⁴, O'Hara and Swain 1996). Using this figure for the number of women who had given birth in 2009 would result in an estimated 86,000 suffering from post-natal depression. If half of these women were provided the targeted health visitor intervention, from the clinical evidence, it would appear that around 12% of them would benefit, compared to the women who were not provided targeted health visitor intervention. Assuming that each woman benefiting would have a QALY of at least 0.05, we estimate that the total benefit to postnatally depressed women who have a targeted health visitor intervention would be around **£770m** in PV terms (applying a discount rate of 1.5% and a value of £60,000 per QALY). If all such women could be targeted the figures could well double.
40. These are just a few examples and are based on quite conservative assumptions. However, health visitors could provide a range of benefits through the core programme, which would provide a total benefit significantly in excess of the costs, particularly when considering benefits over the lifetime of the child rather than 10 years as assumed here. For instance, the Impact Assessment undertaken for the Child Health Promotion Programme in 2008 estimated that the total benefits from having pregnant women checked at 12 weeks of pregnancy for obesity, and children checked at 2.5 years for obesity, could yield benefits of more than **£7bn** over the lifetime of the children.

Set out the assumptions upon which projections for Option 2 have been based, and the risks to which they are subject.

41. The extent and rapidity of the programme creates risks that benefits will not be delivered as expected. This risk is best mitigated by monitoring, evaluation and feedback to enable the programme to be modified to ensure benefit realisation.
42. As set out in the implementation plan, the Department will monitor progress, undertake research to inform and shape ongoing work and evaluate the added value of the extra 4,200 health visitors in the following ways.
43. On workforce expansion, we will monitor workforce trends and assess the impact of workforce initiatives in order to measure success and cost-effectiveness. This will include work with The Centre for Workforce Intelligence.
44. The Department also intends to commission research, including through the National Nursing Research Unit at King's College London, to inform and help shape ongoing work on health visitor expansion. This will include:
- work on cost-effectiveness and outcomes
 - outcome measurement

⁴³ Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care – Jane Morell, Pauline Slade et.al., BMJ, 15 January 2009

⁴⁴ Economic costs of postnatal depression in a high-risk British cohort, British Journal of Psychiatry, 2002

- work on skill-mix
- work on user experience.

45. It will also be important to review progress through the Public Health Outcomes Framework. The consultation document includes proposals for outcomes and indicators covering the early years. Proposals under consideration for future development and inclusion include development of an indicator relating to the 2 to 2.5 year check.

46. Implementation plans will be adapted and fine-tuned in light of emerging evidence to maximise effectiveness.

Set out expected impacts upon Equality and Human Rights:

47. An EqIA for the health visitor commitment is included with the Public Health White Paper EqIA.

SUMMARY AND WEIGHING OF OPTIONS

Option 1 – Do Nothing Likely to result in a further decline in health visitor numbers before local Public Health commissioning was able to reverse this trend.

Option 2 - Increase of 4,200 over 5 years An increase of 4,200 would afford the health visitor workforce the capacity to focus on delivery of the Healthy Child Programme, offering a stronger universal service, more intensive services for disadvantaged families and building community capacity to offer better support, with consequent short and long-term benefits to physical, mental and emotional health and well-being and wider gains to society and the economy.

Background information

The health visitor role

48. Health visitors are nurses or midwives who hold post-graduate specialist practitioner qualifications and work in the field of child family and public health.

49. They combine a nursing or midwifery and public health education giving them the ability to combine biomedical and psychosocial knowledge with understanding of the health system and of child and family health and wellbeing. They apply skills in working with individuals and communities and, through the key roles set out below, seek to maximise health outcomes and reduce inequalities,

50. Health visitors offer proven preventative health services for all families and children in the first years of life, through the evidence based Healthy Child Programme. Increased numbers of health visitors will be focused on building capacity to offer a stronger universal service, more intensive services for disadvantaged families and building community capacity to offer better support.

51. In leading and delivering the Healthy Child Programme (pregnancy through to 5 years) the health visitor will provide and/or oversee the team that provides

A service to all families that includes:

- Antenatal visit/family health assessment/preparation for parenthood.
- New birth visits - parenting, feeding, health checks - planning future health care.
- First year contacts: formal health programme immunisation, physical and developmental checks, information, support, feeding parenting, safety, relationships.
- One to three years: formal health programme, dental health, keeping safe, nutrition, speech language, communication and play and the 2-2.5 year review.

- Three to five years: a formal health programme for school entry.

Specific services for families when there is an issue affecting health and well being

Health visitors use their expert professional judgement to agree appropriate levels of additional support, building on parents' strengths. Some of this support is provided by them, some they delegate or refer to the appropriate professional or practitioner. Examples of common needs and services are:

- Relationship counselling
- Maternal Mental Health/Pre-natal Depression
- Parenting support
- Parenting advice on family health and minor illness
- Sleep problems
- Feeding/weaning problems
- Pre-school behaviour
- Speech/communication problems

Ongoing additional services for vulnerable children and families

Health Visitors are skilled at identifying families with high risk and low protective factors, enabling these families to express their needs and deciding how they might best be met.

This may include:

- Offering evidence-based programmes.
- Encouraging the use of the Common Assessment Framework.
- Referring families to specialists.
- Arranging access to support groups, for example those provided in the local Sure Start Children's Centre.
- Organising practical support - for example working with a nursery nurse on the importance of play.
- Delegating focused contacts to a team member and monitoring effectiveness.

Contribution to multidisciplinary services in safeguarding and protecting children

- Health Visitors are educated to recognise risk factors, triggers of concern, and signs of abuse and neglect, as well as protective factors. Using this knowledge, they can concentrate their activities on the most vulnerable families. Through their preventative work, they are often the first to recognise that the risk of harm to children has escalated to the point that safeguarding procedures need to be implemented.
- Health Visitors maintain contact with families while formal safeguarding arrangements are in place. It is essential to do this so that families receive an effective service during a crisis and ensures that families receive preventative health interventions.
- Health visitors contribute to all stages of the child protection process, including serious case reviews, and may be called upon to appear in court to explain the action they have taken. They support the work of the local safeguarding children board through the delivery of multi-agency training programmes and through their membership of working and task subgroups.

Community/Public Health roles through or in partnership with Sure Start Children's Centres

- Establishing the children's centre health promoting environment.
- Delivering a wide range of health services in the children's centre.
- Establishing effective partnerships between the children's centre, local GPs, the primary healthcare team and maternity services.
- Having an information-sharing protocol in place across local children's services.
- Coordinating health campaigns, improving information.

- Offering education and training for children's centre staff.

Health Visitors – creating and leading effective teams with a good mix of skills.

- Children and families benefit enormously from the broad range of skills offered by different team members.
- Leadership of the Healthy Child Programme gives Health Visitors the opportunity to manage their own staff and create a team approach across professions and service boundaries.
- There is potential for some outreach workers to retrain to become Sure Start health practitioners or Sure Start Health Visitor assistants. Other nurses in the health visiting team could be Sure Start nurses. This would:
 - for outreach workers, give experience of working in multidisciplinary teams and training and experience on family health. This could potentially be linked to new access training.
 - for nurses, provide practical experience and development prior to HV training and (should NMC approve new education programmes) provide an 'on the job approach' to HV training.
 - increase the numbers in the Health Visitor 'supply pipeline' and provide improved services for families in the interim.

Early years health promotion and prevention

52. The Healthy Child Programme is an evidence-based programme and every child should continue to have access to a universal or core programme of preventive pre-school care based on the considerations of agreed screening procedures, evidence favouring health promotion procedures and the need to establish which families have more complex needs. These are all services that children and families need to receive if they are to achieve their optimum health and wellbeing. If the programme were not in place or not delivered equitably then the consequences are that early action to address ill health and disability because many problems in pregnancy, childhood and later life are preventable, will not be taken and will result in adverse outcomes and inequalities in health.

How many people use these services?

53. 671,508 children were born in England in 2009. This means that for the Healthy Child Programme, universal services such as screening, immunisations and development reviews are provided for over 600,000 children every year. Numbers of children and families who benefit from the progressive elements of the Programme are not available. We do know that as part of the Healthy Child Programme's progressive service, the Family Nurse Partnership programme, a nurse-led home visiting service for first time vulnerable young parents, is currently provided to approximately 4,000 clients, with plans to expand the programme so that it will have reached 7000 families by 2011.

Annexes (Health visiting IA)

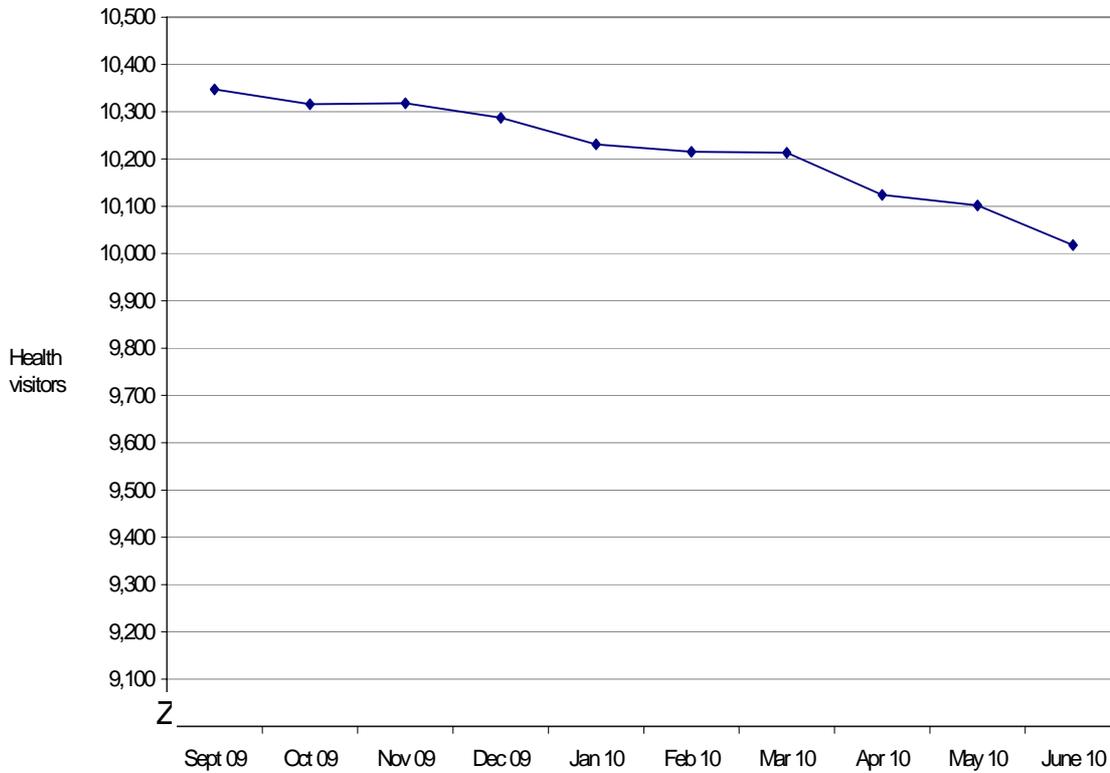
Annex 1 Post Implementation review

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p>Basis of the review: [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review]; To consider the benefits brought to children and families by the expansion of the health visitor workforce by 4,200 over the period (beginning 6 months ahead of close).</p>
<p>Review objective: [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?] Policy review in order to assess benefit and outcomes – will inform future policy and service decisions relating to health visiting.</p>
<p>Review approach and rationale: [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach] As part of the overall programme plan, we are including review and evaluation of the policy in order to build an evidence base which demonstrates whether and how health visitor interventions make a positive impact. We intend health visiting to be a component of a wider evaluation piece to be commissioned by DH R&D, which will look at the entire Healthy Child Programme (age 0 – 19).</p>
<p>Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured] April 2010/11</p>
<p>Success criteria: [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives] To be agreed but would relate closely to the Public Health Outcomes Framework going forward. Local commissioners and providers will be required to report against agreed outcomes for child and family health and well being.</p>
<p>Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review] To be agreed.</p>
<p>Reasons for not planning a PIR: [If there is no plan to do a PIR please provide reasons here] n/a</p>

Annex 2

Health visitors employed by NHS organisations in England (headcount)
Provisional data, NHS Information Centre



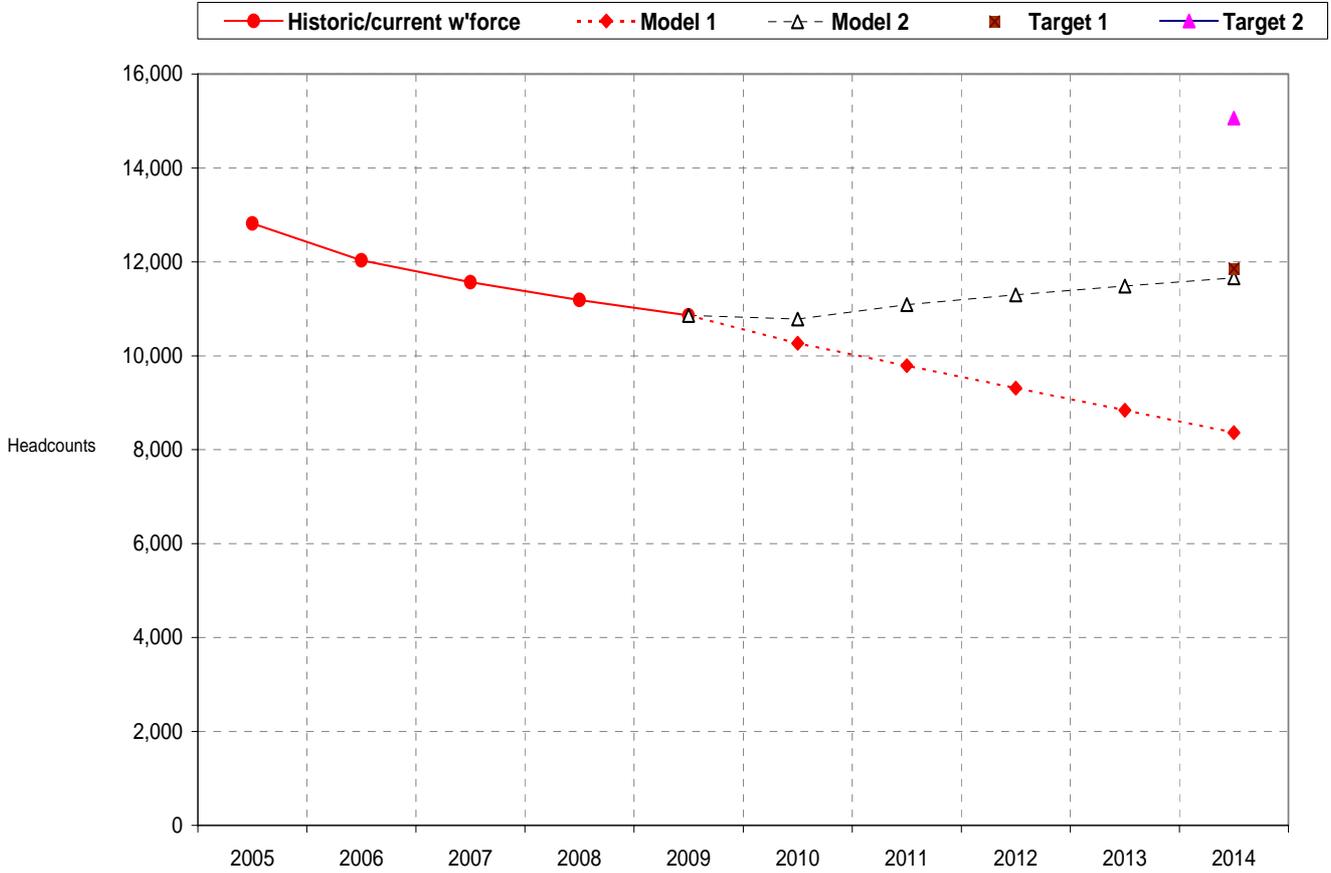
Provisional monthly data from published IC report (Sept 2010)

