The White Paper for Public Health: Healthy Lives, Healthy People

This report provides a detailed briefing of:

- the government's White Paper on Public Health: *Healthy Lives, Healthy People;*
- the supplementary consultation paper on the funding and commissioning routes for public health; and
- the supplementary consultation paper on proposals for a public health outcomes framework.

Section A summarises the proposals. Section B outlines the key issues created by the proposals.

SECTION A: SUMMARISING THE PROPOSED REFORMS AND CHANGES

1. The health challenge

Healthy Lives, Healthy People begins by setting out the key challenges facing the public health community. Health inequalities are explicitly referenced, The White Paper presents a set of challenges and solutions for improving health and wellbeing throughout life. There are separate sections dedicated to different parts of the lifecycle, specific sections related to education and schooling; work and employment; housing; and the physical environment.

2. A new approach for public health

Healthy Lives, Healthy People makes the case for a new approach to public health. It aims to establish public health as a government priority and to get a better balance between actions taken nationally and locally, as well as actions taken by individuals, families, communities and business.

Highlighting the importance of the social determinants of health, the government aims to improve population health through actions taken across the NHS and social care services – but also through education, housing, transport and other sectors that impact on health.

It sets out explicitly to minimise government intervention and regulation and proposes to use an 'intervention ladder' to help determine when and how government intervenes. In line with this thinking, a 'Responsibility Deal' has been established with the business sector to drive improvements in healthy living around five areas: food; alcohol; physical activity; health at work; and behaviour change.

A new professionally-led and defined national public health service [Public Health England] will be established. However, the government intends to place localism at the heart of a new system, with devolved responsibilities, freedoms and funding and a heightened emphasis placed on local action by individuals, families, communities and local government. The new system will b e based on principles of empowering

people, using transparency to drive accountability, and ensuring that communities lead efforts to improve health wherever possible.

A key element of this effort is the transfer of local public health functions from the NHS to local authorities (LAs)
It is explicitly noted however that the creation of Public Health England and the new public health role of local government should not lead the NHS stepping back from its public health responsibilities. Close partnership working between Public Health England and the NHS at a national level, and between local government, Directors of Public Health (DsPH) and GP consortia at the local level, is expected.

Resources for public health will be ring-fenced and new incentives will be established to improve population health, most notably through a health premium that will reward the reduction of health inequalities in local communities and progress in public health outcomes. The ringfencing of public health budgets acknowledges the fact that prevention has not enjoyed parity with NHS treatment and that public health funds have too often been raided by acute and clinical services.

3. Public Health England – a new national public health service

Public Health England will be established as part of the Department of Health (DH) and will incorporate the existing Health Protection Agency and the National Treatment Agency.

A new Cabinet sub-committee on public health is also proposed to bring together all areas of government which can influence public health

The full scope and remit of Public Health England is still being detailed, but includes the following: health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion including those led by health visiting and school nursing, and some elements of the GP contract such as those relating to immunisation, contraception, and dental public health.

A major remit of Public Health England will be ‘health protection’, including the control and management of infectious diseases as well as preparedness for public emergencies. Public Health England will therefore have a local presence in the form of Health Protection Units (HPUs).

Public Health England will also be expected to work closely with the NHS Commissioning Board (NHSCB) to ensure that public health and evidence-based policies are reflected in mainstream NHS commissioning.

4. Local public health

At the local level, a new and enhanced role will be established for local authorities (LAs) to lead on health improvement and health inequalities.

Public Health England will allocate ring-fenced public health budgets, weighted for inequalities, to LAs. The independent Advisory Committee on Resource Allocation (ACRA) has been asked to support the development of an approach for allocating budgets to LAs. A new 'health premium' will also be used to incentivize the performance of LAs.

The public health grant to local authorities will be made under section 31 of the Local Government Act 2003. As a ring-fenced grant, it will carry some conditions about how the budget is to be used.

Local authorities already carry out a range of health protection functions and have many wider responsibilities that bear on public health such as leisure, housing, education and social care. For the purposes of funding, these existing functions will not be covered by the public health ringfenced budget, as they are already funded through the existing funding settlement (for example, local authorities health protection activity is funded as part of existing local authority funding).

