



Ready for health?

an analysis of local authorities'
preparedness for health commissioning

September 2011



Health Mandate



Contents

List of figures and tables	3
Introduction	4
Summary of key findings.....	6
Summary of key recommendations.....	8
Chapter 1: Background and methodology.....	9
Chapter 2: Defining public health	13
Chapter 3: Population needs assessment.....	15
Chapter 4: Funding for public health	18
Chapter 5: Partnership working.....	23
Chapter 6: Preparing for the new world.....	30
Conclusion.....	34
References	35

List of figures and tables

Figure 1: Local authority response rate	12
Figure 2: Local authorities using a definition of public health.....	14
Figure 3: Per capita expenditure on healthy individuals by PCT, 2009/10 (unified weighted population).....	19
Figure 4: Local authorities which received a budget allocation for substance misuse in 2010/11	20
Figure 5: Local authorities which received a budget allocation for sexual health in 2010/11	20
Figure 6: Local authorities which received a budget allocation for independent living in 2010/11	21
Figure 7: Local authorities which received a budget allocation for smoking in 2010/11.....	21
Figure 8: PCT budget allocations to local authorities for the provision of public health services.....	22
Figure 9: Percentage of local authorities which had communications with their PCT and/or commissioning groups on public health issues.....	23
Figure 10: Percentage of local authorities which had discussed public health issues with other local authorities.....	25
Figure 11: Public health issues discussed with other local authorities.....	26
Figure 12: Number of jointly appointed directors of public health.....	27
Figure 13: Local authorities which have a jointly appointed director of public health	28
Figure 14: Percentage of local authorities which have had communications about assuming public health responsibilities.....	30
Figure 15: Percentage of local authorities which have had communications with their PCT, SHA and the Department of Health about the establishment of health and wellbeing boards.....	31
Figure 16: Percentage of local authorities which have had communications with their LINK	33
Table 1: Anticipated key local authority responsibilities in public health service provision from April 2013.....	10
Table 2: Key milestones in the transition of public health responsibilities	11
Table 3: Some definitions of public health provided by local authorities	13
Table 4: Assessment of local authority public health priorities.....	15
Table 5: Local authority contracts with third parties to provide public health services	29
Table 6: Examples of the type of contracts local authorities hold with external organisations	29

Introduction

The Government's White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* sets out a new approach to public health. The White Paper aims to respond to a number of public health challenges from rising obesity rates to a threat of a global pandemic¹. At the heart of the Government's proposed approach is a significant shift in responsibility, separating the commissioning of public health services from the NHS, creating a 'ring fence' for the public health budget, establishing Public Health England to provide national leadership and placing the responsibility for local commissioning with upper tier local authorities. The new public health service will be held to account for delivering on a series of outcomes set out in a public health outcomes framework, due to be published later this year².

Local authorities are already involved in commissioning and delivering services which have an impact on disease prevention and wellbeing. Housing, leisure services, licensing and school dinners, for example, all have a significant impact on population health. Yet, assuming responsibility for the commissioning of public health – combined with the powers to coordinate the delivery of services across public health, NHS and social care services that are embodied in local health and wellbeing boards – represents a step change in the level of responsibility for health, ascribed to local authorities. The way in which local authorities adapt to these enhanced responsibilities, at a time when they are coping with significant reductions in resources for wider activities, will go a long way towards determining the success of the Government's public health policies.

MHP Health Mandate is a specialist health policy and communications consultancy, advising the NHS, voluntary sector and commercial organisations on some of the highest profile issues of the day. A key part of our role is to provide organisations with strategic policy consultancy and analysis, transforming their objectives into workable policies and in turn ensuring that those priorities are translated into positive change in health and social care.

Establishing the new public health arrangements will not be simple. The recently published command paper *Healthy Lives, Healthy People: Update and way forward* makes clear that “*the transition will be difficult*”³. Local authorities have varying levels of involvement and expertise in public health and the extent to which partnership arrangements between local authorities and Primary Care Trusts (PCTs) exist is also variable. Existing arrangements depend as much on local relationships and traditions as they do on statutory principles, meaning that levels of existing involvement by local authorities is patchy.

Understanding the differences in local authorities' existing arrangements and preparedness will be important in planning the transition, ensuring that services are not disrupted and that recent progress in improving public health is maintained⁴. For any organisation seeking to influence public health delivery or to improve outcomes, understanding how to navigate the new public health landscape will be critical.

