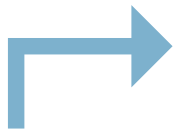


# Public Health in Local Government

Factsheets

# Local government leading for public health



Local government has a long and proud history of promoting and protecting the public's health dating back to Victorian times. It was only in 1974 that the NHS took over most public health functions. The Government is returning responsibility for improving public health to local government for several reasons, namely their:

- population focus
- ability to shape services to meet local needs
- ability to influence wider social determinants of health
- ability to tackle health inequalities.

## Population focus

Local authorities are democratically accountable stewards of their local populations' wellbeing. They understand the crucial importance of "place" in promoting wellbeing. In other words, the environment within which people live, work and play, the housing they live in, the green spaces around them, and their opportunities for work and leisure, are all crucial to their health and wellbeing.

Taking a population perspective, which is at the heart of public health, is a natural part of the role of local government.

## Shapers of place

Since local government holds many of the levers for promoting wellbeing it makes sense to give it greater responsibility and power to shape the locality in a healthy direction.

Every day of the year local councils have direct contact with many of their residents. A fully integrated public health function in local government at both strategic and delivery levels offers exciting opportunities to make every contact count for health and wellbeing. This local political leadership is critical to creating the powerful coalitions we need to promote health and wellbeing.

Local authorities are also well placed to release innovation, trying new ways to tackle intractable public health problems. They have considerable expertise in building and sustaining strong relationships with local citizens and service users through community and public involvement arrangements, which will help extend the engagement of local people in the broader health improvement agenda.

## Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live work and age, including





the health system. The strength of the evidence linking social determinants to good and poor health has been clearly demonstrated in the Marmot Review (2010) (*Fair Society, Healthy Lives*). Social determinants are one of the main mechanisms driving health inequalities.

### Tackling health inequalities

Local authorities have ample experience of the reality of health inequalities in their communities. Many of the social determinants fall within their ambit, so they can take strategic action to prevent inequalities across a number of functions, such as housing, economic and environmental regeneration, strategic planning, education, children and young people's services, fire and road safety.

The Director of Public Health, located within the local authority, will be well placed to bring health inequalities considerations to bear across the whole of the authority's business, and to think strategically about how to drive reductions in health inequalities, working closely with the NHS and other partners.

However, they will also need to look more widely at issues such as crime reduction, violence prevention and reducing reoffending, which may also prevent health inequalities. They can do this through links to existing partnership working and through new relationships, for example with incoming Police and Crime Commissioners.

### Looking forward

In one sense the Health and Social Care Bill can be seen to be returning public health home. But at the same time we recognise that local government has changed hugely since 1974, as have the issues for people's health. In particular, there have been major gains from the close integration of public health with clinical services, not least a greater focus on prevention in pathways, on prioritisation and on reaching the whole population.

There is a sound foundation to build on in terms of that close engagement within the NHS, which will remain critical to the delivery of public health goals, in particular in reducing risks, and in primary and secondary prevention.

Local government for its part has moved from a focus on delivering services to a much wider role of shaping local places. Having taken on the key role in promoting economic, social and environmental wellbeing at the local level, it is ideally placed to adopt a wider wellbeing role.

Therefore local leadership for public health is nothing new, but the context has changed. Bringing public health back into local government is not about recreating a pre-1974 landscape. It is about building a new, enhanced locally-led 21st century public health service, where innovation is fostered and promoted, supported by the expertise to be provided by Public Health England. Clear local political leadership will be critical to success.





### Our vision for local government leadership of public health

Building on local government's long and proud history of public health leadership, our vision is for local authorities to use their new responsibilities and resources to put health and wellbeing at the heart of everything they do, thereby helping people to lead healthier lives, both mentally and physically.

This means:

- including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- investing the new ring-fenced grant in high-quality public health services;
- encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will bring a focus on what a healthy population can do for the local community, not least in terms of regeneration

- tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient for users
- making effective and sustainable use of all resources, using evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent the best possible value for money for local citizens.

To do this successfully will require a willingness to use all the tools at local authorities' disposal in a new way and not just rely on commissioning traditional services. Public Health England will have a key role in sharing and signposting evidence on the most effective, including cost-effective interventions to improve and protect public health.

For local authorities this will mean working with a wide range of partners across civil society, not least the third sector, including through the shared leadership of health and wellbeing boards. They will be supported in this by HealthWatch, which will better enable people to help shape and improve health and social care services at both a national and, through its seat on the local health and wellbeing board, the local level.

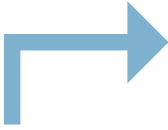
Local authorities already do this up and down the country. From 2013, with new powers and new resources they will be ideally placed to go further in creating healthier communities.