Qualified HVs

Month	Nos	
	HC	FTE
Sept 09	10,347	8,860
Oct 09	10,316	8,833
Nov 09	10,318	8,842
Dec 09	10,287	8,815
Jan 10	10,231	8,771
Feb 10	10,215	8,753
Mar 10	10,213	8,744
Apr 10	10,124	8,705
May 10	10,102	8,718
June 10	10,018	8,667

Annex 3

Modelled changes to health visitor workforce 2010-14



Model 1 continuation of historic trend only - no adjustment for new trainees or recruits or entering workforce

Model 2 continuation of historic trend with adjustment for new trainees and return to practice recruits entering workforce

Target 1 1,000 more HC HVs than 2009 figure

Target 2 4,200 more HC HVs than 2009 figure

Appendix 1 Overarching Post Implementation Review

<p>Basis of the review: [the basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];</p> <p>There will be an overarching review of the policy of developing a public health service which will include an evaluation of the transition process for establishing the public health service.</p>
<p>Review objective: [is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p> <p>Public Health England will be in place by April 2012. The objective of the review will be to evaluate whether the changes deliver the expected health benefits. We will be able to review the success of the transfer of functions and review whether this has taken place at an acceptable cost.</p>
<p>Review approach and rationale: [e.g. Describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) And the rationale that made choosing such an approach]</p> <p>The Department of Health has established a transition programme which will design and implement the new Department of Health - including the new public health service, Public Health England</p> <p>The public health outcomes framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the outcomes framework. Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.</p> <p>DsPH will also need to produce an annual report</p>
<p>Baseline: [the current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p>Success criteria: [criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p>
<p>Monitoring information arrangements: [provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]</p> <p>Once in place, the indicators outlined within the outcomes framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.</p>
<p>Reasons for not planning a PIR: [if there is no plan to do a PIR please provide reasons here]</p>

Appendix 2:

Equality Impact Assessment

1. Introduction

The public health White Paper, *Healthy Lives, Healthy People*, sets out a radical new approach to public health and is focused on protecting the public from health threats (such as infectious diseases and environmental hazards), improving the healthy life expectancy of the population, and improving the health of the poorest, fastest.

This is an initial equality impact assessment (EqIA) of the proposals contained within the public health White Paper. The focus of this assessment is largely on the high-level structural changes needed to establish Public Health England. The five critical work streams are:

1. Structure – relationship to the existing Department of Health, NHS and workforce issues, in other words, staffing Public Health England
2. Commissioning – how public health interventions will be designed and purchased
3. Funding – how the public health service will be funded, including at local authority level
4. Outcomes – what framework and indicators we could use to monitor and drive improvements
5. Information – how the service will collate and disseminate public health evidence

In addition, there is one policy-specific option, which has been assessed within the Impact Assessment – the commitment to increase health visitor numbers.

2. Responsibilities of the Department of Health in relation to inequalities

The Department of Health (the Department) is committed to equality, diversity and human rights. In its role, it seeks to be an effective champion for all, by:

- setting national direction and supporting delivery, in ways that promote equality and tackle inequalities in health that arise from disadvantage and discrimination
- taking action to support people to maximise their health, wellbeing, independence, choice and control, and
- supporting all the people who work in the system and for the Department to deliver these goals, recognising the value of their differences in the contribution they make.

The Department has a statutory duty to have due regard to the need to:

- a) eliminate discrimination and other conduct prohibited under the Equality Act 2010
- b) to advance equality of opportunity between people who share a protected characteristic and people who do not
- c) foster good relations between people who share a relevant characteristic and people who do not.

3. General Overview

The premise of Public Health England will be ***to protect the public; and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest.***”

We know that compared to other comparable countries, there are significant areas for improvement within the current system. For example, rates of mortality amenable to healthcareⁱ rates of mortality from some respiratory diseases and some cancersⁱⁱ, and some measures of strokeⁱⁱⁱ have been amongst the worst in the developed world^{iv}. In part, this is due to differences in underlying risk factors, which is why we need to re-focus on public health. However, international evidence also shows we have much further to go in managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions^v; the incidence of MRSA infection has been worse than the European average^{vi}; and venous thromboembolism causes 25,000 avoidable deaths each year^{vii}. Inequalities in life expectancy between areas such as Barnsley and Burnley and the rest of England are widening. In Burnley, residents are almost 50 per cent more likely than the national average to die of heart disease or stroke before the age of 75. In Leicester men from the most deprived areas of the city die some six years younger than those in the least deprived areas. There are also differences related to ethnic origin – South Asian people are five times more likely to get diabetes than people from a white background.^{viii}

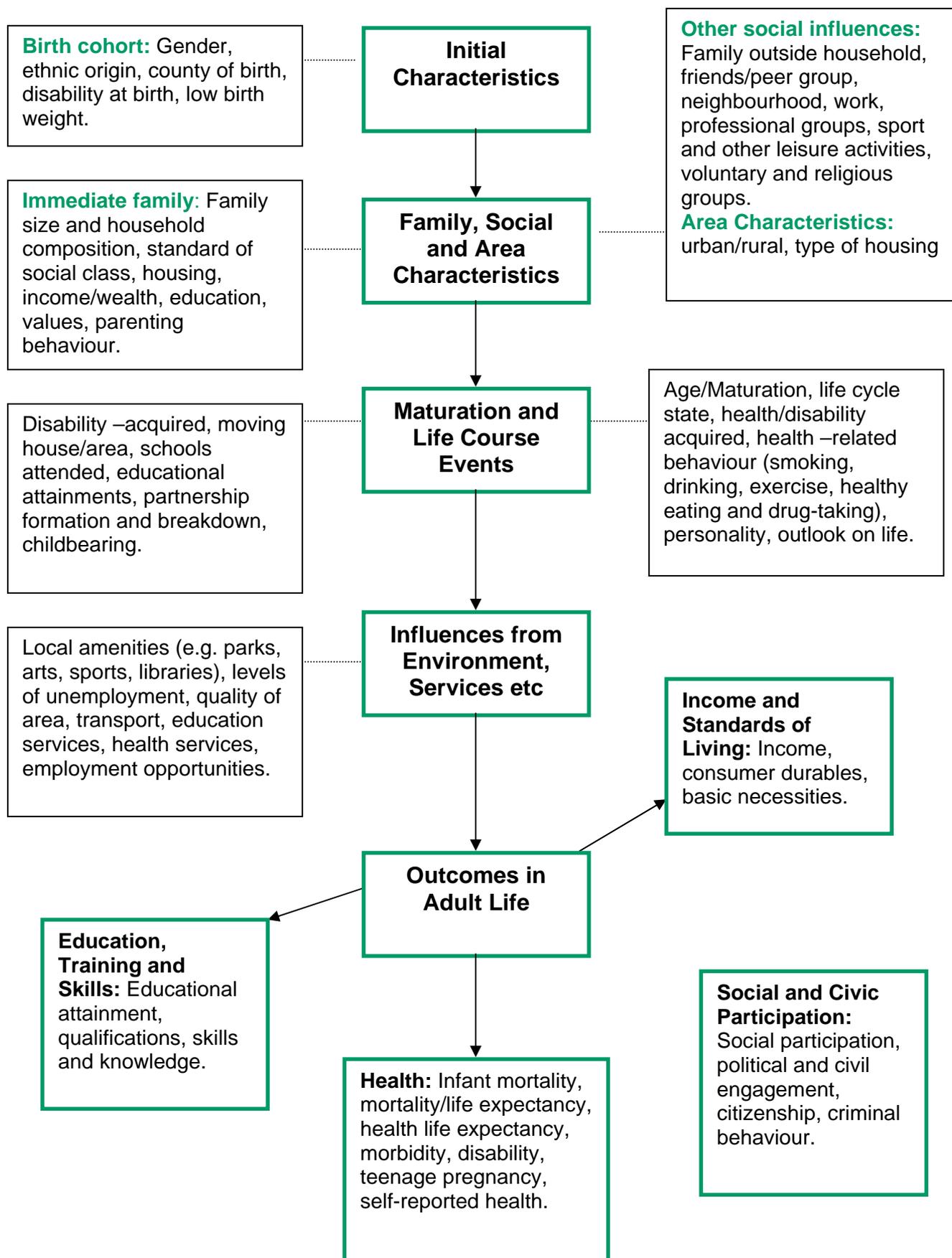
In February 2010, the Marmot Review team published '*Fair Society, Healthy Lives*^{ix}' based on a yearlong independent review into health inequalities in England led by Sir Michael Marmot. The review found:

- reducing health inequalities is a matter of fairness and social justice. In England, there may be people who are currently dying prematurely each year as a result of health inequalities who would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

With particular regard to inequalities, Marmot found that “social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation... These inequalities interact in complex ways with socio-economic position in shaping people's health status.” Given the finding of a ‘social gradient’ in health. It is important for policy makers at a national and local level to give due consideration to tackling the root causes of inequality.

The findings from Marmot are supported by the Office of National Statistics report, '*Focus on Social Inequalities*'. The report uses statistics from the 2001 Census to examine the extent of inequality in a number of key areas of life including health and highlights inter-relationships, for example, that health affects ability to work which in turn impacts on income and living standards. The report describes a “web of complex social, economic and cultural influences which determine relative advantage and disadvantage, many of which are not amenable to influences of public policy”. The diagram below illustrates how these factors could come together during the life course of a person to influence their outcomes in life.

Potential Influences upon inequalities adapted from the Office for National Statistics Report, Focus on Social Inequalities (2004)



The Government is determined to have a stronger, more effective public health strategy.

The current public health system has grown up piecemeal and, as a result, is not making the most of potential synergies across services. There is also little freedom for local communities to design and deliver local solutions for the particular challenges they face. By transferring responsibility for public health improvements from Primary Care Trusts (PCTs) to local authorities, those responsible for commissioning public health services will be better able to work in a coordinated manner across the local authority to tackle issues such as lower educational attainment, insecure employment, poor housing and material disadvantage.

4. Scope of the EqIA.

This EqIA is the first document in a series of equality impact assessments and we would anticipate publishing further EqIAs as policy decisions are finalised and move towards implementation. There will be an extensive period of consultation on specific aspects of the new system for example, how the budget will be allocated and outcomes measured. We want to hear from local government, professionals, academics, clinicians, business, voluntary and public sectors and members of the public. However, it should be noted that a number of the policy proposals are fixed subject to the Parliamentary process.

The EqIA for the public health White Paper predominately focuses on the policy intentions relating to the creation of the public health service including:

- Structure of Public Health England
- Commissioning routes
- Proposed ring-fenced funding for public health
- Public health Outcomes Framework
- Information and intelligence

This EqIA should be read in conjunction with the EqIA for the Health and Social Care Bill (the Bill). In addition, a more comprehensive story on the health of England is set out in *Our Health and Wellbeing Today*, published to accompany *Healthy Lives, Healthy People*. This paper and the EqIA has shaped the content of the public health White Paper.

5. Relevance to Equality and Human Rights – Challenges and opportunities and Policy Discussion

Structure:

This section considers the relevance to equality and human rights of transferring:

- **Staff from the Health Protection Agency (HPA) to the Department**

We would expect all staff and assets associated with the responsibilities to transfer to the Department. We have not considered here any potential future reductions in posts, which may need to be achieved to meet the wider government cost-reduction programme.

- **Directors of Public Health from PCTs to Local Authorities**

Each PCT currently has a Director of Public Health. In order to deliver their public health improvement function, the Bill would require local authorities to have a Director of Public Health. The Department's current understanding is that the existing PCT Directors of Public Health (DsPH) would transfer to local authorities by virtue of Transfer of Undertakings (Protection of Employment) Regulations (TUPE) or statutory transfer schemes. Centrally, it would be inappropriate to dictate whether all public health staff currently working in PCTs will transfer to local authorities, as local authorities need to be able to determine workforce requirements in line with business need, whilst ensuring due regard to employment legislation.

Commissioning

This section consider the relevance to equality of transferring Commissioning functions from PCTs to local authorities. Whilst the changes outlined above would largely affect staff, the transfer of commissioning functions from PCTs to local authorities has the potential to impact on the services provided to patients and service users.

Ring Fenced Funding

The principle of ring-fencing funding to protect public health spend should ensure that money is best allocated according to need. Equality groups are more likely to benefit from a mechanism (the health premium) that targets inequalities.

Outcomes Framework

The public health Outcomes Framework and indicator set (under development) will support the public health White Paper to achieve one of its primary goals; reducing health inequalities. Addressing these health inequalities directly will have a positive impact on population health.

Information and Intelligence

We expect that improving collection and dissemination of public health information will have a positive effect on equality as better understanding of the outcomes of different groups helps to promote better targeting of effective interventions.

Health Visiting

The government has committed to increase health visitor numbers by 4,200 by May 2015. Socio-economic status has a significant impact on health inequalities amongst children and an increase in health visitor numbers will help reduce inequalities by better supporting parents and their children.