A new role for local government will be to encourage coherent commissioning strategies and promote the development of joined up commissioning plans across the NHS, social care, public health and other local partners. A central structural innovation of the government's proposed reforms is the establishment of local Health and Wellbeing Boards (HWBs) to enable this vision of integrated and joined-up commissioning and provision.

Existing details about the proposed establishment of HWBs are summarised in Appendix 3. At present, proposed minimum membership of HWBs includes elected representatives, GP consortia, DsPH, Directors of Adult Social Services, Directors of Children's Services and local HealthWatch. However, local areas will be able to expand membership to include local voluntary groups, clinicians and providers, where appropriate. It is envisaged that HWBs will develop joint health and wellbeing strategies and consider the pooling of budgets to enable joined-up commissioning.

To enable this, the government intends to place greater weight on the production and use of the Joint Strategic Needs Assessment (JSNA). GP consortia and LAs will each have an equal and explicit obligation to prepare the JSNA through arrangements made by the HWB. While at present, JSNA obligations extend only to its production, the forthcoming Health and Social Care Bill will place a duty on commissioners to use and apply the findings and recommendations of the JSNA.

In addition to GP Consortia sitting on HWBs and working closely with LAs, they will also be given a more explicit population health remit that will be linked to the national incentive scheme for GPs (the Quality and Outcomes Framework). Furthermore, local public health expertise is expected to inform the local commissioning of NHS-funded services which will require DsPH to advise and work with GP consortia. With the anticipated squeeze in budgets and the proposed changes to the remit of NICE, GP Consortia are likely to want the local PH team to be involved in decisions about prioritising / rationing clinical procedures.

The DH will strengthen the public health role of GPs in the following ways:

- Ensure the public availability of information on the performance and achievement of practices. It is argued that by increasing transparency and information, local communities will be enabled to challenge GPs to enhance their performance.
- New incentives for GP-led activity will be designed with public health concerns in mind. The DH proposes that a sum at least equivalent to 15% of the current value of the Quality and Outcomes Framework (QOF) should be devoted to public health and primary prevention indicators from 2013 (funding for this element of QOF will come from the Public Health England budget).
- Strengthen the focus on public health issues in the education and training of GPs

The White Paper places a heavy emphasis on local transparency and public accountability. Local people are to have access to information about commissioning decisions and how public health money is being spent. Providing people with transparent information on the cost, evidence-base and impact of services will help ensure that the new system is effective and cost-efficient.

In terms of the delivery of services and interventions, local authorities will be encouraged to contract services from a wide range of providers across the public, private and voluntary sectors. As part of building capable and confident communities, local areas may consider grant funding for local communities to take ownership of some highly focused preventive activities, such as volunteering peer support, befriending and social networks.

Healthy Lives, Healthy People allows the development of supra-borough partnerships and arrangements. It does not, for example, preclude the establishment of a single public health structure across the three boroughs of Inner North West London. Similarly, the current proposals do not preclude the possibility of a tri-borough HWB.

Within London, the Mayor also has a statutory responsibility for tackling health inequalities and there is a good rationale for establishment of a pan-London public health resource. The Secretary of State has asked the Mayor and boroughs to agree to an appropriate division of resources and functions to improve health. One proposal currently on the table is for a 3% top slice of the LA public health budget to be allocated to a London-wide public function with a further 3% to be allocated at the discretion of London Boroughs.

Directors of Public Health are expected to 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. In addition, they are expected to work closely with Directors of Children's Services and Directors of Adult Services.

The critical tasks of DsPH will include:

- promoting health and wellbeing within local government;
- providing and using evidence relating to health and wellbeing;
- advising and supporting GP consortia on the population aspects of NHS services;
- developing an approach to improving health and wellbeing locally, including promoting equality and tackling health inequalities;

- working closely with Public Health England health protection units (HPUs) to provide health protection as directed by the Secretary of State for Health; and
- collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

DsPH will be employed by local government and jointly appointed by the relevant local authority and Public Health England. They will be professionally accountable to the Chief Medical Officer (CMO) and be part of the Public Health England professional network. They will discharge their functions in a number of ways, ranging from direct responsibility for achieving public health outcomes to advising colleagues and partners on public health. The White Paper also notes that they will need to be supported by a team with specific public health and commissioning expertise.