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## Local government's new public health functions



Subject to Parliament, each upper tier and unitary local authority in England will take on a new duty to take such steps as it considers appropriate for improving the health of the people in its area.

An obvious way in which local authorities will fulfil this duty will be commissioning a range of services from a range of providers from different sectors, working with clinical commissioning groups and representatives of the NHS Commissioning Board to create as integrated a set of services as possible.

However, local authorities can fulfil this duty in a wide range of ways, including the way they operate the planning system, policies on leisure, key partnerships with other agencies for example on children's and young people's services, and through developing a diverse provider market for public health improvement activities.

In all they do, local authorities will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues. The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

Local political leadership will be critical in ensuring that public health receives the focus it needs. The role of the Cabinet lead for health within the council is critical,

but there needs to be a much broader engagement in this agenda among all local political leaders.

It will be vital that district councils are closely involved in the development and implementation of local strategies, and that existing health and wellbeing partnerships in two-tier areas are built on in the creation of the new system.

### Commissioning

*In Healthy Lives, Healthy People: Update and way forward* we published a provisional list of what should be funded from the public health budget, and who the principal commissioner for each activity should be.

We have sought wherever possible to devolve responsibility and resources for commissioning public health services to local government, although in a number of cases, where a public health service is deeply intertwined with the delivery of clinical services, or where services are part of the primary care contractual arrangements, the Secretary of State for Health will ask the NHS Commissioning Board to commission services on his or her behalf (for example national screening and immunisation programmes).

Our aim is to create a set of responsibilities





which clearly demonstrate local authorities' leadership role in:

- tackling the causes of ill-health, and reducing health inequalities
- promoting and protecting health
- promoting social justice and safer communities.

The list of new local authority responsibilities is set out in the Public Health in Local Government: Commissioning responsibilities factsheet.

For all commissioning decisions, local authorities will want to ensure services are delivered in ways that meet the needs of disadvantaged and vulnerable groups and which consciously respond to the three aims of the equality duty.

Local authorities will also wish to work with clinical commissioning groups to provide as much integration across clinical pathways as possible, maximising the scope for upstream interventions. The health and wellbeing board will be critical to driving this agenda.

We also expect local authorities will wish to commission, rather than directly provide, the majority of services, given the opportunities this would bring to engage local communities and the third sector more widely in the provision of public health, and to deliver best value and best outcomes.

The recent Open Public Services White Paper outlines how modernising public services, ensuring high quality and accessibility, requires increased choice, wherever possible, and public services that are open to a range of providers. It highlights the role that staff-led enterprises have to play in meeting the Government's

commitment to improving choice and quality in the delivery of healthcare services. This right to provide<sup>1</sup> enables staff to consider a wide range of options, including social enterprise, staff-led mutuals, joint ventures and partnerships. Their freedom to innovate and respond to service user need will put them in a strong position to drive up quality and improve health outcomes.

We expect promoting choice of provider to drive up quality, empower individuals and enable innovation. It will also provide a vehicle to improve access, address gaps and inequalities and improve quality of services where users have identified variable quality in the past.

Local authorities already have a wealth of experience in commissioning services from a range of providers so we would encourage them to adopt this diverse provider model which will increase the number of service providers, maximising user choice, provided they meet the necessary quality and safety requirements within a price set by commissioners.

This will allow providers to compete for services within the market – a process which is both quicker and less bureaucratic than traditional procurement by competitive tender, which only enables competition for entry into the market. Local authorities should decide which services to prioritise for choice on a diverse provider model based on local needs and priorities. This should be informed by the joint strategic needs assessment and early and continuing engagement with health and wellbeing boards. More information on this can be found at: <http://healthandcare.dh.gov.uk/jsnas-jhws-explained>





Local authorities are also in an excellent position to test out new and joint approaches to payment by outcomes, such as reducing drug dependency and to extend such approaches with external investment, such as the proposals being developed on social impact bonds to improve services and outcomes.

We envisage that Public Health England will disseminate the learning from such developments with a view to encouraging further innovation at the local level.

### Mandatory steps

The Health and Social Care Bill includes a power for the Secretary of State for Health to prescribe that local authorities take certain steps in the exercise of public health functions, including that certain services should be commissioned or provided.

The purpose of this power is not to identify some services as more important than others. Rather the issue is that in some service areas (particularly health protection) greater uniformity of provision is required. In others the Secretary of State for Health is currently under a legal duty and needs to ensure that that obligation is effectively delivered when a function is delegated

to local government (the provision of contraception is an example).