6. Discussion

Structure:

Staffing the Public Health Service – Transfer of HPA and other bodies and the transfer of Directors of Public Health (Wider work is underway as part of the ALB review which will consider equality impacts of changes).

The over-riding policy objective is to protect the public, and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest, by establishing a public health service incorporating both national and local structures. The public health service will need to be staffed appropriately to achieve these objectives. This will also need to be looked at in the context of the wider structural reforms for the NHS, which will see the disestablishment of Strategic Health Authorities (SHAs) and PCTs.

We recognise that this may be a time of uncertainty for staff and it will be important to communicate clearly with staff. In developing policy options, it has been important to involve them and consider advice from front-line staff such as DsPH currently in post. To this end, there are a number of DsPH who are working for the Department on a part time basis. In addition, there is regular engagement with DsPH through an advisory group. Staff within the HPA will be kept informed of developments relating to the transfer through a fortnightly bulletin although formal consultation has not yet commenced.

Transfer of staff from the HPA and other bodies to the Department

Given the vital nature of their work, we will need to ensure public health expertise and workforce is not lost but located elsewhere. In order to achieve cost efficiencies to respond to the financial challenge facing the public sector we will need to consider maximising the use of corporate services and minimising duplication in activity across different organisations. Be that as it may, at this stage, we would expect all staff and assets associated with the HPA to transfer to the Department. Equally, with regard to the transfers of Directors of Public Health (and associated staff) we would assume that any later reductions in staffing numbers would be the responsibility for the local authority in question to determine.

The HPA have published extensive data^x on the composition its workforce by equality strand and have sought to improve the information on staff ethnicity, disability and sexual orientation. By bringing the HPA into the Department, we have the opportunity to collect detailed equality data, which can be used to better understand and support the workforce. The HPA is made up of 11 divisions, incorporating corporate functions such as finance, communications and HR and specialist functions such as the Regional microbiology Network. The following charts by protected characteristics have been produced using data from the HPA workforce report.

Demographic Data of HPA Workforce

Gender	Female	Male	Total
Number of staff (headcount)	2593	1508	4101
Percentage of staff (headcount)	63.23%	36.77%	100%

Ethnic Origin	White	Mixed heritage	Asian	Black	Chinese	Other	Filipino	Unknown	Total
Number of staff	2797	51	285	125	34	45	2	762	4101
Percentage of staff	68.20%	1.24%	6.95%	3.05%	0.83%	1.10%	0.05%	18.58%	100%

Religious Beliefs and Beliefs of Staff	Number of Staff	Percentage of Staff
Atheism	202	4.93
Buddhism	14	0.34
Christianity	785	19.14%
Hinduism	54	1.32%
Islam	27	0.66%
Jainism	9	0.22%
Judaism	6	0.15%
Sikhism	4	0.10%
Other	110	2.68%
Undefined	2588	63.11%
Don't wish to disclose	308	7.51%
Total	4101	100.15%

Sexual Orientation	Bisexual	Gay	Heterosexual	Lesbian	Undefined	Don't wish to disclose	Total
Number of staff	8	11	1230	5	2583	264	4101
Percentage of staff	0.20%	0.27%	29.99%	0.12%	62.98%	6.44%	100%

In addition to the charts above, the HPA report explained that 13 staff within the HPA declared that they had a disability. The HPA has supported the development of the LGBT staff support group, BME staff support group and women's staff support group. The Department offers similar support mechanisms.

There is no evidence from the NHS Litigation Authority that organisational restructuring has led to a challenge on the basis of an infringement on human rights. However, an advice note for public authorities issued by the Equality and Human Rights Commission suggests that^{xi} decisions such as efficiency drives, budget cuts, reorganisations and relocations, redundancies and service reductions could have a disproportionate impact on certain groups of people. The Equality and Human Rights Commission also note that there have been recent press reports which have suggested that women are more likely to be impacted for example due to revisions to maternity and/or flexible working policies. Approximately two-thirds of the HPA workforce are female and policy makers will need to be mindful of the increased likelihood of impact. Although we anticipate moving all staff from the HPA to the Department on the 1 April 2012, the Department has to be mindful of the need to cut costs across government and the HPA cannot be immune to this. However, at this stage, it is too early to speculate on the internal structure of the Department after this date.

Another area of concern associated with restructuring is possible relocation. The Joseph Rowntree Foundation^{xii} suggests that “Employers’ assistance for relocating employees is focused predominantly on the financial aspects of moving house. However, there is increasing evidence of the impacts relocation has on partners’/spouses’ jobs, children’s education and care for older relatives. Yet many employers remain unwilling to take account of these wider issues”. There is also for example a risk that if an organisation in an urban centre is relocated, a greater proportion of BME staff may be impacted.

At this stage, we anticipate that staff and assets will transfer from the HPA to the Department. The HPA have a number of regional locations and we would not advocate a mass move, for example to the Department’s buildings in London. This should mitigate against potential impacts resulting from relocation.

Where appropriate, the transfer of staff will take place by virtue of TUPE or statutory transfer schemes with due consideration to equality legislation and employment law. In addition, it will be important to ensure that there are no infringements on Human Rights^{xiii} with particular regard to Article 8: the right to protection of private and family life. It should however be noted that all organisations named above are public authorities with responsibilities to uphold human rights conventions.

Transfer of Directors of Public Health to Local Authorities

The responsibilities that PCTs currently have for local health improvement will transfer to local authorities, who will employ the Director of Public Health, jointly appointed with the Secretary of State. From 2013/14, the Department will allocate a ring-fenced public health budget and local DsPH will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new “health premium” designed to promote action to improve population-wide health by promoting equality and reducing health inequalities.

DsPH currently have an important role within PCTs. The section below details the potential impact of transferring functions in more detail. The Association of Directors of Public Health (ADPH), the representative body for DsPH in the UK, responded to the Consultation for *Equity and Excellence: Liberating the NHS* following significant consultation and involvement with members. The full consultation response can be found at the ADPH website. The ADPH recognises that the proposed structural changes in England raise huge opportunities for public health and the organisation welcome the increased formal role of local authorities in the health agenda. The integration of local DsPH into local authorities also opens the chance of real improvements in health and wellbeing. However, the ADPH also recognises that there are potential risks around staffing capacity and transition. The ADPH notes that in previous reorganisations, 10-15% of the specialist workforce have left the service.

Data on the demographics of DsPH is currently not held centrally. The ADPH have provided statistics on the gender of their members including DsPH and those acting as interim and executives. These figures can only be seen as a broad indication and not definitive. The percentage of males to female is broadly equal with 47% male and 53% female.

The majority of DsPH will not need to “reapply” for their jobs but will instead transfer by virtue of TUPE. Transfers, where appropriate, will take place between PCTs and local authorities. Both types of organisations are well versed in their duties on equality and have previously experienced organisational change. Determining the wider public health workforce within a local authority will

be the responsibility for the local organisation. Many DsPH have already worked jointly between a PCT and a local authority with the ADPH estimating that 85% of appointments across England were joint appointments.

However, there are some areas where the number of PCTs does not align with the number of upper tier and unitary local authorities. In these cases, it is expected that there will be open and transparent competition for roles. This will need to be dealt with on a case-by-case basis, but we would expect the process to comply with equality legislation. As further mitigation, there are currently vacancies at Director of Public Health level. However, as discussed above, we recognise that relocations can have an adverse impact on staff.

Diversity within Senior Leadership and the professions

There is evidence to suggest that there is not equality of opportunity in accessing career opportunities. For example:

- Women earn on average 23% less per hour than men.
- Women working part-time are paid around 40% less per hour^{xiv}
- People of BME background are 13% less likely to find work than a white person^{xv}
- Disabled people are still more than twice as likely to be out of work as are non-disabled people^{xvi}

There are additional barriers to entering traditional professional occupations and senior executive positions both within the public and private sectors. For example, medicine is one of the most socially exclusive professions. A typical doctor born in 1970 grew up in a family with an income 62% above that of the average family, in today's terms, this equates to growing up in a family that is richer than five in six of all families in the UK^{xvii}. There is limited data on the full demographic break down of the public health workforce. However, the Faculty of Public Health have undertaken a series of surveys^{xviii} from 2003 onwards, Of the 2648 workforce questionnaires that were circulated as part of the 2007 census, 1712 were returned and 939 were identified as working at a consultant level in public health and related areas. Of the 939 respondents, 50% were between the ages of 45 and 54 years of age. 49% were male. There was not detailed ethnicity information on 14.6% of the group but 65.8% described themselves as white British with the remainder from a wide variety of ethnic backgrounds.

Senior Leadership

Although the NHS is the largest employer of women, BME groups and gay and lesbian people across Europe, there is continued under-representation from minority groups at a senior level. The NHS has made extensive efforts to address this, for example through the Breaking Through Programme, which is a positive action programme to identify, select and develop talented managers and clinicians from BME backgrounds and support them to achieve director-level positions. In March 2000, the Department set up a survey^{xix} to monitor progress on targets to increase the representation of women and black and minority ethnic groups on the boards of NHS organisations. On the 31 March 2004:

- 43% of executive directors were women.
- 7.5% of executive directors were in black and minority ethnic groups – (however this varied at the time from 0.00% in Dorset and Somerset to 28.3% in North East London).

Similar challenges are experienced within local authorities. Within the Local Government Workforce Survey: England 2010^{xx} local authorities were asked to state the percentage of the top five percent of earners from their authority who were from BME groups, had a disability or were women.

Percentage of the top five % of earners within surveyed local authorities by ethnicity, disability and gender (adapted from the Local Government Workforce Survey)	
BME Groups	2%
Those with Disability	3%
Women	44%

Local authorities were asked if they were taking any action to increase the percentage of BME groups in senior management positions. 46% of local authorities had already taken action or were planning to take action. 78% of local authorities monitored their workforce across equality strand. 4% were not yet considering monitoring which is a risk for the organisations involved. However, 100% of local authorities that responded had mechanisms in place or were considering developing mechanisms to tackle any harassment or discrimination that may arise from the lack of diversity in their workforce.

Equality and Diversity: Local and Democratic Legitimacy

A potential risk is that councillors are not representative of the population as a whole^{xxi}. In 2006, only 29% of councillors in England were women and 4.1% had a non-white ethnic background (compared to 9.5% of the population over 21 years old). The National Census of Local Authority Councillors for 2008 shows little change in these figures: 68.4% of councillors were male, with only 30.8% female. 3.4% came from an ethnic minority background compared with the percentage of BME people in the general population (9.5%). The average age of councillors has increased from 55.4 years in 1997 to 58.8 years in 2008. The proportion under 45 has fallen from 18.4% to 13.1% over the same period.

Public Health and the NHS

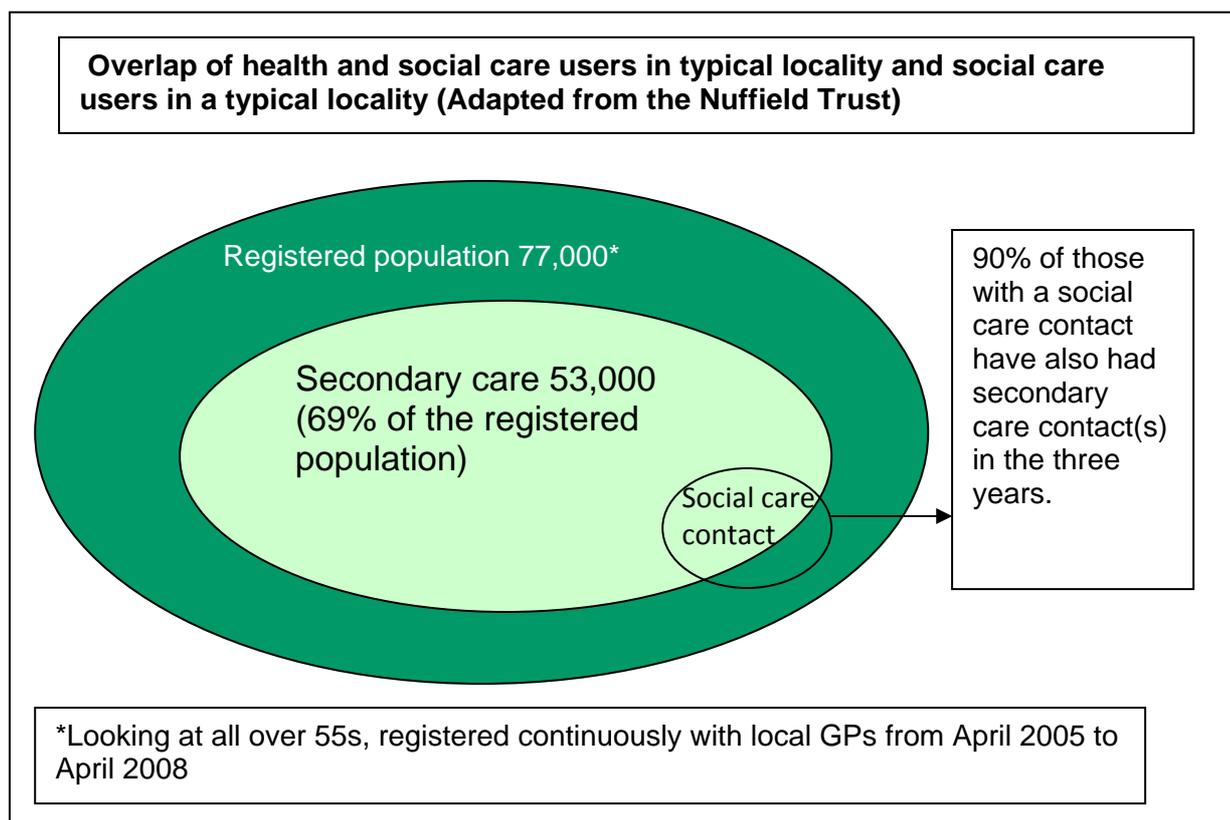
Public Health England will work hand in hand with the NHS. There will be protected public health funding, separate from the healthcare budget, to ensure that it is not squeezed by other pressures, though it will still be subject to the running costs reductions and efficiency gains that will be required across the system. Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. We have also proposed new local statutory health and wellbeing boards to support collaboration across NHS and local authorities, in order to meet communities' needs as effectively as possible.

We believe that local authorities are best placed to deliver local public health services in the new system as opposed to GP consortia. Local authorities are likely to have a wider population base than a consortium, which may allow for greater economies of scale in providing (or commissioning) public health interventions. In addition, local authorities are better placed to consider the full substitutability and complementarity of different services that may deliver public health outcomes when commissioning services.