5. Funding and Commissioning details

Public Health England will have three principal routes for funding services:

1. through the public health ring-fenced budget to local government;
2. by asking the NHSCB to commission services (e.g. from GPs; and
3. commissioning or providing services directly.

The default position is that, wherever possible, public health activity should be commissioned by local authorities according to locally identified needs and priorities. If a service needs to be commissioned at scale, or is best done at national level, then it should be commissioned or delivered by Public Health England at a national level; and if the activity in question is best commissioned as part of a pathway of health care, or if the activity currently forms part of existing contractual NHS primary care commissioning arrangements, then Public Health England should commission that public health activity via the NHS Commissioning Board (NHSCB). If appropriate, there may also be an option for GP consortia to commission on behalf of Public Health England

As previously mentioned, existing functions in local government that contribute to public health will continue to be funded through the local government grant. The supplementary consultation paper on the funding and commissioning arrangements for public health do however describe the proposed commissioning arrangements for the various elements of a public health programme, as shown in Appendix 1.

6. Transition Plans to 2013

The White Paper sets out a transition period running to 2013. Accountability for delivery in 2011/12 remains with the SHA and PCTs. Public Health England will be established from 2012 and the new enhanced role for LAs will be established in 2013 with ‘shadow running’ to start in 2011.

There will be ‘shadow’ allocations to local authorities for each local area for this budget in 2012/13, providing an opportunity for planning before allocations are introduced in 2013/14.

During the transitional year, 2011/12, the forthcoming NHS Operating Framework for 2011/12 will set out the operational arrangements

Milestones for 2011/12

2011/12 will be a period of detailed policy and operational design, while transition to shadow bodies and planning for implementation take shape on the ground. Locally the Council will be aiming to be an early implementer for the Health &Well-being Board and engaging the GP PBC Steering Group and other partners to develop a model.

There will be an overarching human resources framework. One strand will cover all staff in the NHS, including public health staff currently working in the NHS and those that will move to local authorities. Another strand will cover staff in the Department of Health. The third strand will cover staff in arm's-length bodies.

Milestones for 2012/13

Public Health England will come into being in April 2012 as an identifiable part of the Department of Health.

Shadow ring-fenced allocations for local authorities will be published.

SECTION B: KEY ISSUES

The information provided above is drawn from White Papers and consultation documents. There is therefore still some lack of clarity and uncertainty and the possibility of future changes and modifications to the proposals. The White Paper and its accompanying consultation documents have a number of structured questions designed to elicit feedback from all relevant stakeholders. In addition, it is worth considering the White Paper in the light of current and local developments to the public health workforce.

7. Update on local public health

The Public Health Directorates within the PCT has not escaped the downsizing that has been driven by the need to reduce management costs and make cost savings across the health care economy as a whole.

In order to sustain a credible PH capacity and in line with other PCT developments, a merger of the three PH Directorates of inner NW London is underway. The merger involves a reduction in the number of PH posts by about 66%. On top of this, new and additional responsibilities are being placed onto PH Directorates (for example, a number of functions previously managed by the Medical Directorate).

The current proposed organogram for the future PH Directorate has public health functions organised into four teams:

Health Improvement

- Patient and community engagement to influence health seeking behaviour
- Information, education and communication strategies to improve knowledge and influence behaviour
- Support for and commissioning of Health Champions, Health Trainers and Expert Patient Programmes
- Support for and commissioning of third sector organisations to help deliver on PH goals
- Providing a conduit for community intelligence to feed into the planning and commissioning roles of the NHS and LA
- Support to Local Health Watch

Health Protection, Emergency Planning, Clinical Governance and Preventive Medicine

- Clinical governance
- Screening, Immunisations
- Health Checks
- Sexual Health
- Emergency Planning
- Safeguarding
- Infection Control

Health Intelligence and Knowledge Management

- Collate, manage, analyse and use of all data related to NHS and population health
- Management and development of a data warehouse to enable data linkages across the health and social care system
- Disseminate information and analysis about local health needs
- Lead on production of JSNA

Medicines Management

- Control drugs
- Pharmaceutical analysis and needs assessments
- Community Pharmacy contracting and support
- Prescribing support

A lot of time and effort is being spent to determine the precise roles, functions and responsibilities of the proposed new structure in order to ensure that as much of the broad range of public health challenges highlighted in the White Paper can be delivered on.