This report is part of MHP Health Mandate's contribution to discussions about how best to manage the transition to the new health and social care architecture. It is intended to help inform the work of the Future Forum, the Health Select Committee and the Department of Health itself, as well as that of the many stakeholders with an interest in improving public health.

The report assesses:

- How local authorities define public health, which will be critical in determining how they interpret, and act upon their new responsibilities
- Which, if any, public health issues have been prioritised by existing population need assessments by local authorities
- Existing local authority expenditure on public health services
- Partnership arrangements with PCTs and third party organisations in delivering public health services
- The preparedness of local authorities to assume the statutory coordination functions for public health, NHS services and social care, embodied in health and wellbeing boards

The report also makes recommendations as to how some of the risks in the transition could be mitigated, as well as how the opportunities that the new system creates can be maximised.

Summary of key findings

Defining public health

- Just over half (54%) of upper-tier and unitary local authorities have a definition of public health. Of these, nearly three quarters (72%) use the definition adopted by the Faculty of Public Health and the Department of Health in their White Paper, *Healthy Lives, Healthy People*⁵
- Although some local authorities have very sophisticated definitions of public health in place, others, such as Slough Borough Council, simply used the World Class Commissioning mantra of "adding life to years and years to life" while North Lincolnshire Council reported that they were "not sure we have ever defined public health". This calls into question the extent to which all local authorities are prepared to assume responsibility for public health

Population need assessment

- Most Joint Strategic Needs Assessments (JSNAs), which play a key role in setting the strategic framework for local commissioning, address a broad range of public health issues such as obesity, substance misuse and sexual health. However, there is wide variation in the quality, detail and specificity of JSNAs
- Given the current focus on reablement, it is encouraging that two thirds of local authorities referred to some form of enabled independent living as part of their needs assessment. Local health and wellbeing boards will need to play a key co-ordinating role in the commissioning of services to support independent living
- The impact of public service agreement (PSA) targets established under the last government can clearly be seen in JSNAs, with – for example – nearly half focusing on addressing childhood obesity. This reflects the PSA target to halt the year-on-year rise in obesity among children under 11 by 2010. By contrast, only 25% of JSNAs focused on addressing adult obesity
- The vast majority of local authorities identify alcohol misuse as a priority. However, less than a quarter (22%) have a specific strategy in place to address alcohol misuse. This is concerning, considering the rising mortality rates from liver disease. The forthcoming national liver disease strategy will need to address this issue

Funding for public health

- Just over half (52%) of local authorities who responded were able to provide details on the size of allocations received from PCTs to provide public health services in 2010/11, while a fifth of local authorities confirmed that the PCT holds the budget to provide services in this area. Over a quarter (27%) of respondents were unable to provide any details of the funding arrangements in place with their PCT
- Of those who were able to respond with regard to budget allocations for specific areas of public health for 2010/11, just over half (54%) received funding to address substance misuse, just over

a third to address obesity (36%), over a quarter to address sexual health (26%), under a fifth (18%) to address independent living; and 17% received funding to address smoking

Partnership working

- Over half (57%) of local authorities who responded had arrangements in place with external organisations to provide public health services. Of these, 84% held contracts to provide services to address substance misuse while nearly a third (29%) of authorities held contracts to provide services to address obesity and sexual health
- The vast majority of the contracts were held with local organisations but a number of authorities hold contracts with national organisations such as MEND, Addaction, Turning Point, Equinox and Age UK
- Nearly a third (29%) of local authorities reported no communication with their PCT or clinical commissioning groups in the last year on public health issues including, obesity, smoking, substance misuse, sexual health and independent living. This absence of coordination will be an issue that local health and wellbeing boards will need to address
- Only half (50%) of local authorities had discussed the commissioning or provision of public health servicing with other local authorities. This calls into question the extent to which good practice is being shared between local authorities
- Three quarters (75%) of local authorities reported that they shared a joint director of public health with their local PCT. The majority of these posts were established from 2006 onwards when guidance was issued by the Association of Directors of Public Health recommending such joint appointments. The scope of most of these posts is based on the model job description for joint directors of public health supplied by the Faculty of Public Health