Furthermore, while commissioning consortia will be responsible for commissioning services for the whole of their local population, there is a risk that if consortia rely heavily on GP services to

deliver public health interventions, unregistered people (and the people who may benefit the most) may fall through the net. This could have the effect of deepening health inequalities. For example, evidence suggests that homeless people and those sleeping rough tend to be more likely than the general population not to be registered with a general practitioner.⁴⁵ Furthermore, a 1994/95 survey covering 117 GP practices in and around Bristol found that only 27% would permanently register a homeless person, with 24% only treating homeless people on an emergency basis.⁴⁶ This might mean that homeless people would be unlikely to receive preventative treatments.

There is however, a risk of fragmentation. Currently people belonging to a vulnerable group would have their health services provided or arranged by one local body (PCT). In the current system there will be two commissioning bodies. However, a narrow focus on health takes too simplistic a view of the current system. Whilst a vulnerable person may have their health services commissioned by the local PCT, they may well benefit from services provided by the local authority such as social services. Indeed, currently there is already a degree of fragmentation where a service user has contact with social and health services. For example, research by the Nuffield Trust^{xxii} showed that in a typical locality, 90% of social care users over the age of 55 had been in contact with secondary care during a three-year period.



There are a number of organisations where there is joint leadership between the local authority and the PCT, such as NHS Herefordshire (Primary Care Trust) and Local Authority. The organisation notes positive outcomes such as more older people with mental health problems

⁴⁵ Anderson et al (2003) Single homeless people, London: HMSO
 Allen and Jackson (1994) Health care needs and services in resettlement units, London Policy Studies Institute for the Resettlement Agency and Department of Social Security
⁴⁶ Wood et al (1997) Do homeless people get a fair deal from General Practitioners?, Journal of Royal Society of Health 117(5):292-297

are able to live safely and with dignity in their own homes and a joint focus on improving health and wellbeing outcomes. For example, there is now a more coherent approach to tackling childhood obesity. By moving health improvement commissioning responsibilities to local authorities, we would expect a greater understanding of the wider social determinants at a population level.

Commissioning

Transfer of commissioning functions from PCTs to Local Authorities

Summary of proposed changes

There is evidence to suggest that “social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation... These inequalities interact in complex ways with socio-economic position in shaping people’s health status”.^{xxiii} There is a social gradient in health and the root causes of inequality have a profound impact on health outcomes.

Transferring the local public health commissioning responsibilities to local authorities allows for tailored local solutions to meet widely varying local needs and facilitates joined up approaches across many other areas of local government work (such as housing, planning, social care, and leisure) and with other important local partners (such as the police, business and schools) – all of which can have a huge impact on the wider determinants of health and wellbeing. In addition, local authorities have a democratic mandate from the local population, unlike PCTs. This additional legitimacy and accountability will ensure that local authorities are held to account by their local populations.

Local authorities have a public health role at present. In particular, they perform functions in relation to the control of disease under the Public Health (Control of Disease) Act 1984. The new policy is that “upper tier” local authorities are to be given additional responsibility for improving the health of their local population focusing on activities such as:

- influencing lifestyle choices by providing education and training, information and campaigns (an example would be campaigns highlighting the benefits of eating “five a day”, or pointing to the dangers of smoking);
- facilitating activity which improves health such as promoting leisure classes, working with other parts of local government to promote healthy activity (e.g. encouraging active travel, promoting exercise, reducing excess seasonal deaths through housing improvements, using existing social groups to increase skills to enable healthy eating and nutrition); and
- activities which prevent illness (a good example being smoking cessation classes which help smokers quit, thereby reducing the number of people who suffer from cancer and heart disease).

In addition to health improvement functions, we propose transferring responsibility for fluoridation from Strategic health Authorities to local authorities, transferring responsibility for medical inspection of school pupils and, the weighing and measuring of children from Secretary of State and Primary Care Trusts to Local Authorities.

Within each “upper tier” local authority, the responsibility for these functions will fall to a Director of Public Health appointed jointly by the local authority and the Secretary of State but employed by local authorities. It is proposed that the Director of Public Health will be responsible for a ring-fenced budget allocated to the local authority for its health improvement function. The Director of Public Health will have a duty to produce an annual report and we would expect this to include equality data based on the protected characteristics.

Diversity of Supply

Potential benefits of commissioning a more diverse range of services could include increased innovation. This is of particular relevance to public health services, where ill-health and inequalities may reflect social and cultural factors. Improvements in public health are therefore more likely to require innovative approaches to tackling behaviour change.

In commissioning services, local authorities, as public bodies, will also need to be aware of and meet the obligations and duties set out in equality and human rights legislation and regulations. They will be supported to do this by a ring-fenced budget. We expect the overall impact on equality and human rights to be positive. Local authorities will have a responsibility to impact assess the services they deliver and will be held accountable at a local level for the services delivered.

There is, however, a risk that some inequalities could remain entrenched, for example because of:

- inadequate commissioning
- a lack of high quality local suppliers
- or a set of nationally determined outcomes which focus efforts on particular groups to the detriment of others.

To avoid this, the Department will need to ensure the public health Outcomes Framework (detailed within *Healthy Lives Healthy People* and the accompanying consultation document) is sufficiently flexible to allow for local authorities to address the needs of disadvantaged groups in their areas. Local authorities will need to monitor the health status of local groups and adjust commissioning strategies as necessary.

Local Authorities and Equality

The policy will transfer responsibility for public health commissioning from PCTs to local authorities, which is designed to locate responsibility for promoting the public’s health with a single organisation locally, which is best-placed to deliver health improvements, working across the range of its functions to deliver policies which tackle the wider determinants of health (eg housing, transport), whilst also promoting positive behaviour change (eg through promoting leisure activities, smoking cessation). One way in which this will happen is by local authorities using their commissioning powers to increase the diversity of suppliers, opening up the market to those that are well-placed to identify and address the needs of disadvantaged groups. The Government will set national outcomes for public health and introduce incentive payments for local authorities that chose to work towards them.

Local authorities are already well-versed of their responsibilities under equality and human rights legislation. The proposed changes will add further functions across which they will exercise these responsibilities, supported by a ring-fenced budget to deliver those new

responsibilities. In addition, local authorities already provide and commission a range of services and have a wider corporate knowledge of issues relating to wider social determinants.

A focus on localism does however bring increased responsibility. There is evidence to suggest that there are excellent examples of good practice in relation to equality and diversity in both PCTs and local authorities but there is also room for improvement within both types of organisation.

For example, in September 2007, the Disability Rights Commission (DRC) conducted a review^{xxiv} of Disability Equality Scheme assessments by PCTs to determine their overall compliance with the Disability Equality Duty (now superseded by legislation contained within the Equality Act 2010). Out of the 152 PCTs, a sample of 20 was chosen to reflect the national speak of BME communities, population density and rural/urban areas. The DRC found that only two of the schemes were assessed as being compliant and the requirement of involving disabled people in developing PCT schemes was only properly fulfilled in three schemes. Evidence gathering and impact assessment were consistently weak across most of the schemes.

In 2003 the Office of the Deputy Prime Minister conducted a review into equality and diversity^{xxv} in local government in England. The report found that In those areas of the country with significant and visible diverse communities, local authorities are likely to be more aware of both the pressures and opportunities that diversity brings. However, local authorities in those areas of the country that are perceived to be more homogeneous may not recognise these factors to the same extent. The report found that there was a growing emphasis on partnership working at a local level with better joint working with statutory agencies, private, voluntary and community sector organisations. There is a risk that in moving to a more political environment, issues that are highly contentious or where there is a lack of electoral incentive may not be tackled in areas of the country where the equality agenda is not understood or is actively opposed. However, the creation of statutory health and wellbeing boards and the leadership role of the Director of Public Health should mitigate against this.

The Care Quality Commission (CQC) currently has responsibility for the independent regulation of health care and adult social care services in England. In February 2010, the CQC published a report into the state of healthcare in England^{xxvi}. The report provides a useful comparator of the respective strengths and weaknesses of local authorities and PCTs as commissioners.

Areas of Stronger and Weaker Performance by PCTs and Councils as Commissioners (adapted from the Care Quality Commission The state of Health Care and Adult Social Care in England Report^{xxvii}.)	
Primary Care Trusts (stronger areas)⁴⁷	Councils (Stronger areas)
Ensuring that the local director of public health's annual report informs the local polices and practices of health care organisations.	The performance of councils delivering improved health and emotional wellbeing was high: 92% were assessed as performing well or excellently. Forty-three councils (29%) provided excellent outcomes.
Systematic and managed disease prevention and health promotion programmes (taking into account best practice guidelines).	37 councils (25%) were judged excellent for improving quality of life for people who use services.
Patient and public views are sought and taken into account in planning and delivering health care processes.	Councils have continued to perform strongly in making a positive contribution, with 49% of councils performing well and 51% achieving excellent outcomes.
Health care services are provided in environments which promote effective care.	134 councils (91%) performed excellently or well in meeting the outcome on freedom from discrimination and harassment.
Access to information about the process for making a complaint.	Overall, councils continued to perform relatively well in achieving economic wellbeing. Sixty-six per cent of councils performed well, and 30% achieved excellent outcomes.
Primary Care Trusts (weaker)	Councils (Weaker areas)
Having a systematic and planned approach to records management (87% of PCTs are compliant).	Only 26 councils performed excellently at increasing choice and control. Fifty-nine per cent performed well and 23% performed adequately.
Ensuring that all health care staff participate in mandatory training programmes (87%).	Only 12 councils performed excellently in maintaining dignity and respect. The number of councils performing well was 60%. Two councils performed poorly.
Challenging discrimination, promoting equality and respect for human rights (88%).	

The CQC report 'Challenging discrimination, promoting equality and respect for human rights' suggests that both PCTs and councils performed less well in areas relating to human rights including promoting equality and respect. Only 12 councils performed excellently in maintaining dignity and respect and tackling discrimination

Wider findings on equality and diversity.

The CQC found that 91% of NHS Trusts met the Equality Standard in 2008/09 but noted that this should have been met since 2004 and performance against this standard is low in comparison to other minimum standards where compliance ranged from 88%-100%.

⁴⁷ Further examples were listed within the CQC report and the list above is not exhaustive.

90% of councils performed excellently or well in ensuring that there is freedom from discrimination and harassment. However, tackling the causes of discrimination and harassment for people who use services, or who are in vulnerable circumstances, or from hard-to-reach groups or ethnically diverse communities, was judged a strength in just over 13%.

Risk: Challenging discrimination, promoting equality and respect for human within PCT commissioning has been identified as weakness by the CQC. This could worsen during the transition.

Mitigation The CQC report suggests that 134 councils (91%) performed excellently or well in meeting the outcome on freedom from discrimination and harassment which would imply that local authorities are better placed than PCTs although we are not complacent and appreciate there are areas for improvement.

The Oneplace^{xxviii} national report details the findings from the Comprehensive Areas Assessment (CAA) which sought to assess how well communities are being served by their local public services. Within the report, red and green flags highlight areas of significant concern and of notable achievement or innovation. The report noted that there was evidence of marked inequalities despite equally finding examples of innovative work which addressed the effects in inequalities. The table below details both the red and green flags relating to inequalities.

Green and red flags relating to tackling inequality identified within the Oneplace National Report (2010).	
22 green flags including:	33 red flags including:
Support to help the long-term unemployed find work.	Widening gaps in educational attainment of children within areas.
Initiatives which encourage healthier lifestyles, including free personal advice.	A lack of improvement in rates of premature death from disease.
Improved educational attainment and successful work to improve skills levels	Failures to support children with special educational needs or disabilities.
Community outreach work to help older people remain independent	A lack of understanding of the needs of minority communities.
Involving children from minority communities in culture and arts activities.	High numbers of young people not in education, employment or training.

Within the 'red flags' the issues of particular note for the public health service are linked to the lack of improvement (in some areas), in the rates of premature death from disease and a lack of understanding (in some areas) of the needs of minority communities.

Risk: A lack of improvement in rates of premature death from disease.

Mitigation: This factor was only flagged in a limited number of areas and where further action was identified as necessary, local organisations are working to resolve the 'red flagged' issues. For example the report flagged high death rates in deprived areas as a significant concern for Lancashire. The most deprived parts of Lancashire suffer from long-standing and deep-rooted health problems. The Lancashire partnership has increased its focus on health inequalities in and has completed a thorough analysis to identify the ten health outcomes where inequalities are greatest. The most notable areas include liver disease, poor mental health, lung cancer and diabetes

Risk: Public sector organisations in some areas of the country lack understanding of the needs of minority communities.

Mitigation: There are currently a wide range of resources available for local authorities on the IdEA website including cited examples of best practice. Local authorities (and other organisations within the system) will need to ensure a thorough understanding of their local populations. For the first time, commissioners will be truly held to account for the provision of health services by their local populations.

Examples of good practice identified by the OnePlace Report (2010)

- Local partners are also tackling inequalities in income levels and life chances by raising educational attainment. In **Kensington and Chelsea** the gap in educational results for children and young people from black and ethnic minority backgrounds or those receiving free school meals is consistently smaller than in similar areas nationally. Recognising that factors including poor housing, social conditions and health reduce children's concentration and learning, the local partnership increased pupils' learning and progress by providing targeted support to families through family support workers, children's social services, housing and mental health professionals.
- The recession has put additional pressures on services that assist disadvantaged groups. Though some areas have struggled to cope with increasing demand, others have improved the quality of the services they provide. **Bristol City Council** is reducing the impact of the recession in areas of deprivation by increasing support for credit unions and offering additional financial advice and apprenticeship placements.
- Decent, affordable housing is central to the success of sustainable areas. In **Kirklees**, an interlinked approach has delivered more energy efficient homes, saving residents money on bills while cutting carbon emissions – the main cause of climate change. This approach has also created jobs, improved residents' health and wellbeing and reduced the number of households in fuel poverty.
- In **Hackney**, a programme to support mothers and their babies focuses on West African and Caribbean and very young pregnant women who have been identified as at-risk groups for infant mortality.

Joint Strategic Needs Assessment and Health and Wellbeing Boards.

The Department recently consulted on proposals for local statutory health and wellbeing boards. During the consultation, there was support for local statutory health and wellbeing boards, with a desire to see clarity of accountability in the system between local authorities, GP consortia and the NHS Commissioning Board. Local government and the NHS have also wanted to see close partnership working and joined-up commissioning strategies between the NHS and local authorities.