8. Consultation Questions to Healthy Lives, Healthy People

<u>Role of GPs in public health</u>

Are there additional ways in which we can ensure that GPs will continue to play a key role in areas for which Public Health England will take responsibility?

Public Health evidence

What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

What can wider partners nationally and locally contribute to improving the use of evidence in public health?

Regulation of public health professionals

We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

Cross-cutting issues

What do you think the top 5 issues are in implementing the White Paper vision and related strategy and proposals?

9. Consultation questions on funding and commissioning routes for public health

Funding and Commissioning Flows

Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

Defining Commissioning Responsibilities

Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

Do you consider the proposed primary routes for commissioning of public health funded activity (the third column in Appendix 1) to be the best way to: a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?

Which services should be mandatory for local authorities to provide or commission?

Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

Allocations

Which approaches to developing an allocation formula should we ask ACRA to consider?

Which approach should we take to pace-of-change?

Health Premium

Who should be represented in the group developing the formula for the proposed health premium?

Which factors do we need to consider when considering how to apply elements of the of the Public Health Outcomes Framework to the health premium?

How should we design the health premium to ensure that it incentivises reductions in inequalities?

Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
What are the key issues the group developing the formula will need to consider?

10. **Additional Local Issues / Questions**

Transition arrangements

Are the current transition arrangements for PH adequate, appropriate and safe?

Clearly the PH staffing structures for 2011/12 will have a HR consequence for local government when the roles and functions of PH eventually transfer across from the PCTs to LAs. The HR framework to accompany this transfer of functions is however unclear at present, and there are differing opinions as well about whether there should be an automatic transfer of existing NHS staff to LAs. Is there a local view on this issue?

Tri-borough arrangements

Are the proposed governance and accountability arrangements for a tri-borough DPH and PH structure appropriate to the vision outlined in the White Paper?

Funding and commissioning

It is unclear what percentage of the ring fenced budget will be left for LAs to carry out their new and expanded roles and responsibilities. There is a view that too much of the budget is being ear marked to flow through the NHSCB rather than through local structures. In addition, it has been noted that a number of nationally funded data collecting surveys will be abandoned, placing into jeopardy the availability of quality population health information. Is there a local view on this?

Local partnerships

Making the vision of the White Paper work in practice will depend to a large degree on: a) the effective functioning of Health and Wellbeing Boards; b) effective collaboration between GP consortia and public health; and c) the development of an effective and informed Local Health Watch. While appropriate organisational structures and policies are critical to deliver the vision, a culture of collaboration, cooperation and partnership work will be even more important. Is adequate attention paid to these softer aspects of the transition over the coming two years?

Appendix 1: Proposed commissioning arrangements for the various elements of a public health programme

	Activities to be funded from the new public health budget	Proposed commissioning route/s (including direct provision in some cases)	Examples of associated activities to be funded by the NHS budget
Infectious disease	Current functions of the Health Protection Agency and public health oversight of prevention and control including coordination of outbreak management,	Public Health England At a local level, local authorities will need to work closely with Public Health England Health Protection Units (HPUs).	Treatment of infectious disease Co-operation with Public Health England on outbreak control and related activity
Sexual Health	Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, and outreach and prevention.	Local authority to commission comprehensive open-access sexual health services. In the case of contraception, Public Health England will fund the commissioning by the NHS Commissioning Board of contraceptive provision through primary care commissioning arrangements, and local authorities will fund and commission contraceptive services (including through community pharmacies) for patients who do not wish to go to their GP or who have more complex needs. Local authorities will also be responsible for commissioning fully integrated termination of pregnancy services.	HIV treatment and promotion of opportunistic testing and treatment
Immunisation	Universal immunisation	Vaccine programmes for children, and flu	Vaccines given for clinical

against infectious disease	programmes and targeted neonatal immunisations	and pneumococcal vaccines for older people, via NHS Commissioning Board (via GP contract) The NHS will continue to commission targeted neonatal Hepatitis B and BCG vaccination provision, funded by Public Health England. Local authority to commission school programmes such as HPV and teenage booster	need following referral or opportunistically by GPs
Standardisation and control of biological medicines	Current functions of the HPA in this area	Public Health England	
Radiation, chemical and environmental hazards, including the public health impact of climate change	Current functions of the HPA, and public health oversight of prevention and control, including outbreak management co-ordination of	Public Health England supported by local authorities	
Screening	Public Health England will design, and provide the quality assurance and monitoring for all screening programmes	The design and quality assurance of screening programmes will be a direct responsibility of Public Health England, as will funding and managing the piloting and rolling out of new programmes and extending current ones. The NHS Commissioning Board will commission	