Democratic involvement

- Despite the fact that nearly 90% of local authorities identified themselves as early implementers of health and wellbeing boards, only 63% of respondents confirmed that they had undertaken an assessment to inform the development of a board in their area
- Nearly a sixth (16%) of respondents were unable to provide the name of the elected councillor responsible for developing a local health and wellbeing board, raising questions about the lack of democratic oversight of the development process
- Nearly a third (32%) of local authorities have had no communication with their Local Involvement Network (LINK) as part of the development process. This is especially concerning considering the Government's plans to strengthen the voice of patients and carers at local level, giving responsibility to local authorities for commissioning HealthWatch services (the successor to LINKs) in their area

Summary of key recommendations

1. As part of the public health reform process, the Department of Health should clarify the definition of 'public health' which should be used by all those involved in commissioning and delivering public health services. Public Health England and every upper tier or unitary local authority in England should be required to use this definition.
2. The Government should use the opportunity created by the reforms to public health and NHS structures to address the variation in quality and detail of JSNAs.
3. In calculating the budget allocation for local authorities, the Department of Health should take into account existing local authority expenditure as well as PCT expenditure, and in addition make an assessment of public health need.
4. Public Health England and the Local Government Association should establish mechanisms to encourage the sharing of good practice in public health commissioning between local authorities.
5. Local authorities should explore effective lead commissioning models and look to replicate these through their local health and wellbeing boards.
6. Every local authority should develop a job description for the director of public health role. This should be based on the Faculty of Public Health's model job description.
7. Local authorities should publish details of their contractual relationships with third parties in an open and transparent way. Local authorities should also ensure they have appropriate arrangements in place to enable effective performance management of contracts.
8. The Department of Health should reissue advice to local authorities about the transition. It would be good practice for all local authorities to publish a local transition timetable.
9. Local authorities should publish updates on their progress in establishing local health and wellbeing boards.
10. As part of its learning network on local health and wellbeing boards, the Department of Health should identify examples of good practice which can be used as models by other local authorities. It should also create a capability assessment framework to enable the benchmarking of local authority preparedness.
11. Local authorities should take steps to involve LINKs in the development of local health responsibilities, including the development of the local health and wellbeing board.
12. In setting out the next steps for public and patient involvement in health through the development of HealthWatch England, the Department of Health should set out how local HealthWatch should be involved in local health and wellbeing boards.

Chapter 1: Background and methodology

The Department of Health published its White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* in November 2010⁶. The White Paper sets out the Government's vision for public health, including transferring the responsibility for the commissioning of local public health services to upper tier local authorities.

The history of local authority involvement in public health

The proposals represent a significant shift in responsibility, but it is important to note that giving local authorities more responsibilities for public health is not a new idea. Public health services were traditionally the responsibility of local authorities until 1974⁷.

Since then, local authorities have continued to play a significant role in funding and commissioning many interventions which influence public health, including many of the social, economic and environmental factors, such as air quality management, environmental health, food hygiene, housing, leisure services, education, planning, community safety and transport. In addition, successive pieces of legislation have increased the powers of local authorities to tackle alcohol and substance misuse⁸.

Public health reform

The Government's proposed reforms to public health are intended to protect public health services from short term cuts made to budgets in order to protect more politically sensitive NHS services, whilst also ensuring that decisions about public health prioritisation are taken by representatives who are close to, and understand the needs of, local communities⁹.

Public health can cover anything from preventative services to the delivery of very specific population health interventions. As a result, concerns have been raised that local authorities could choose to divert spending from 'core' public health services to fund, for example, existing local authority activities which can no longer be afforded from other budgets¹⁰. Many of the witnesses to the Health Select Committee's ongoing inquiry into public health have raised questions about how the 'boundaries' for the ring-fenced budget will be drawn¹¹ and have argued that instead of a ring-fenced budget, local authorities should pull resources together across different policy areas to have an integrated budget on public health¹².

The recently published command paper, *Healthy Lives, Healthy People: Update and way forward*¹³ suggests that the estimated public health budget of £4 billion will be spent by local authorities on functions as diverse as mental health promotion, nutrition, physical activity and obesity programmes, substance misuse and tobacco control, with clinical commissioning groups (CCGs) maintaining a leading role in immunisations, screening programmes, HIV treatment, and contraception.

Work is ongoing to define the exact scope of public health services which local authorities will be responsible for. Table 1 sets out the anticipated areas of public health for which local authorities will be responsible.