GP consortia and local authorities, including DsPH, will each have an equal and explicit obligation to prepare the Joint Strategic Needs Assessment (JSNA⁴⁸), and to do so through the arrangements made by the health and wellbeing board. The health and wellbeing board will be able to establish a shared local view about the needs of the community and to support joint commissioning of NHS, social care and public health services to meet the needs of the whole local population effectively.

The JSNA process should ensure that local authorities have a good understanding of the needs of their population, and the ring-fenced public health budget should ensure they have resources to tackle issues identified in JSNAs, including disadvantage and inequalities. However, we are aware that there could be further improvements to the way in which JSNAs tackle equality issues by better linking equalities issues to social determinants^{xxix}

‘Tackling Health Inequalities’ (2003)^{xxx} outlined what could be different from the status quo in terms of engaging communities and individuals. The report highlighted certain measures that would improve health inequalities that the proposals for increasing local democratic legitimacy in health are compatible with. In particular:

- local people being involved in identifying health needs, influencing decision making and evaluating their local services;
- developing new ways of engaging communities in the planning and provision of services, and promoting communities to stimulate greater community participation in decision making; and
- recognising and making best use of links between specific health policies and those that are initiated outside of the Department of Health but play a key role in social support. E.g. employment and education policies.

The policies of increasing local democratic legitimacy in health are consistent with the measures highlighted above. Specifically, by creating local health and wellbeing boards, local people, both sitting on the board and having a say in who sits on the board (through democratic power), will be actively engaged in the measures listed above. The creation of health and wellbeing boards therefore increases the opportunity of health inequalities being better catered for.

Support for Local Authorities

The Local Government Association suggests that “councils and their partners have a real opportunity to challenge inequality, to ensure that everyone has an equal chance in life and to respond to the diverse needs of the communities they serve”. The Equalities and Cohesion team at the Local Government Improvement and Development helps councils to meet these challenges by providing up-to-date information on equality policy and practice, such as where to find evidence and data, guidance on legislation and examples of good practice. Some examples of the good practice case studies are included below.

⁴⁸ . A joint strategic needs assessment is an assessment of the health and social care needs of the population in a local area and has been a statutory duty for Primary Care Trusts and Local Authorities to undertake one since 2008. They aim to establish a shared, evidence based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities.

Richmond upon Thames' peer mentoring approach to Equality Impact Assessments (adapted from Improvement and Development Agency for Local Government IDeA).

The London Borough of Richmond upon Thames uses a peer mentoring approach to Equality Impact Assessments (EqIAs). This has helped the council to identify needs for service and policy areas. Service managers have gained knowledge and confidence in the understanding of EqIAs. They can now use a more robust approach to equality action planning. At Richmond, the approach to EqIA is not just about trying to identify adverse or differential impact. It has been about making a baseline assessment of a service or policy area. This is to ensure that needs are identified and services are trying to meet these needs. The process is also used as a tool to help with equality action planning. During the mentoring process, five workshops were run on 'How to Conduct an Equality Impact Assessment'. A drop-in session for problem solving was included with the workshop. Mentors also gave a presentation to equality leads, looking at the importance of EqIA action plans and integrating the process into service planning. Examples of EqIAs completed at London Borough of Tower Hamlets were used as examples of best practice.

Challenges

- Consultation and monitoring for EqIAs was particularly challenging for managers.
- Managers had varying levels of knowledge and experience of conducting EqIAs and equalities work in general.
- There was concern about data collection for sexual orientation and religion and or belief.
- Encouraging managers to link action plans to service plans so that equality objectives were mainstreamed.

Outcomes and impact

- Management 'buy-in' into the process of conducting EqIAs.
- Managers now have greater knowledge and confidence to carry out EqIAs.
- The work has supported a number of draft EqIAs across the council, including replacement of the council's website with a new website to provide both information and transactional services,
- Richmond has revised guidance to managers to say that all high-impact areas should undertake a full assessment and will review documentation.
- All corporate and generic data relevant to EqIAs is now on one webpage.
- Managers have gained a clearer understanding about the need to collate evidence and using a wider evidence base. This includes customer complaints and gathering local and national statistics. Richmond has revised guidance to managers to say that all high-impact areas should undertake a full assessment and will review.

The London Borough of Merton has developed an initiative intended to improve the lives of vulnerable adults. The programme offers travel training to people with learning difficulties. This gives them the chance to gain independence, get a job, go to college or attend social and leisure activities.

The initiative was guided by the recommendations in the Department of Health's (DH) 'Valuing People Now' document. It focuses on people having more choice and control over their lives and the services they use.

Challenges

The council researched the needs of service users with learning disabilities. It found that service users needed support to travel to and from a variety of locations throughout the borough. This could be to participate in work placements and employment, or leisure and social activities. The need for service users to receive travel training to build independence, awareness and confidence was discussed. It was agreed that developing these skills would help disabled service users contribute to and be part of the local community.

The council applied for funding from the Learning Disability Development Fund (LDDF). This application was successful and enabled Merton to appoint two travel trainers to present the travel training programme. Participants were supported to learn routes to a chosen destination in small groups or on a one-to-one basis. Trainees used a variety of modes of transport to attend educational classes, employment, and social and leisure activities. Trainees working towards independent travel were issued with personal travel wallets. This included a list of items to take on each journey, such as keys, money, freedom pass, taxi card, mobile phone and a personal alarm. The pack also includes emergency contact details, photographs of relevant landmarks and staff details at selected help points throughout their journey. Trainees who did not achieve independent travel continued to be supported by the travel trainers.

Outcomes and impact

- On a weekly basis approximately 20 service users entered the programme. Further support has been offered to help with work placements, college courses, therapy sessions and accessing leisure centres.
- One participant from the programme has now been offered a work placement and travels independently to and from their workplace. And another service user has overcome a fear of travelling in the rain. This person is no longer dropped to and from work placement when it is raining.
- Individuals are now going to their local shops, posting letters and visiting friends in their community without support. These life-changing skills have clearly increased service users self-esteem, motivation, confidence levels and the drive to achieve personal goals.

The new approach to public health

Chapter 2 of *Healthy Lives, Healthy People* describes a radical new approach to public health in England, including a 'ladder' of interventions designed to promote healthier lifestyles in ways that recognise the choices that we all have as well as the aspects of life that can be beyond our control. The ladder begins with simple information about health, rises up through guided choice of lifestyles, and ends with eliminating choice altogether – for example, by banning a particular product.

The Government intends to use the less intrusive approaches wherever possible, working with business to make healthy choices easier rather than banning or significantly reducing choice. But the public health White Paper also recognises that 'one size fits all' policies do not work, and risk leaving behind the poorest and most disadvantaged. Information or services need to be culturally and linguistically sensitive if they are to produce more equal outcomes for Black and minority ethnic communities and other groups. They need to be accessible to people with a learning disability or sensory impairments. Interventions also need to offer more support to those who may be less confident in making choices – for example, the evaluation of direct payments for social care found that mental health services users gained the most benefit from them but were also the least likely to take them up. Significantly, though, the take up within some individual local authorities was good, showing what could be achieved when they worked actively with people to encourage and support them.

Nationally, we will continue to engage and involve widely as policy develops and individual new interventions will be subject to appropriate impact assessment. Locally, the best way to achieve more equal outcomes from interventions is by giving diverse communities a real say in their design and delivery. Local government is directly accountable to those communities and best positioned to understand and meet their needs.

Ring-fenced Funding

Giving insufficient priority to public health services is likely to lead to lower improvements in health of the population over the medium to long term and a higher need for NHS treatment services. Over 80% of NHS funding is allocated to PCTs and the Department has not broken down PCT allocations by policies or services, at either the national or local level. It has been for PCTs to decide their priorities for investment taking into account both local priorities and the NHS Operating Framework. The incentives faced by PCTs and Department central budgets have not led to sufficient priority being given to public health.

The main policy objective is to safeguard spending on public health services by establishing a ring-fenced public health budget and thereby help to improve public health and overall health outcomes. Investment in public health services is a cost-effective way to improve population health and reduce the need for NHS treatment services. A second objective is to ensure that the funding for public health work is provided according to the baseline need and that public health funding allocations act to reduce inequalities. A third objective is to ensure that local areas, which achieve improvements in public health outcomes are rewarded for their achievement. This will encourage local areas to improve their performance.

A survey of all PCT DsPH, in post in May 2003, found that 76% felt that national work programmes displaced local priorities completely, or to a large extent, with waiting lists being the most commonly identified factor. The most common areas of 'foregone' priorities from were

health promotion and public health (26% of PCTs) and primary care development (24% of PCTs), which included areas such as expansion of practice nursing for chronic disease management and diabetes identification and care.^{xxxii}

A separate survey^{xxxiii} was conducted in April 2007 by the Association of Directors of Public Health where PCT Directors of Public Health were asked what proportion of their funds were actually committed on public health programmes during the financial year 2006/7. 103 returns were received from 152 PCTs (68% return rate).

The Department earmarked funds in the 2006/7 and 2007/08 financial year which were allocated to PCTs for public health programmes. This money was not ring-fenced and the survey suggests that 66% of the allocation was spent on other things. The major areas for investment, where DsPH expressed concern for their local population were sexual health, obesity, smoking, alcohol. Others were concerned about investment in coronary heart disease, mental health, health trainers, drugs, cancer, screening and long-term conditions.

The Chief Medical Officer's report in 2005 goes even further and suggests that 'raiding public health budgets can kill: protecting investment in health is not just important, it is essential to sustaining our health service'. The report suggests that whilst public health services are essential to protect and improve the health of the population, there is strong anecdotal information from within the NHS, which tells a consistent story for public health of poor morale, declining numbers and inadequate recruitment, and budgets being raided to solve financial deficits in the acute sector.

The principle of ring-fencing the budget to protect public health spend should ensure that money is best allocated according to need. Disadvantaged groups are more likely to benefit from a mechanism (the health premium) that targets inequalities. However, this may depend on the balance between how different groups benefit from spending on public health activities and other areas of local government spending. It is also possible that there could be an indirect impact that follows from differing commissioning approaches taken by local authorities as opposed to GP consortia. However, these bodies have not previously held responsibility for health commissioning in this way and it is not possible to quantify the potential effect. The proposed ring-fenced budget has the potential to have a positive impact but until policy options are clarified, it is too early to accurately determine the impact.

Risk: Disadvantaged groups may equally benefit from direct spend on education, housing or other local authority services.

Mitigation: Local authorities will take balanced spending decisions based on their understanding of the holistic needs of the local community. The Director of Public Health will be well placed to ensure that all local authority policies and spending are focused on reducing disadvantage.

Risk: By removing the flexibility for commissioners to 'raid' budgets to pay, for example for a deficit in acute care, may impact negatively on disadvantaged users who frequently use acute services.

Mitigation: A fair but realistic allocation will be provided on the ring-fenced budget. The Government is committed to protecting NHS funding in real terms. There is medium to longer-term value in funding preventative services (see below).

Value of prevention

There is robust cost-benefit evidence that prevention and early intervention can break down cycles of inequality running through generations of families (Marmot et al, 2009). The economic returns of early childhood interventions exceed cost by an average ratio of six to one (NICE, 2009). A number of studies have demonstrated significant cost benefits from early years interventions, and particularly for long-term outcomes^{xxxiii}.

Total health expenditure in England in 2006/07 is estimated to have been £93.5 billion^{xxxiv}. Using OECD *System of Health Accounts* definitions (i.e. excluding expenditure on preventative pharmaceuticals and including expenditures only on activities that can be classed as organised social programmes), prevention expenditure in England in 2006/07 is estimated to be £3.7 billion. As a percentage of estimated total health expenditure in England over the same period, we conclude that prevention expenditure in 2006/07 was 4.0% of total health expenditure. The Department estimates that around 15 to 20% of inequalities in mortality rates can be directly influenced by health interventions which prevent or reduce the risk of ill health, representing thousands of people dying earlier than might otherwise be the case.

The National Audit Office (NAO) produced a report in July 2010 on *'Tackling Inequalities in Life Expectancy in Areas with the Worst Health and Deprivation'*^{xxxv}. The report details the performance of the Department against tackling inequalities in life expectancy. The report concludes that the Department has made a serious attempt to tackle health inequalities across England but that many of the causes of such inequalities are outside the influence of the Department. The report was somewhat critical of the fact that it took three years from publication of the health inequalities strategy for the Department to establish health inequalities as a top six NHS priority. The NAO was unable to conclude that the Department's approach provided value for money during the early 2000s. The report recommended that future initiatives aimed at addressing health inequalities should be set so there is clarity as to their contribution to improving health outcomes and that commissioners of public health services should publish information on progress in reducing health inequalities for those sub-sets of their population with high levels of deprivation. The NAO suggest that greater investment in prevention is necessary if the NHS is to help tackle health inequalities now and in the future. The refocusing of public health, its new location within local government and the protection of public health funding through the ring-fence should all help facilitate investment in prevention.

Public Health Outcomes Framework

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

The public health outcomes framework and indicator set (under development) will support the public health White Paper to achieve one of its primary goals; reducing health inequalities. Addressing these health inequalities directly will have a positive impact on population health.

It is well documented that certain members of our community, in particular those that have experienced marginalisation, experience the worst outcomes in health. For example, life expectancy is worse in areas of deprivation, obesity and associated clinical outcomes such as Type II diabetes is worse in certain ethnic groups (e.g. Pakistani males).

Although the indicator set is under development, it is anticipated that measures of health inequality will be included, for example, measuring the gap between life expectancy between different socio-economic groups / males and females / regional inequalities.

It is likely that the public health outcomes framework will concern clinical end-points and process indicators (where a clinical end-point is inappropriate). Each indicator will need to be considered in terms of its potential impact on equality and diversity. More importantly, it will be the interventions deployed to improve health (as measured by the indicator set) that have the greatest potential to impact on reducing health inequalities. Any negative impacts will need to be mitigated at a local level through commissioning processes.

It is possible that indicators may be chosen which focus on specific groups e.g. cancer mortality for under 75 years of age. These indicators will only be selected where their inclusion can be justified by a strong evidence base and where the intention is to reduce specific inequalities in health. Such indicators will be individually impact assessed prior to final selection.

The case for addressing inequalities in health was made recently in the University College London's '*Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England Post 2010.*' This review by Marmot et al. covers a number of issues involved with reducing health inequality at both national and local levels.