Finally, certain other steps are critical to the effective running of the new public health system at a local level, for example, ensuring that the local authority provides public health advice to NHS commissioners.

The mandatory services and steps that were identified in *Healthy Lives, Healthy People: update and way forward* included:

- appropriate access to sexual health services
- steps to be taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- the National Child Measurement Programme
- NHS Health Check assessment.

We previously signalled that we would be mandating elements of the Healthy Child Programme 5-19. More work is still required to model the impact of making any elements of the programme mandatory to ensure value for money. We do not intend to mandate any elements of the programme for 2013.

The net result of these steps will be that local authorities have key responsibilities across the three domains of public health – health improvement, health protection and healthcare public health.



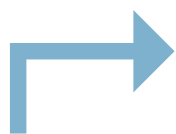
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<sup>1</sup> Public health practitioners can find more information on how to exercise the right to provide at: <http://healthandcare.dh.gov.uk/right-to-provide-what-it-means-for-nhs-and-social-care-staff>

# The role of the Director of Public Health



In taking forward their leadership role for public health local authorities will rely heavily on the Director of Public Health and the specialist public health resources he or she has at their command. Indeed the Health and Social Care Bill makes clear that the Director of Public Health is responsible for exercising the local authority's new public health functions.

We have highlighted the duty on each unitary and upper tier authority to take such steps as it considers appropriate for improving the health of the people in its area.

The Health and Social Care Bill makes clear that each authority must, acting jointly with the Secretary of State for Health, appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health. That individual could be shared with another local authority, where that makes sense (for example, where the senior management team is shared across more than one authority and the authorities are geographically contiguous). Below we cover key aspects of the function and scope of the role of Director of Public Health.

## Appointments

We are working with local government and public health stakeholders to produce guidance, which will cover:

- appointments to existing Director of Public Health vacancies in a way that ensures they are fit for purpose for the future
- managing the transition of Director of Public Health posts to local government during 2012/13
- a process for local authorities and Public Health England (in the Secretary of State's behalf), acting jointly, to appoint new Directors of Public Health from 1 April 2013.

The guidance will build on the existing joint appointments process for Directors of Public Health and be consistent with Faculty of Public Health standards, including the use of appointments advisory committees and faculty assessors, and best practice in local government recruitment.

This will ensure Directors of Public Health in local government have the necessary technical, professional and strategic leadership skills to promote, improve and protect health and provide high-level, credible, peer-to-peer advice to the NHS about public health in relation to health services.







## Reporting arrangements

We promised in *Healthy Lives, Healthy People: update and way forward* to discuss with stakeholders how best to ensure that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services.

We have consulted local government and public health interests, and intend to bring forward amendments to the Health and Social Care Bill to reflect our desired policy position. Subject to Parliament, we will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989.

After Royal Assent, we intend to issue statutory guidance on the responsibilities of the Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services.

While the organisation and structures of individual local authorities is a matter for local leadership, we are clear that these legal responsibilities should translate into the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business.

This means that we would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public

health responsibilities and that they will have direct access to elected members.

## Responsibilities

The Director of Public Health as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. Directors of Public Health will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services.

What these legal responsibilities should translate into is the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business. Thus the Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. Often the Director of Public Health will not be personally responsible for the problem, but he/she will know how to resolve it through engaging with the right people in the new system. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director





of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality.

With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

### **Core skills**

To deliver its new public health functions the local authority will need a specialist trained Director of Public Health and public health support with the full range of appropriate skills to deliver the functions we have described. That means we will need to ensure that job descriptions reflect the highest possible standards as set out by the Faculty of Public Health.

It is important to reaffirm that the Government believes the multidisciplinary nature of public health is a key strength of the profession. We believe that the transfer of new public health responsibilities to local authorities

in no way changes this, and indeed reaffirms the importance of attracting to public health high-quality individuals from a wide range of disciplines including, but not limited to, medicine.

We will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a professional public health workforce, set out proposals for how learning and development will be taken forward in the reformed health system, and outline options for how public health knowledge can best be embedded across the wider workforce.

The new arrangements will provide opportunities and challenges for employers, including the wider local authority workforce.

### **Professional appraisal and support, and capacity building**

Continuing professional development is a professional obligation for all public health professionals, both medical and non-medical. It ensures that public health professionals develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving the health of communities. Local authorities will wish to support this professional development.