Table 1: Anticipated key local authority responsibilities in public health service provision from April 2013¹⁴

Policy area	Proposed activities	Commissioning route
Alcohol and drug misuse services	Prevention and treatment	Local authority
Children’s public health for under 5s	Health visiting service, prevention interventions	NHS Commissioning Board
Children’s public health 5-19	Health promotion and prevention interventions	Local authority
Community safety	Domestic violence services, counselling and support services	Local authority
Dental public health	Epidemiology and oral health promotion	Local authority supported by Public Health England
Immunisation programmes	Universal immunisation programmes	Local authority to commission school programmes (such as HPV), and NHS Commissioning Board to commission vaccine programmes
Obesity and community nutrition initiatives	Programmes to prevent and address obesity	Local authority
Physical activity	Activities to address inactivity and other intervention to promote physical activity	Local authority
Public mental health services	Mental health promotion, mental illness and suicide prevention	Local authority
Prevention	Behaviour and lifestyle campaigns and/or services to prevent cancer and long-term conditions	Local authority
Screening	Public Health England will design, and provide quality assurance and monitoring for screening programmes	NHS Commissioning Board (cervical screening is included in the GP contract)
Sexual health	Contraception, testing and treatment of sexually transmitted infections, termination of pregnancy services, outreach and prevention	Local authority but contraceptive services to be commissioned by the NHS Commissioning Board via GP contract
Social exclusion	Support for families with multiple problems	Local authority
Tobacco control	Stop smoking services, prevention and enforcement	Local authority
Workplace health	Local initiatives	Local authority

It is not clear how much money there will be left to be spent by local authorities once nationally-commissioned services, such as screening, immunisation and health protection functions, have been supported.

The transition period is relatively rapid, meaning that local authorities only have a small window in which to develop the capabilities necessary to define the scope of their public health offer and commission effectively. Table 2 outlines the key milestones in the transition period.

Table 2: Key milestones in the transition of public health responsibilities¹⁵

Transition timetable	
Shadow budget allocations for local authorities determined	December 2011
Formal transition plans to be agreed between local authorities and regional directors of public health	March 2012
Chief Executive for Public Health England in post	April 2012
SHAs and PCTs abolished and NHS Commissioning Board takes on its full functions	April 2012
Public Health England established	April 2013
Local authorities take on their new responsibilities	April 2013

Methodology

This report is intended to contribute to the understanding of the current level of preparedness of local authorities, as well as the extent to which they are already involved in public health. In order to gather data, MHP Health Mandate undertook an audit of all upper-tier and unitary authorities using the Freedom of Information (FOI) Act 2000.

The following issues were examined in the audit:

- The definition of public health used by local authorities
- The strategic planning processes used by local authorities in relation to public health
- Details of expenditure on public health services, including resources provided to local authorities by PCTs
- Evidence of partnership working with PCTs and third party organisations
- Progress in developing local health and wellbeing boards

This report is based on:

- Quantitative and qualitative analysis of the existing public health priorities of upper-tier and unitary local authorities through analysis of JSNAs
- Quantitative and qualitative analysis of the responses received to our FOI audit, focusing on five key areas of public health: obesity (including health living and eating), smoking, substance misuse (including drugs and alcohol), sexual health (including teenage pregnancy) and independent living

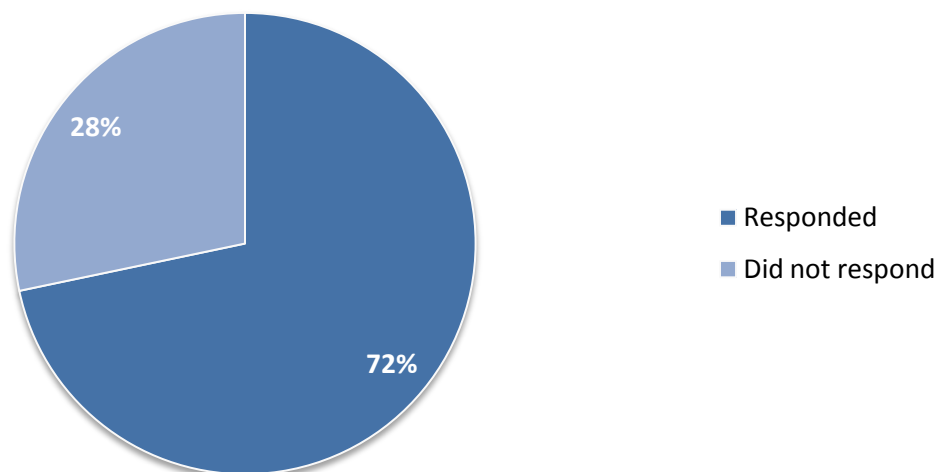
It is important to note that, although public bodies have a duty to respond to requests made under the Freedom of Information Act 2000, they are under no obligation to respond in a consistent manner. Therefore the data and analysis presented in this report are based on the interpretation of MHP Health Mandate consultants of the information provided.