The evidence paper produced for the public health White Paper provides an overview for many of the issues relating to an EqIA. The consultation processes include:

- Departmental stakeholder events.
- Engagement with public health community (Directors of Public Health Advisory Group), including with BME communities.
- Engagement across wider public health workforce, including regional teams (Public Health Observatories, Regional Directors of Public Health Groups).

Challenges include:

- Ensuring indicators reflect health improvements that can be made across all the identified Equality Groups.
- Ensuring that the indicator set does not provide perverse incentives to marginalise smaller community groups inadvertently where there is not a significant critical mass (e.g. gypsy traveller community.)

Opportunities:

- In order to further reduce any adverse impacts on particular groups, the completed public health Outcomes Framework and each individual indicator (once the final set has been agreed) should be equality impact assessed. In addition, the risk of adverse impact should form part of the criteria for selection.

- The public health outcomes framework and indicator set will provide an opportunity to expose inequalities in health and for any improvements to be monitored nationally. This could result in the identification of areas of best practice where significant achievement can be made.
- The evidence base to support the framework should identify evidence-based interventions to reduce inequalities in health (where available). This will contribute to a reduction / removal of existing inequalities, e.g. improving breast-screening uptake in women residing in those areas ranked as being the most deprived and in some BME communities.
- The public health outcomes framework and indicator set can act as a lever for improved commissioning and local action to help reduce inequalities in health.

Information

The nation has a wealth of information on public health, collected in a variety of ways, and used by different people and organisations for many purposes. Public Health England offers a unique opportunity to review these complex functions and draw together those which make a difference into a more coherent form. This reflects our renewed commitment to doing what works in public health. We will build on current successes while reducing duplication and filling critical gaps. We will start an evidence revolution to support information-led, knowledge-driven public health. This means identifying the users of evidence, understanding their needs, and finding the most cost-effective way to meet them, based on the principles of quality, transparency and efficiency.

Information and intelligence supports and is generated through the underpinning public health functions of surveillance and epidemiology and provides the rational basis for public health decision-making at individual, local and strategic level. The policy objective is to consider and weigh options for ensuring provision of issue- and locality-specific public health evidence functions, in line with changes happening across the public health system.

We expect that improving collection and dissemination of public health information could have a positive effect on equality groups as better understanding of the outcomes of different groups can help to promote better targeting of effective interventions.

During the consultation, the Department will be asking what commissioners and providers would find the most helpful to support them to improve and protect population health and tackle health inequalities more effectively.

Health Visiting

Health visitors are public health professionals working in the community who provide key, universal services to children, parents and families. Numbers of health visitors in England have been declining for several years whilst birth-rates have been increasing. Projections suggest health visitor numbers will continue to fall unless there is direct intervention to reverse the trend. The public health White Paper builds on the Coalition promises to pay for an additional 4,200 health visitors by May 2015.

The Government's commitment to significantly grow the health visitor workforce should be seen within the wider context of the early years and early intervention agenda for children and

policies, which aims to support families in general. As a public health profession, a key aspect of the health visiting role is tackling health inequalities at early stages in life (in the case of children) but also at the parenting stage. A health visitor should routinely advise on parental diet, smoking, substance use, environmental health, weight and mental health issues. They will also routinely signpost and/or refer to more specialist services where appropriate. Health visitors also hold the potential to be significant shapers of and players in the Big Society. A key element of their role will be to ensure the 2-2.5 year review takes place. This is a critical life stage for children and one at which time crucial support needs can be identified by health visitors

Socio-economic status has a significant impact on health inequalities amongst children. N J Spencer^{xxxvi} suggests that children born to lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer significant episodes or morbidity. The main benefits of increasing the number of health visitors will be to children and families. There are likely to be positive effects for children from earlier identification of development needs (the 2.5 year checks), but the main benefits are likely to be over the lifetime of the child. Health Visitors are skilled at identifying families with high risk and low protective factors, enabling these families to express their needs and deciding how they might best be met. Preventing and addressing problems in maternity and childhood lays the groundwork for a healthy and well life, and can help stop poor health being passed down generations, reduce inequalities and improve infant, maternal and child health. Health visitors are skilled at identifying families at risk or in need of extra support due to short or longer term issues and pressures families may experience, and can develop new ways of delivering services to families who find it difficult to connect with traditional service arrangements. They have a role in building a stronger local community and using that capacity to provide a wide range of services and choices to local people.

Securing a future health visiting service that is universal, energised and fit for long-term growth demands immediate action and investment. More health visitors will drive-up health outcomes and reduce inequalities, working with all family members. We would anticipate a positive impact on disadvantaged groups. The policy intention is to improve health outcomes by ensuring continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and a range of interventions for those with greater needs, championing wider health and wellbeing, prevention and public health and building family and community capacity. This is likely to have a particular impact on women (and pregnant woman and socio-economically disadvantaged children).

7. Summary of Evidence and Stakeholder Feedback

In considering the policy options presented in this assessment we have taken into account the existing evidence base on public health and health inequalities, which is discussed further in the Evidence Base at Appendix A. This demonstrates an understanding of some of the broader equalities issues that need to be considered as changes to the system are finalised and implemented. The Marmot review has been a significant influence on a number of the proposals outlined within this report with social influences having a great impact on health outcomes. Our health and wellbeing is not static and many influences can affect it at different stages of life. People's health and wellbeing varies significantly across England. As the Marmot Review demonstrated, there is a strong social gradient of health. People in disadvantaged areas are now living longer overall, but are still more likely to have the shortest life

expectancies and experience a greater burden of poor health. This inequality is driven by the underlying social factors which affect people's health and wellbeing – 'the causes of the causes. There is a gap of up to seven years in life expectancy between richer and poorer neighbourhoods, and up to 17 years for disability-free life expectancy (DFLE). There is also wide variation within areas, for instance in Kensington and Chelsea life expectancy for men is 7.1 years lower in the most deprived parts of the Borough. Low income and deprivation are particularly associated with higher levels of obesity, smoking, harmful alcohol use, illegal drug use and anxiety and depression.

Additional pieces of evidence of particular significance to equalities are the sections on organisational form, engagement with public health professionals and the Joint Strategic Needs Assessments (JSNA) report from Race for Health and Shared Intelligence. A document detailing the evidence base relating to public health will be published alongside the public health White Paper.

- The Centre for Health Economics, University of York suggested that "organisational barriers have potentially become more significant recently due to the proliferation of different types of services, governed by different health professionals all of who have their own idea of an 'ideal user'. Navigation of an entry point into such services may therefore be more difficult for those from disadvantaged groups.^{xxxvii} The transfer of Directors of Public Health to local authorities presents the opportunity to better align health with social care. The Department of Health's Integrated Care Pilot programme is exploring different ways of delivering more patient-centred and joined up services.
- Race for Health and Shared Intelligence were commissioned by the Department of Health to prepare a report exploring approaches taken by Joint Strategic Needs Assessments (JSNAs) to understand race equality in health and healthcare. There is further work that could be done within the JSNA process to ensure that equalities issues are linked to local evidence on social determinants^{xxxviii}.
- On 16 September 2010, the UK Faculty of Public Health (FPH) published results^{xxxix} of a survey sent to 3,300 public health specialist members (of which 1,160 members responded) asking for feedback in response to the NHS White Paper, *Equity and Excellence: Liberating the NHS*. There were two questions directly relevant to equality issues. 91.3% agreed that the emphasis on the equity of outcomes is welcomed by the FPH. The majority of surveyed members (59.1%) expressed neutral views about whether the introduction of a new health premium would promote action on reducing inequalities. However, there were more positive responses than negative. (29.5% compared to 11.4%). Overall, members did not feel able to assess (53.3%), at that time, whether they believed the NHS White Paper proposals would lead to an improvement in the health of the population of England

Consultation Feedback

As part of the wider consultation process on *Equity and Excellence: Liberating the NHS*, a number of voluntary and equality organisations submitted formal feedback. The predominant focus was not on the proposals relating to Public Health England.

A number of organisations gave feedback on the proposals relating to the new public health service and they are referenced below. However, there will be further opportunity for consultation on selected elements of *'Healthy Lives, Healthy People'*.

The National LGB&T Partnership raised concerns that the changes proposed in the NHS White Paper will give local authorities more power over health and social care services without challenging them to take into account the needs of vulnerable minority groups, namely lesbian, gay, bisexual and trans (LGBT) communities, which many have been reticent to do thus far. However, the organisation recognised that some local authorities are making a worthwhile effort to engage with LGBT communities and that their enlightened approach should serve as a model for those whose performance falls short of best practice.

Local authorities, like other public sector bodies, have a responsibility to impact assess services and to take into account the needs of diverse groups of people including LGBT communities. We would therefore expect local authorities to fully reflect the needs of their populations within such assessments. In addition, there will be additional accountability to the local population through the health and wellbeing boards.

The Samaritans were broadly supportive of the proposals in relation to public health suggesting that "the new role of local authorities in the delivery of public health services opens up the opportunity to deliver services aimed at improving public mental health and well being, designed specifically around the needs of the local community".

The National Childbirth Trust (NCT) felt that ring-fencing of the public health budget is to be welcomed; however to truly take a preventative role, actions to support parents in the transition to parenthood need to be properly funded as effective support at that stage can help parents get off to the right start. NCT is strongly supportive of school education on relationships (both sexual and within families); pregnancy (both the biological and emotional journey); birth (as a physiologically normal event within the transition to motherhood or fatherhood); and the role and responsibilities - as well as the required skills, knowledge and resources – associated with becoming a parent.

Age UK noted that a significant factor in developing and delivering services for older people is prevalence of multiple conditions and frailty. The organisation felt that measures of both should be incorporated in the allocation of funding to Public Health England and local authority public health budgets.

The Afiya Trust welcomed the Government's commitment to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all. As we know, from decades of evidence, there are continuing disparities in health and social care outcomes for people from many minority ethnic communities. The Afiya Trust also commented that they felt it was not possible to achieve better health and wellbeing for all without addressing the specific needs of our diverse, minority ethnic communities.

We are engaging with a wide variety of organisations and will continue to do so through the development of the public health services. As an example of this, a 'roundtable' was held with the Minister of State for Care Services in relation to public health and the voluntary sector on the 20 October 2010. Feedback suggested that the focus on wider social determinants was a positive step and that the voluntary sector could play a significant role. For example, the voluntary sector is a trusted voice that speaks for those who cannot or feel unable to speak for

themselves and is a valuable resource for Public Health England given the large number of organisations, and volunteers.

Overall Assessment of Impact

- In summary, we believe that the creation of Public Health England has the potential to make a positive impact on equality groups through reducing the barriers and inequalities that currently exist. However, more evidence is needed for a detailed assessment.
- Regarding the transfer of staff from the HPA and the National Treatment Agency for substance misuse to the Department, we would expect a neutral impact given that at this time, it is expected that all staff within those organisations as of 31 March 2012 will transfer to the Department on 1 April 2012.
- The proposed ring-fenced budget has the potential to have a positive impact but until policy options are clarified, it is too early to accurately determine the impact.
- The public health Outcomes Framework and indicator set has the potential to contribute to a reduction in barriers and inequalities that currently exist. However, as this work-stream is under development, there is not enough evidence to make this assessment. However, as the Outcome Framework seeks to contribute to promoting equalities in health for the whole population, a negative impact is unlikely.
- It is likely that improving collection and dissemination of public health information will have a positive effect on equality as better understanding of the outcomes of different groups help to promote better targeting of effective interventions.
- We anticipate that the commitment to increase health visitor numbers would have a positive impact on disadvantaged groups. The policy intention is to improve health outcomes by ensuring continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and a range of interventions for those with greater needs, championing wider health and wellbeing, prevention and public health and building family and community capacity. This is likely to have a particular impact on women (and pregnant woman and socio-economically disadvantaged children

Appendix B details a consideration of the potential impacts against each of the protected characteristics. As we move into the consultation phase of the White Paper and outline the available options, we will be in a better position to make an accurate assessment. Discussions with stakeholders will better equip us to mitigate any potentially negative impacts.

Public Health England Actions

- publish a further EqIA with the consultation response
- continue to engage with stakeholders between the publication of the Public Health White Paper and the publication of the final EqIA

- arrange a workshop with Department colleagues to discuss EqIA issues to feed into policy development
- include specific questions relating to equality issues within the Outcomes Framework consultation document.
- We will have specific groups who we will consult as part of the consultation process for example The Race Equality Foundation, the Equality and Diversity Council, Department's Strategic Partners and the Department's internal staff diversity groups covering disability, race and sexual orientation
- We will be consulting on key aspects of the development of Public Health England and during the consultation will organise specific events to reflect the protected characteristics.

Public Health Outcome Framework Actions

Given the importance of the outcome framework in addressing inequalities, there are a number of specific actions as below:

- continuation of a weekly workshop established for internal stakeholders to inform the development of the public health Outcome Framework and indicator set (as established September 2010);
- coordinate external stakeholder event(s) throughout October 2010 to review and further develop a proposed framework and indicator set;
- circulate relevant documentation and matters arising to the Directors of Public Health Advisory Group to inform the development of the Outcomes Framework, to identify any adverse impact and opportunities for mitigation;
- development of the public health Outcomes Framework will be aligned to the 'Equality Delivery System' developed by the Department of Health's Equalities Council; and
- maximise opportunities to monitor inequality impacts and act accordingly by working within the principles adopted by the Information Centre to disaggregate its existing data set by the broadest set of diversity measures.

Role of the EqIA in policy development.

As part of the drafting process of the public health White Paper, a paper outlining the evidence base was produced (*Our Health and Wellbeing Today*). This has fed into the policy making process and the EqIA. The evidence suggests that there are significant inequalities, which the new public health service will need to address and which are described in the White Paper and its associated documentation. For example, the uneven way that conditions like tuberculosis and mental illness are spread across social and ethnic groups, and the way that differences in smoking varies between higher and lower income gaps have widened health inequalities. We believe that local authorities will be better able to understand the wider social determinants within their patch and have more opportunities to tackle wider determinants. The EqIA has shaped thinking in relation to the proposed workforce transfers. It will be vitally important to pay due regard to employment legislation and to ensure that there is no discrimination.

Directors of Public Health will have the responsibility of publishing an annual report detailing the work undertaken. This will enable local people to hold local authorities to account. In addition, local authorities will need to make an accurate joint strategic needs assessment and equalities issue should be considered. However, a challenge for the future will be for Public

Health England to adequately tackle inequalities where there is not widespread impetus to do so, for example, dealing effectively with the public health needs of gypsies, asylum seekers etc.