		established programmes on behalf of Public Health England, as specified and with funding transferred for that purpose.	
Accidental injury prevention	Local initiatives such as falls prevention services	Local authority	
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Local authorities will take on responsibility for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities. This could include local activities to raise public awareness, provide information, train key professionals and deliver family and parenting interventions.	Treatment for mental ill health Treatment of mental ill health, including Improving Access to Psychological Therapies (IAPT), will not be a responsibility of Public Health England but will be funded and commissioned by the NHS
Nutrition	Running national nutrition programmes including Healthy Start Any locally-led initiatives	Public Health England and local authority	Nutrition as part of treatment services, dietary advice in a healthcare setting, and brief interventions in primary care
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising	Local authority	Provision of brief advice during a primary care consultation e.g. Lets Get Moving

	the physical activity opportunities offered by the natural environment		
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services	Obesity and physical activity programmes, including encouraging active travel, will be the responsibility of local authorities. Local authorities will be responsible for running the National Child Measurement Programme at the local level, with Public Health England co-ordinating the Programme at the national level.	NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting, or bariatric surgery
Drug misuse	Drug misuse services, prevention and treatment	Local authority	Brief interventions
Alcohol misuse	Alcohol misuse services, prevention and treatment	Local authority	Alcohol health workers in a variety of healthcare settings
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications	Local authority	Brief interventions in primary care, secondary, dental and maternity care
NHS Health Check Programme	Assessment and lifestyle interventions	Local authority	NHS treatment following NHS Health Check assessments and ongoing risk management

Health at work	Any local initiatives on workplace health	Local authority	NHS occupational health
Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects	Local authority and Public Health England	Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes and secondary care services such as specialist genetic services
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis via awareness of symptoms	Local authority	Integral part of cancer services, outpatient services and primary care. Majority of work to promote early diagnosis in primary care
Dental public health	Epidemiology, and oral health promotion (including fluoridation)	Public Health England will lead on the co-ordination of oral health surveys while local authorities will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes the NHS Commissioning Board, which will commission dental services. Contracts for existing (and any new) fluoridation schemes will become the responsibility of Public Health England	All dental contracts
Emergency	Emergency preparedness	Public Health England, supported by local	Emergency planning and

preparedness and response and pandemic influenza preparedness	including pandemic influenza preparedness and the current functions of the HPA in this area	authorities	resilience remains part of core business for the NHS. NHS Commissioning Board will have the responsibility for mobilising the NHS in the event of an emergency
Health intelligence and information	Health improvement and protection intelligence and information, including: - data collection and management; - analysing, evaluating and interpreting data; modelling; - using and communicating data. This includes many - existing functions of the Public Health Observatories, Cancer Registries and the Health Protection Agency	Public Health England and local authority	NHS data collection and information reporting systems (for example, Secondary Uses Service)
Children's public health for under 5s	Health Visiting Services including the Healthy Child Programme for under 5s and the Family Nurse Partnership	Public health services for children under 5 will be a responsibility of Public Health England which will fund the delivery of health visiting services, including the leadership and delivery of the Healthy Child Programme for under 5s (working closely with NHS services such as	All treatment services for children (other than those listed above as public health-funded) NHS Partners will need to help to focus on child protection and specifically

		maternity services and with children's social care); health promotion and prevention interventions by the multiprofessional team and the Family Nurse Partnership. Local areas will need to consider how they join-up with Sure Start Children's Centres to ensure effective links. In the first instance, these services will be commissioned on behalf of Public Health England via the NHS Commissioning Board. In the longer term, health visiting to be commissioned locally.	the early intervention end of support for families through Local Safeguarding Children Boards.
Children's public health 5-19	The Healthy Child Programme for school-age children, including school nurses	Public health services for children aged 5-19, including public mental health for children, will be funded by the public health budget and commissioned by local authorities. This will include the Healthy Child Programme 5-19; health promotion and prevention interventions by multiprofessional teams and the school nursing service.	All treatment services for children (other than those listed above as public health funded, e.g. sexual health services or alcohol misuse)
Community safety and violence prevention	Specialist domestic violence services in hospital settings, and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential	Local authority	Non-confidential information sharing