### **Way forward**

The Director of Public Health's new role offers a great opportunity to build healthier communities. But to make the





most of these Directors of Public Health will need to:

- be fully engaged in the redesign of services that address the coming challenges
- influence and support colleagues who have a key role in creating better health, such as planning officers and housing officers
- facilitate innovation and new approaches to promoting and protecting health, while bringing a rigorous approach to evaluating what works, using the resources of Public Health England
- contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

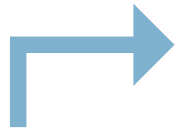


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## Commissioning responsibilities



Local authorities will be responsible for:

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

- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

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

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

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





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

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

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

As we explained in *Healthy Lives, Healthy People: Update and way forward*, we believe that the NHS Commissioning Board will be best placed to lead the commissioning of public health funded services for children under five in the first instance, including health visiting, the Healthy Child Programme and Family

Nurse Partnership, given the commitment to a 50% increase in the health visiting workforce and a transformation in the health visiting service by 2015, and to ensure associated improvements in support for families.

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

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

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





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

### Sexual health services

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

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

Second, the Secretary of State for Health currently has a duty, reiterated in the Health and Social Care Bill, to provide advice on contraception, medical examination of people seeking advice on contraception, the treatment of

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

### Health protection plans

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

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





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

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

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

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

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

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

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

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

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

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

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





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

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

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

Directors of Public Health will play a role in

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

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. But it will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency.

Thus clinical commissioning groups will have a duty of cooperation with local authorities; NHS-funded providers can be required through contracts to share plans and appropriate information; Directors of Public Health can use their annual report and membership of the health and wellbeing board to raise concerns more formally; and the Secretary of State for Health can use the Mandate and his agreement with the Board to ensure that the NHS Commissioning Board takes appropriate account of the advice of Directors of Public Health.

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

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







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

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

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

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

#### Population healthcare advice to the NHS

We will also mandate local authorities to provide population healthcare advice to the NHS. Good population health outcomes, including reducing health

inequalities, rely not just on health protection and health improvement, but on the quality of healthcare services provided by the NHS. That is why we are preserving a key role for local authority public health teams in providing public health expertise for the NHS commissioners of these services.

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

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

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





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

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

Given close working and responsiveness between public health teams and clinical commissioners we would expect clinical commissioners to make full use of the

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

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

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

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



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# Public health advice to NHS commissioners



## Strategic planning: assessing needs

| Public health advice to NHS commissioners   | Examples  |
|---|---|
| Supporting clinical commissioning groups to make inputs to the joint strategic needs assessment and to use it in their commissioning plans  | Joint strategic needs assessment and joint health and wellbeing strategy with clear links to clinical commissioning group commissioning plans |
| Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with the clinical commissioning groups and local authorities  | Neighbourhood/locality/practice health profiles, with commissioning recommendations   |
| Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality                    | Clinical commissioners supported to use health related datasets to inform commissioning   |
| Health needs assessments for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures | Health needs assessments for condition/disease group with intervention/commissioning recommendations  |



**Strategic planning: reviewing service provision**

| <b>Public health advice to NHS commissioners</b>  | <b>Examples</b>  |
|---|--|
| Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the equality duty | Vulnerable and target populations clearly identified; public health recommendations on commissioning to meet health needs and address inequalities |
| Support to clinical commissioning groups on interpreting and understanding data on clinical variation in both primary and secondary care. Includes public health support to discussions with primary and secondary care clinicians if requested   | Public health recommendations on reducing inappropriate variation  |
| Public health support and advice to clinical commissioning groups on appropriate service review methodology   | Public health advice as appropriate  |





**Strategic planning: deciding priorities**

| Public health advice to NHS commissioners   | Examples   |
|---|--|
| Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence base for the setting of priorities  | Review of programme budget data<br><br>Review of local spend/ outcome profile                        |
| Advising clinical commissioning groups on prioritisation processes – governance and best practice   | Agreed clinical commissioning group prioritisation process   |
| Work with clinical commissioners to identify areas for disinvestment and enable the relative value of competing demands to be assessed  | Clear outputs from clinical commissioning group prioritisation                                       |
| Critically appraising the evidence to support development of clinical prioritisation policies for populations and individuals   | Clinical prioritisation policies based on appraised evidence   |
| Horizon scanning: identifying likely impact of new National Institute for Health and Clinical Excellence guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation | Public health advice to clinical commissioners on likely impacts of new technologies and innovations |





Procuring services: designing shape and structure of supply

| Public health advice to NHS commissioners  | Examples  |
|--|---|
| Providing public health specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning) | Public health advice on focusing commissioning on effective/cost-effective services                 |
| Providing public health specialist advice on appropriate service review methodology  |   |
| Providing public health specialist advice to the medicines management function of the clinical commissioning group   | Public health advice to medicines management, for example ensuring appropriate prescribing policies |