We are still at a consultation stage on specific policy development such as the mechanics of the ring fenced budget and welcome comments from organisations representing equality groups and will consider responses throughout the consultation. We anticipate the publication of a further EqIA after the consultation period.

Appendix A: Evidence Base

Introduction

In considering the policy options presented in this assessment we have taken into account the existing evidence base on public health and health inequalities demonstrating an understanding of some of the broader equalities issues that need to be considered. We recognise that there are gaps in the evidence relating to specific public health policy development.

The premise of Public Health England will be ***to protect the public; and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest.*** We know that compared to other countries, there are significant areas for improvement within the current system. For example, rates of mortality amenable to healthcare^{xi} rates of mortality from some respiratory diseases and some cancers^{xii}, and some measures of stroke^{xiii} have been amongst the worst in the developed world^{xiii}. In part, this is due to differences in underlying risk factors, which is why we need to re-focus on public health. However, international evidence also shows we have much further to go on managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions^{xiv}; the incidence of MRSA infection has been worse than the European average^{xv}; and venous thromboembolism causes 25,000 avoidable deaths each year^{xvi}.

Organisational form

The Centre for Health Economics, University of York suggested that “organisational barriers have potentially become more significant recently due to the proliferation of different types of services, governed by different health professionals all of whom have their own idea of an ‘ideal user’. Navigation of an entry point into such services may therefore be more difficult for those from disadvantaged groups.^{xvii} The transfer of Directors of Public Health to local authorities presents the opportunity to better align health with social care. The Department of Health’s Integrated Care Pilot programme is exploring different ways of delivering more patient-centred and joined up services. A progress report is expected in November 2010, which will provide some early findings from the pilots, which may support the transition process to the public health service.

Joint Strategic Needs Assessment (JSNA)

Race for Health and Shared Intelligence were commissioned by the Department of Health to prepare a report exploring approaches taken by Joint Strategic Needs Assessments (JSNAs) to understand race equality in health and healthcare.

Race equality is beginning to be recognised and addressed within the JSNA. A majority of JSNAs had moved beyond the core dataset and were presenting locally unique and relevant data. Flowing from the presentation of data, some JSNAs understood and were exploring needs relevant to race equality, using community engagement to enhance the professional evidence-base. However, the report found that there was scope for improvement. The study found that although there was no particular model or approach that would produce the most culturally responsive JSNA there were a number of actions that could improve JSNAs^{xlviii}

Race equality was far less prominent an issue in JSNAs compared to socio-economic inequalities. It was felt that there could be a stronger connection between ethnicity and deprivation and the opportunity to link needs assessments with local authority and health organisation equality strategies was sometimes missed. The study also found that the composition of the community and the level of diversity present had no significant impact on the extent to which JSNAs addressed race equality issues. It was recognised that the transition to the new system could provide an opportunity to consider the messages identified within the report.

Marmot Review

In February 2010, the Marmot Review team published 'Fair Society, Healthy Lives'^{xlix} based on a year long independent review into health inequalities in England led by Sir Michael Marmot. The review found:

- reducing health inequalities is a matter of fairness and social justice. In England, there may be people who are currently dying prematurely each year as a result of health inequalities who would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

With particular regard to inequalities, Marmot found that "social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation... These inequalities interact in complex ways with socio-economic position in shaping people's health status." Given the finding of a 'social gradient' in health, it is important for policy makers at a national and local level to give due consideration to tackling the root causes of inequality.

Engagement with public health professionals

On 16 September 2010, the UK Faculty of Public Health (FPH) published results^l of a survey sent to 3,300 public health specialist members (of which 1,160 members responded) asking for feedback in response to the White Paper, *Equity and Excellence: Liberating the NHS*. There were two questions directly relevant to equality issues. 91.3% agreed that the emphasis on the equity of outcomes is welcomed by the FPH. The majority of surveyed members (59.1%) expressed neutral views about whether the introduction of a new health premium would promote action on reducing inequalities. However, there were more positive responses than negative. (29.5% compared to 11.4%). Overall, members did not feel able to assess (53.3%) at that time whether they believed the White Paper proposals would lead to an improvement in the health of the population of England. The questions directly related to equality issues are outlined below:

Table 1a adapted from the uk faculty of public health’s survey results in response to the white paper: equity and excellence.

	The emphasis on the equity of outcomes is welcomed by FPH and the public health community.	The introduction of a new health premium will promote action on reducing inequalities.
Strongly agree	41.2%	4.5%
Agree	50.1%	25.0%
Neither agree nor disagree	6.9%	59.1%
Disagree	1.4%	9.5%
Strongly disagree	0.4%	1.9%

Employment Legislation

The process of transferring staff will, where appropriate, be underpinned by due regard to employment legislation in relation to discrimination and the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). TUPE protects employees' terms and conditions of employment when a business is transferred from one owner to another. Employees of the previous owner, when the business changes hands, automatically become employees of the new employer on the same terms and conditions, as though their employment contracts had originally been made with the new employer. Their continuity of service and any other rights are all preserved. Both old and new employers are required to inform and consult employees affected directly or indirectly by the transfer. As discussed within the Structure section of the EqIA, it is currently assumed that on the 1 April 2012, all HPA staff will transfer to the Department of Health. Directors of Public Health are also expected to transfer from PCTs to Local Authorities although as discussed there may be a requirement for open competition in some areas. The composition of the wider public health workforce at a local-level will be subject to local determination.

Protected Characteristics

The following sections identify points to consider with regard to equality and human rights in access to services, experience and outcomes. This highlights some of the challenges facing Public Health England and underlines why there is a need for a renewed focus on public health.

Age

A wide range of services will be needed by people depending on their age. The proposal to transfer Directors of Public Health from PCTs to Local Authorities will help to ensure close links with other services such as social care, that support older people. Improvements in healthcare, quality of life and lifestyle mean we are all living longer. There will be a substantial increase in the number of people requiring care and support over the coming years. The Government expects the number of disabled younger adults and older people with potential care needs to rise from under 6 million now to around 7.66 million in 2030, an increase of around 1.7 million over 20 years.^{li}

Our population is ageing rapidly. By 2024, an estimated 50% of the population will be over the age of 50, due to a combination of increased life expectancy and low birth rates. Many people over 65 are also carers. Many risk factors for poor health, such as obesity, hypertension, disability and poverty increase with age:

- The prevalence of most acute and chronic diseases increases with age including cancer, cardiovascular disease, diabetes, suicide, and dementia. Older people also often suffer co-morbidities.
- The proportion of people with a long term illness or disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability.
- Older people over 75 account for the largest proportion of deaths from accidents.^{lii}

Dementia affects 750,000 people in the UK. Numbers are expected to double by 2030. The annual costs of dementia in the UK amount to £17 billion. Around 50% of dementias have a vascular component, which is associated with diet and lifestyle. There are increasing numbers of frail older people. In winter 2008-09, there were 35,000 excess deaths in England. Many of these deaths could have been prevented and are associated with cold household temperatures.

The Equality Act 2010 will ban age discrimination in services and public functions, including in social care and healthcare. (The duty in relation to age will not come into force until April 2012). It also creates a new equality duty on public bodies and others carrying out public functions. Implementing the ban on age discrimination in health and social care will allow a person's age to be taken into account where it is right and relevant to do so, and not where it is not, when making an assessment of their needs.

Banning age discrimination could lead to 'Active Ageing' - when health, labour market, employment, education and social policies support active ageing there will potentially be:

- fewer premature deaths in the highly productive stages of life
- fewer disabilities associated with chronic diseases in older age
- more people enjoying a positive quality of life as they grow older
- more people participating actively as they age in the social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life
- lower costs related to medical treatment and care services^{liii}.

Disability

Disability affects the length and quality of life, and can adversely affect access to services. There is heterogeneity amongst disabled people arising both from variations in impairment and from variations in socio-demographic characteristics. It is estimated that approximately 20% of people within the United Kingdom have an impairment this percentage increases to 47% when focussing on those over the state pension age.^{liv} According to the 2001 Census, 18% of people reported a long-term illness or impairment that restricted their daily activities.

There is evidence that disabled people experience unequal access to health services and inequalities in health. Particular barriers can be demonstrated for some specific groups especially people with learning disabilities or long-term mental health conditions who experience poorer health outcomes and shorter life expectancy. For example, the Disability Rights Commission 2006 Report *Closing the Gap* highlighted high incidence of obesity and respiratory disease in people with learning disabilities and obesity, smoking, high blood pressure, respiratory disease and stroke among people with long-term mental health conditions. It was also found that four times as many people with learning disabilities die of preventable causes as people in the general population.

Evidence has also identified that people with learning disabilities experience both worse access to general health services as well as worse health outcomes than the general population for a variety of diseases and conditions, such as respiratory disease, heart disease, mental ill health, hearing and visual impairments and osteoporosis. Epilepsy is over 20 times more common in people with learning disabilities than in the general population. Sudden unexplained death in epilepsy is five times more common in people with learning disabilities than in others with epilepsy.^{iv}

Mental ill health is linked to increased mortality from cardiovascular disease, cancer, respiratory disease, metabolic disease, nervous system diseases, accidental death and mental disorders^{vi}. Another risk factor is the fact that poor mental health is associated with poor compliance with treatment for health problems^{vii}

Carers

Carers provide unpaid care and support to ill, frail or disabled friends or family members. People from all walks of life and backgrounds are carers - over 3 in 5 people in the UK will become carers at some time in their lives. Caring can be a rewarding experience, yet many face isolation, poverty, discrimination and ill-health^{viii}. Carers UK^{ix} suggest that this is dependent on a number of factors:

- lack of appropriate information
- lack of appropriate support
- isolation
- financial stress

The Carers Strategy (2008)^{ix} found that cultural concepts of caring are not universally shared throughout communities in Britain; many people from other countries do not have experience of a welfare state and therefore, among a whole range of concepts, would not understand the concept of a 'carer'.⁵ The National Black Carers and Carers Workers Network have highlighted that they have been unable to find a word in Gujarati, Urdu, Punjabi or Bengali which translates into 'carer';

We know that women were more likely to be carers than men, 18 per cent compared with 14 per cent. There were no gender differences in the proportion caring for someone in the same household but women were more likely than men to look after someone outside the household, 12 per cent compared with 9 per cent. Women also predominated in the sub-groups with the heaviest commitments: 11 per cent of women compared with 7 per cent of men were main carers and 5 per cent of women compared with 3 per cent of men spent 20 hours a week or

more on caring tasks^{lxi}. In addition, Bangladeshi and Pakistani groups are more likely to be carers than any other ethnic group^{lxii}.

From October 2010, Carers have legislated protection under the Equality Act 2010 (discrimination by association).

Race

The Afiya Trust in 'Achieving Equality in Health and Social Care *Spring 2010*' suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities".^{lxiii} This is also echoed by Goddard who suggests that perceptions of cultural sensitivity of services has been reported as an important influence on both entering into the health care system and maintaining contact. Barriers to help-seeking include perception of language difficulties, lack of awareness about beliefs and values and lack of translation facilities.^{lxiv}

BME communities can be affected disproportionately by the biggest causes of poor health (musculoskeletal conditions, heart disease, stroke, diabetes, respiratory diseases, anxiety, depression and dementia). *The Health of Minority Ethnic Groups Health Survey for England (2004)*^{lxv} found that:

- the prevalence of diabetes among South Asians can be up to five times that of the general population;
- rates of diabetes among Black Caribbean's are also higher than the general population;
- South Asians experience significantly higher rates of coronary heart disease;
- there is also evidence of higher rates of heart disease amongst Irish men and women;
- incidence of first-time stroke is twice as high among African Caribbean people as it is among Europeans;
- African and South Asian people are also at higher risk of stroke.

No Patient Left Behind' outlined some of the key issues preventing certain BME groups obtaining equal access to primary care services, including dysfunctional communication between healthcare organisations and patients and poor NHS links with local communities.^{lxvi} To take forward the recommendations within this report, the Department of Health set up a GP Access Programme that works to improve practice in five high impact areas: monitoring ethnicity, training, improving communication, having a reflective workforce and better engagement with BME patients. Positive outcomes from this work included 'Improving the patient experience', a training DVD/online resource for practices endorsed by the chairmen of the Royal College of General Practitioners and British Medical Association.^{lxvii}

Our findings confirm and extend the practice-based evidence on poorer health in Gypsy Traveller populations. There is now little doubt that health inequality between the observed Gypsy Traveller population in England and their non-Gypsy counterparts is striking, even when compared with other socially deprived or excluded groups and with other ethnic minorities.

The evidence base on travellers (variously described as gypsies, Romanies or the Roma people) have poorer health status than non-travellers, but reliable evidence on the health of

adults is sparse. A team of health services researchers from the University of Sheffield, aided by gypsy travellers and health service staff, conducted a large-scale epidemiological study using standard health measures, supplemented by in-depth interviews to explore health experiences, beliefs and attitudes. Significant health inequalities were found and the study suggested that “barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers”. However, there were also positive experiences of those GPs and health visitors who were perceived to be culturally well-informed and sympathetic, and such professionals were highly valued.

Religion and Belief

There are a wide range of religions and beliefs practiced in the UK today. We need to be aware of and sensitive to how these impact on and influence attitudes to planning, giving and receiving healthcare from pre-conception through to dying and even after death. It should never be assumed, however, that an individual belonging to a specific religion or belief system will necessarily comply with or fully observe all the practices and traditions of that religion or belief system. For this reason, each person should be treated as an individual, and those treating them should try to ascertain their views and preferences before treatment begins.^{lxviii} For example, whilst specific religions or beliefs may forbid the use of alcohol, this does not imply that people adopting that religion or belief will not need to access substance misuse services but there may be stigma and fear of accessing such services. Cultural beliefs within communities may also be a barrier for accessing services. Banton and Johnson^{lxix} suggest that “time and time again alcohol use, especially problematic use, is viewed as something that should not be disclosed to others within and outside the South Asian and African Caribbean communities”.