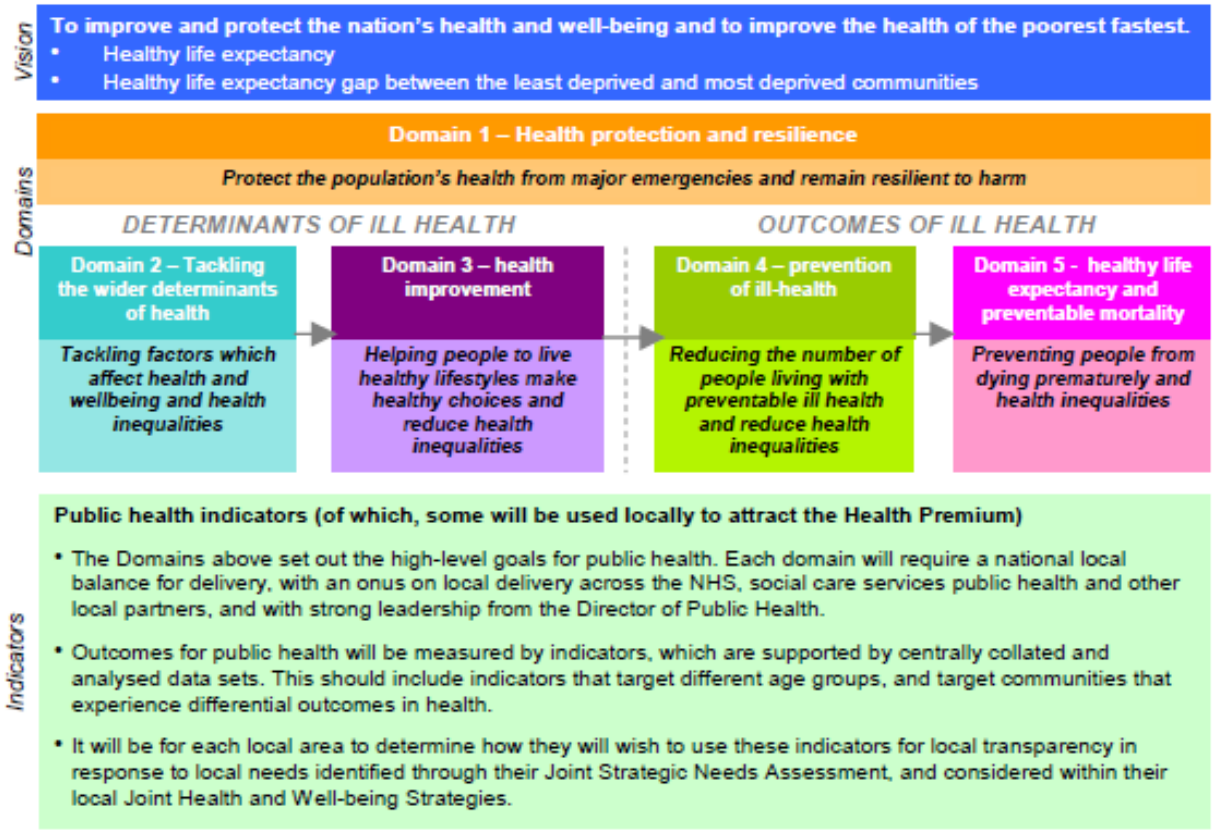
	information sharing activity		
Social exclusion	Support for families with multiple problems, such as intensive family interventions	Local authority	Responsibility for ensuring that socially excluded groups have good access to healthcare
Public health care for those in prison or custody	e.g. All of the above	Where public health services are delivered in prison or for those in custody, these interventions will be funded by Public Health England. However, such interventions will be commissioned by the NHS Commissioning Board on behalf of Public Health England	Prison healthcare

Appendix 2: Proposed Framework for Public Health Outcomes

The government is proposing a set of public health indicators that are intended to have three purposes:

- set out the Government's goals for improving and protecting the nation's health and narrowing health inequalities through improving the health of the poorest, fastest;
- provide a mechanism for transparency and accountability across the public health system at the national and local level
- provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

The framework is based on five inter-linked domains as shown below.