Procuring services: planning capacity and managing demand

| Public health advice to NHS commissioners   | Examples   |
|---|--|
| Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes                            | Public health advice on development of care pathways/specifications/quality indicators |
| Public health advice on modelling the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs | Public health advice on relevant aspects of modelling/capacity planning                |





**Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views**

| Public health advice to NHS commissioners   | Examples  |
|---|---|
| Public health advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance                            | Clear monitoring and evaluation framework for new intervention/service public health recommendations to improve quality, outcomes and best use of resources |
| Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes |   |
| Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out health equity audits and to advise on health impact assessments              | Health equity audits<br><br>Public health advice on health impact assessments and meeting the public sector equality duty                                   |
| Interpreting service data outputs, including clinical outputs   | Public health advice on use of service data outputs   |





### The National Child Measurement Programme

The National Child Measurement Programme (NCMP) annually weighs and measures children in reception year and year six in maintained schools in England. The NCMP provides high-quality, locally reliable data on child overweight and obesity levels and trends. This surveillance data is key to improving our understanding of overweight and obesity in children and is used both locally and nationally to inform the planning and development of policy and programmes. It also provides an opportunity to raise public awareness of child obesity and to assist families to make healthy lifestyle changes through provision of a child's result to their parents.

The quality and reliability of the data gathered through the NCMP is dependent on sustaining a high participation rate within every area, and on the data being collected in a consistent way. This ensures: a complete picture of the national prevalence of child obesity; consistency of data between areas; local data that is as robust as possible; and year-on-year, allows reliable statistical comparisons to be made.

To ensure that the quality of the data is maintained, in addition to giving local authorities funding and power to deliver the

NCMP as part of their local public health responsibilities, the Government will mandate the collection and return of NCMP data so that the programme can continue to successfully fulfil its public health surveillance function.

### NHS Health Check Assessment

The NHS Health Check programme is for people in England aged 40 to 74 and aims to prevent heart disease, stroke, diabetes and kidney disease, which account for a significant burden of ill health and premature mortality. It is a risk assessment and risk management programme, and both elements are important. Those receiving a NHS Health Check risk assessment need to be supported to manage their risk through appropriate follow-up. The Government intends to mandate local authorities to offer everyone eligible between the ages of 40-74 a Health Check assessment every five years. While the provision of lifestyle advice and interventions will not be mandated, there is an expectation that local authorities will commission appropriate services and ensure that the NHS Health Check assessments are adequately followed up.

Local authorities will need to work closely with clinical commissioning colleagues to ensure that people identified as high risk through their assessment, or requiring additional testing or medical interventions are provided with the services they need. This is an area which the health and wellbeing board may wish to focus on to ensure that there is a well-integrated system, where checks are properly followed up by appropriate treatment.

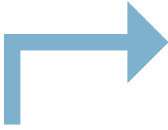
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## Professional appraisal and support, and capacity building



Continuing professional development is a professional obligation for all public health professionals, both medical and non-medical, but there are currently different legal requirements for professional appraisal of public health specialists who are doctors and those from a non-medical background.

Since November 2009, a doctor must have held a licence to practise medicine. It is planned that this licence should be renewed every five years in a process known as revalidation.

The Medical Profession (Responsible Officers) Regulations 2010 give senior doctors in designated bodies functions for specified doctors that will ensure doctors are regularly appraised and where there are concerns about a doctor's fitness to practise, they are investigated and, where appropriate, referred to the General Medical Council.

The regulations also give the Secretary of State for Health the powers to nominate a responsible officer for a designated body where the body has failed to nominate or appoint a responsible officer in accordance with regulations or where the body appoints a person that does not meet the conditions set out in regulations.

We recognise that for specialists working in Public Health England and in local authorities, revalidation will be an important focus for maintaining and improving their practice. Responsible officers will play a crucial role in the process of medical revalidation.

Non-medical specialists are not currently subject to the same legal requirements in relation to revalidation. However, the Department of Health will also expect non-medical public health specialists to undergo a professional appraisal.

We are considering a number of options including guidance to encourage this process to take place.

The Faculty of Public Health is the standard-setting body for specialists in public health and has an important role in continuing professional development. The Faculty also provides guidance on both appraisal and revalidation.

The Faculty has also published Good Public Health Practice that sets out the general professional expectations of public health professionals.

We know that specialists in public health will be committed to following this guidance. Public health leaders in Public Health England will support this,





for example, by offering to conduct professional appraisal for directors of public health and for public health specialists in local authorities.

The professional appraisal will link with the managerial appraisal undertaken by local authority chief executives.

Public Health England will support public health professionals to follow frameworks of good practice and will work with local government to improve and innovate in public health practice.



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