Sexual Orientation

Lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities which are often unrecognised in health and social care settings. Research suggests that discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risks. Many people are reluctant to disclose their sexual orientation to their healthcare worker because they fear discrimination or poor treatment.^{lxx} LGBT people have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people. Although there has been some controversy about these assumptions, researchers have pointed to the lack of social spaces for LGBT people apart from pubs and clubs. They suggest that LGBT people have been obliged to use the ‘scene’ and to fit in with a drinking culture. There is also an association between harassment in the workplace and alcohol problems for lesbian and bisexual women in comparison with heterosexual women.^{lxxi, lxxii}

Gender

There is significant variation in health outcomes. In males, life expectancy in urban areas ranged from 72.3 years in the most deprived quintile to 80.3 years in the least deprived, compared with 73.5 years and 79.9 years respectively in rural areas. The variations were much smaller in females, with life expectancy ranging from 78.1 years to 83.6 years in the most

deprived to the least deprived urban areas and from 78.4 years to 83.3 years respectively in rural areas. The figures show that inequalities were widest among men in urban areas (8.0 years)^{lxxiii}. Although women live longer than men, they also spend more years in poorer health.

Research indicates that the gender of the practitioner can impact on people's willingness to use services, e.g. improved attendance rates for cervical cancer screening in practices with female practitioners, or men indicating a preference for male practitioners, for certain procedures and health problems. It has also been argued that although gender sensitive delivery of care is relevant in some cases, the ability of health professionals to attend to the individual in a sensitive and understanding manner is equally important.^{lxxiv}

The Men's Health Forum^{lxxv} found that men are much less likely to visit their GP than women. Under the age of 45, men visit their GP only half as often as women. It is only in the elderly that the gap narrows significantly and even then women see their GP measurably more frequently than men. A survey of men conducted by the Men's Health Forum suggested that many men are unhappy with the service provided at their local GP surgery for reasons that are rectifiable; unhelpful opening hours; perceived emphasis on services for women and children; and undue bureaucracy.

Pregnancy and Maternity

A key area of health and care for women is pregnancy and maternity. Apart from a slight drop in live births in the early part of the decade, the number of births has been rising steadily. This increase in numbers has also been accompanied by an increase in the rate of births (more live births per 100,000 population) compared to 1 or 5 years previously.

There has been substantial progress in reducing infant deaths, which is a good proxy for maternal health in general. The infant mortality rate in 2009 was the lowest ever recorded in England and Wales, with fewer than 5 deaths per 1000 live births in the UK (around 3300 deaths in total) compared to 22 deaths per live birth in the 1960s⁴⁹. Whilst relatively few children die in infancy, these rates are higher than in comparable European countries and infant mortality is a key indicator of wider health inequalities. There is a 70% gap in infant mortality between managerial and professional groups and routine and manual groups, and rates for some ethnic groups are almost twice the national average.

The overall rate of teenage conceptions has decreased for both under 16s and under 18s, and the under 18s conception rate is now the lowest it has been for 20 years. Despite this, the percentage of all live births to mothers under the age of 20 in the United Kingdom remains the highest when compared to other EU-15⁵⁰ countries.^{lxxvi}

There is evidence that certain groups of young people seem to be vulnerable to becoming teenage parents^{lxxvii} including:

- Young people in or leaving care
- Homeless young people
- School excludees, truants and young people under-performing at school
- Children of teenage mothers

⁴⁹ Ref ONS

⁵⁰ Member states that were part of the European Union prior to expansion in 2004.

- Members of some ethnic minority groups for example, Caribbean, Pakistani and Bangladeshi women are more likely than white women to have been teenage mothers
- Young people involved in crime

The health and wellbeing of women before, during and after pregnancy is an important factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life. Good quality antenatal care is important for good outcomes. However, many women simply do not access or keep in touch with antenatal services, because of issues such as domestic violence, teenage pregnancy or not having English as a first language^{lxxviii}.

Socio-economic status has a significant impact on health inequalities amongst children. N J Spencer^{lxxix} suggests that children born to lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer significant episodes or morbidity. In addition, young women living in socially disadvantaged areas are less likely to opt for an abortion if they get pregnant^{lxxx}.

Transgender

Under the new Equality Act 2010⁵¹, trans people who have changed their sex, are in the process of changing their sex or have informed someone that they are planning to change their sex, are given additional protection against discrimination. In addition, trans people will no longer have to be under medical supervision to be protected from discrimination and harassment.^{lxxxi}

The term 'transgender' is used to describe people who have a strong belief that they properly belong to their non-biological gender. Often 'transgender' and 'trans' are used interchangeably. Data and research on trans health are limited but the evidence base is growing. We know that trans people are particularly vulnerable to discrimination and harassment, and also experience inequalities in access to healthcare and health outcomes.

The funding of gender identity services are currently the responsibility of Primary Care Trusts and it is proposed that specialist commissioning including gender identity services will lie with the NHS Commissioning Board. However, it is important for organisations delivering public health services to be aware of the potential discrimination that transgender people may experience. Access to appropriate services can be difficult. Trans service users are at risk of being excluded from screening programmes (cervical, breast, prostate) or do not receive information about important general health and wellbeing issues because of the preconceptions of health care staff.^{lxxxii}

Inequalities by socio-economic group

As outlined by the Marmot review, there are significant socio-economic inequalities which impact upon health outcomes. Harm from alcohol, illicit drugs, and smoking is concentrated in people from lower socio-economic groups; 30% of males and 20% of females in the most disadvantaged groups have at least two or three high risk behaviours compared with less than 10% and less than 5% respectively in the least disadvantaged groups. The most deprived fifth

⁵¹ This aspect of the Equality Act 2010 came into force in October 2010.

of the population experience 2 to 3 times greater loss of life due to alcohol (although people drinking more than the NHS guidelines are present throughout society)^{lxxxiii}. Problem drug users also tend to be concentrated in the poorest communities and evidence puts their rates of premature death at between 12 and 17 times greater than the non drug using population.^{lxxxivlxxxv lxxxvilxxxvii}

Consideration of Human rights

The policies in *Equity and Excellence: Liberating the NHS* aim to support many of the rights enshrined in the European Convention of Human Rights. This is shown through the strengthened involvement of patients in the design of services and decisions about their own care, the requirement for shared decision-making set out in putting patients and the public first, explicitly requiring 'no decision about me without me' and extending patient rights to information, choice and involvement.

In considering the potential impact on human rights, we have looked at core values of fairness, respect, equality, dignity and autonomy (also known as FREDA values). The Department of Health as a public body has a responsibility to act in a way, which is incompatible with the Convention, unless the wording of an Act of Parliament means there is no other choice. The legislation proposed within the forthcoming Health and Social Care Bill will be compatible with human rights.

Appendix B

Creation of the Public Health England (Outcomes Framework, Ring Fenced Budget, Commissioning, Increasing Health Visitor numbers)

Impact on Protected Characteristics (Neutral and Positive)

Protected characteristics	Potential impacts of the policy	Opportunity to Promote Equality
Disability (including carers of disabled people)	Positive	<p>Given the strong focus and commitment to tackling inequalities, we would expect there to be a positive impact on this characteristic.</p> <p>There is evidence to suggest that people with mental health problems or learning disabilities have a lower life expectancy and there may be difficulties in accessing public health initiatives: mental health will be a key part of the public health outcomes framework consultation.</p> <p>The opportunity to ring fenced public health spend will help to ensure that funding is not raided for other local authority services. This will ensure that money is spent on public health as the local director of public health feels appropriate. Previously, money could be taken from public health to fill a funding gap for acute services.</p>
Gender, gender reassignment	Neutral	We would hope that the strong focus and commitment to tackling inequalities would have an impact but we do not have particular evidence to support this at present.
Marriage and civil partnership	Neutral	The creation of public health England is unlikely to have a significant impact on equality issues relating to marriage and civil partnership. We do however recognise that there is evidence to suggest that there are health benefits when people are in long-term relationships.
Race, religion or belief	Positive	Given the strong focus and commitment to tackling inequalities, we would expect there to be a positive impact on this characteristic.
Sexual orientation	Neutral	We would hope that the strong focus and commitment to tackling inequalities would have an impact but we do not have particular evidence to support this at present.
Age	Positive	Given the strong focus and commitment to tackling inequalities, we would expect there to be a positive impact on this characteristic. We would expect the transfer of

		commissioning functions to local authorities to have a positive impact for older peoples and children's services given the removal of organisational barriers between social care and health.
		There is an opportunity to provide a better integrated services for older people. Research by the Nuffield trust ^{xxxxviii} showed that in a typical locality, 90% of social care users over the age of 55 had been in contact with secondary care during a three year period.
Socio-economic deprivation	Positive	Given the strong focus and commitment to tackling inequalities, in particular through the planned allocation methodology for the ring fenced budget, we would expect there to be a positive impact on this characteristic . The details are to be developed but a key criterion will be that they reflect socio-economic need and deprivation.
Cross-cutting opportunities relating to the outcomes framework	Positive	In order to further reduce any adverse impacts on particular groups, the completed public health outcomes framework and each individual indicator (once the final set has been agreed) should be equality impact assessed. In addition, the risk of adverse impact should form part of the criteria for selection. The public health outcomes framework and indicator set will provide an opportunity to expose inequalities in health and for any improvements to be monitored nationally. This could result in the identification of areas of best practice where significant achievement can be made. The evidence base to support the framework should identify evidence based interventions to reduce inequalities in health (where available). This will contribute to a reduction / removal of existing inequalities, e.g. Improving breast-screening uptake in women residing in those areas ranked as being the most deprived. The public health outcomes framework and indicator set can act as a lever for improved commissioning and local action to help reduce inequalities in health.

Impact on protected characteristics (risks and mitigation)

Protected characteristics	Potential impacts of the policy	Identify potential or actual adverse impacts and mitigation
Disability (including carers of disabled people)	There is evidence to suggest that people with mental health problems or learning disabilities have a lower life expectancy and there may be difficulties in accessing public health initiatives, for example cancer screening.	Ensuring that people with disabilities (including mental, physical and mental health) have the access they need to services will be important. Equality impact assessments will be carried out where appropriate for national and local initiatives to ensure that issues such as access are considered.
Gender, gender reassignment	Women tend to be seen as 'healthier' than men. There is a risk that the needs of women (particularly around birth and maternity services) will be overlooked.	The government has announced a commitment to increasing the number of health visitors which will better support early years interventions. Equality impact assessments will be carried out where appropriate for national and local initiatives to ensure that issues such as access are considered.
	Men are less likely to access primary care for example cognitive behavioural therapy (CBT) for depression	Local initiatives need to recognise and address behavioural differences between men and women.
	Women may be disproportionately impacted by organisational change.	Where appropriate, the transfer of staff will take place by virtue of TUPE or statutory transfer schemes with due consideration to equality legislation and employment law. In addition, it will be important to ensure that there are no infringements on human rights ^{lxxxix} with particular regard to article 8: the right to protection of private and family life. It should however be noted that all organisations named above are public authorities with responsibilities to uphold human rights conventions.
	Lack of data on trans service users, could lead to inadequate needs assessment and inequities in	The department of health equality and inclusion team will be working with the equality and human rights

	service provision.	commission (EHRC) to help strengthen the evidence base on the health needs of trans people
Race, religion or belief	Race for health and shared intelligence were commissioned by the department of health to prepare a report exploring approaches taken by joint strategic needs assessments (JSNA) to understand race equality in health and healthcare. There is further work that could be done within the JSNA process to ensure that equalities issues are linked to local evidence on social determinants ¹ .	Local authorities have a wide range of support materials available in supporting the impact assessment process. Best practice examples have been included within this EqIA. Local authorities need to involve BME communities in planning and delivery interventions.
	Councillors are not representative of the population as a whole ^{xc} . In 2006, only 29% of councillors in England were women and 4.1% had a non-white ethnic background (compared to 9.5% of the population over 21 years old).	The proposed creation of the local health and wellbeing boards will allow local people to both sit on the board, and have a say in who sits on the board (through democratic power) thereby providing greater, local democratic legitimacy.
	Ensuring that the indicator set does not provide perverse incentives to marginalise smaller community groups inadvertently where there is not a significant critical mass (e.g. Gypsy traveller community).	Equality impact assessments will be undertaken for each of the final indicators in the public health outcomes framework.
Sexual orientation	The national LGB&T partnership raised concerns that the changes proposed in the NHS white paper will give local authorities more power over health and social care services without challenging them to take into account the needs of vulnerable minority groups.	Local authorities have a responsibility to assess services and take into account the needs of diverse groups including LGB&T communities. We would therefore expect local authorities to fully reflect the needs of their populations within such assessments. In addition, there will be additional accountability to the local population through the health and well-being boards.
Age	There is a risk older people may be disproportionately impacted by organisational restructuring.	With regards to the workforce transfers, we need to consider any future redundancies in line with employment legislation to ensure a particular age

		group is not disproportionately impacted.
	There is a risk that the needs of older people will be overlooked given the radical changes from PCTs acting as commissioners to local authorities taking on this additional responsibility.	Members of the public have less direct contact with commissioning organisations rather than providers. In addition, the NHS information revolution will ensure that comprehensive and accessible data and information will be available to patients, to enable them to make more informed choices about their healthcare and healthy living.
Socio-economic deprivation	There is a risk that initiatives will benefit the better off in society, those who are more articulate and better able to understand information.	There is a clear commitment from the Department of Health to ensure that the initiatives outlined within the white paper have the greatest potential impact and improve the health of the poorest, fastest. Local authorities will be held to account on the services they provide.
	There is a risk that the ring fenced budget allocation for local authorities will not be sufficient to meet demand.	Local authorities are well placed to use all of their budgets to best meet demand from their local population.
Cross-cutting issues	Ensuring indicators reflect health improvements that can be made across all the identified equality groups.	The detail of the outcomes framework will be subject to consultation.
	By removing the flexibility for commissioners to 'raid' budgets to pay, for example for a deficit in acute care, may impact negatively on disadvantaged users who frequently use acute services.	Local authorities will take balanced spending decisions based on their understanding of the holistic needs of the local community. The director of public health will be well placed to ensure that all local authority policies and spending are focused on reducing disadvantage.
	Disadvantaged groups may equally benefit from direct spend on education, housing or other local authority services.	A fair but realistic allocation will be provided on the ring fenced budget. The government is committed to protecting NHS funding in real terms. There is medium to longer term value in funding preventative services.
	Challenging discrimination, promoting equality and	The CQC report suggests that 134 councils (91%)

	<p>respect for human within pct commissioning has been identified as weakness by the CQC. This could worsen during the transition.</p>	<p>performed excellently or well in meeting the outcome on freedom from discrimination and harassment, which would imply that local authorities are better placed than PCTs although we are not complacent and appreciate there are areas for improvement.</p>
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