Within each domain a set of indicators have been proposed and are now subject to public consultation. These indicators are listed as below.

<u>Domain 1</u>

- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a

regular cycle. Systems failures identified through testing or through response to real incidents are identified and improvements implemented.
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.
- Life years lost from air pollution as measured by fine particulate matter
- Population vaccination coverage (for each of the national vaccination programmes5 across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan.

Domain 2

- Children in poverty
- School readiness: foundation stage profile attainment for children starting Key Stage 1
- Housing overcrowding rates
- Rates of adolescents not in education, employment or training at 16 and 18 years of age
- Truancy rate
- First time entrants to the youth justice system
- Proportion of people with mental illness and or disability in settled accommodation
- Proportion of people with mental illness and or disability in employment
- Proportion of people in long-term unemployment
- Employment of people with long-term conditions
- Incidents of domestic abuse
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- Killed and seriously injured casualties on England's roads
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise
- Older people's perception of community safety
- Rates of violent crime, including sexual violence
- Reduction in proven reoffending
- Social connectedness
- Cycling participation

Domain 3

- Prevalence of healthy weight in 4-5 and 10-11 year olds
- Prevalence of healthy weight in adults
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)

- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds
- Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)
- Self reported wellbeing 5 year olds.

Domain 4

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- Child development at 2 - 2.5 years
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge
- Health-related quality of life for older people
- Acute admissions as a result of falls or fall injuries for over 65s
- Take up of the NHS Health Check programme by those eligible
- Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed

Domain 5

- Infant mortality rate
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
- Mortality rate from cancer in persons less than 75 years of age
- Mortality rate from Chronic Liver Disease in persons less than 75 years of age
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age
- Mortality rate of people with mental illness
- Excess seasonal mortality

Appendix 3: Summary of proposals for establishment of Health and Wellbeing Boards

The government proposes establishing a statutory Health and Wellbeing Board (HWB)within each upper tier local authority. The primary purpose of the Board would be "to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability".

The Government proposes that statutory HWBs would have four main functions:

- assess the needs of the local population and lead the statutory joint strategic needs assessment;
- promote integration and partnership, including through joined-up commissioning plans across the NHS, social care and public health;
- support joint commissioning and pooled budget arrangements where this makes sense;
- undertake a scrutiny role in relation to major service redesign

Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the HWB would give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.

It is anticipated that HWBs would lead in determining the strategy and allocation of any local application of place-based budgets for health and relate to other local partnerships, including those relating to vulnerable adults and children's safeguarding. But to reduce bureaucracy, local authorities should want to replace current health partnerships where they exist, and work with the local strategic partnership to promote links and connections between the wider needs and aspirations of local neighbourhoods and health and wellbeing. It is proposed that the statutory functions of the overview and scrutiny committee (OSCs) would transfer to the health and wellbeing board.

The government indicates that there would be a statutory obligation for the local authority and commissioners to participate as members of the Board. However, the proposed composition of the Board appears to be broad and includes**:**

- local elected representatives including the Leader or the Directly Elected Mayor,
- social care commissioners,
- GP consortia;
- Director of Public Health;
- relevant local authority directors on social care, public health and children's services;
- a representative of local HealthWatch;
- local representatives of the voluntary sector;

It is also stated that providers may be invited into discussions, and that representation from the NHS Commissioning Board may be requested if required.

The elected members of the local authority would decide who chaired the board.

Having a seat on the HWB is designed to give HealthWatch a more formal role in commissioning discussions and “provide additional opportunity for patients and the public to hold decision makers to account and offer scrutiny and patient voice”.

The government recognises the novelty of arrangements bringing together elected members and officials in this way and is seeking views as to how local authorities can make this work most effectively. But it is hoped that this emphasis on proactive local partnership would minimise the potential for disputes. Where disputes do arise, the Board may “choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel”. But where the dispute is unable to be resolved locally, the Board would have a power to refer the issue to the NHS Commissioning Board.

Neighbouring boroughs may choose to establish a single board covering their combined area.

Appendix 4: Diagrammatic representation