Similarly, different terminology is used by different local authorities and efforts have been made to standardise this. For example, 'independent living' has been defined as people living independently with support (for instance, living with their family or supported by telecare or telehealth) or without (for instance, living in their own home). People living in residential care, nursing homes or group homes are excluded from this definition.

Response rate

Requests were made under the Freedom of Information Act 2000 to 152 upper tier and unitary local authorities in April 2011. In total, 109 responses were received by the analysis cut-off date of 8 July providing a response rate of 72%, as set out in Figure 1. We are grateful to those local authorities who responded.

Figure 1: Local authority response rate



The quality of responses was more variable, however. For example, a third of local authorities who responded were unable to provide us with any details about funds received from PCTs. Only just over half of local authorities were able to provide details of their public health expenditure, raising questions about their ability to manage public health budgets effectively or account for their use of public money in this area.

Chapter 2: Defining public health

By its very nature, the term public health is a broad concept and can be used to encompass a number of different areas as diverse as obesity, road safety and sexual health. It can also include a range of diverse interventions, ranging from those delivered by traditional health services (such as vaccinations or cancer screening) to those delivered by non-health providers (such as good quality housing or school meals).

There are therefore a number of definitions of public health used – from those which consist of a list of characteristics, to those which provide an overarching set of principles.

Table 3: Some definitions of public health provided by local authorities

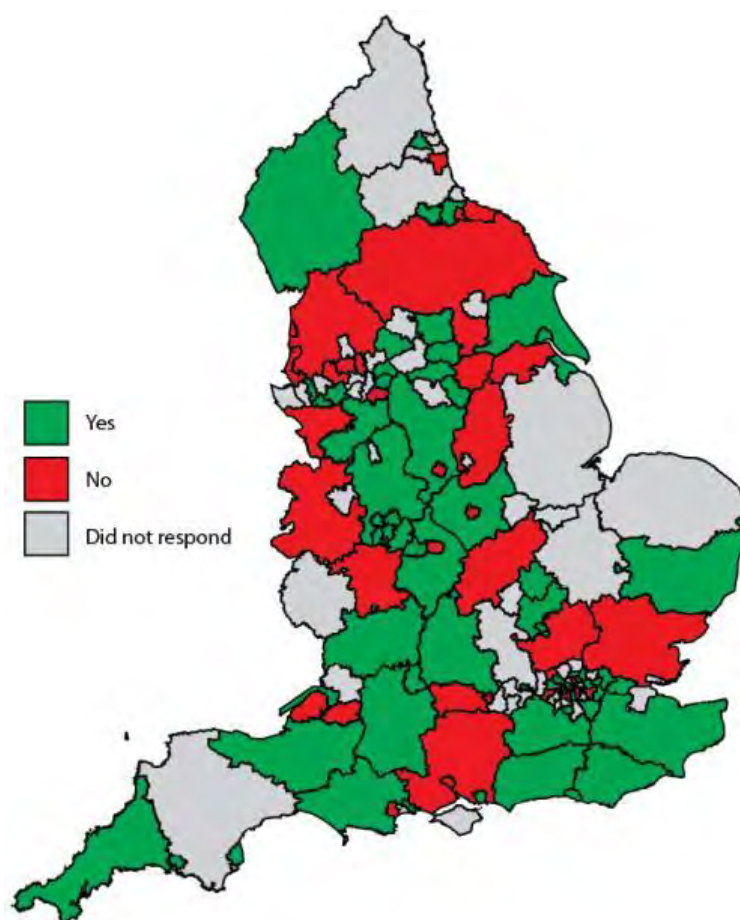
Definitions of public health	
Wiltshire Council ¹⁶	The definition used is “ <i>Public Health is the multidisciplinary branch of medicine specialising in population health</i> ” Sir Donald Acheson, Chief Medical Officer, <i>Acheson Report</i> (1988).
Portsmouth City Council ¹⁷	By definition the purpose and role of Public Health is to protect and improve the health and wellbeing of the people of Portsmouth by targeting and tackling inequalities so as to achieve optimal health and prolong life, through the organised efforts and informed choices of society, public, private, voluntary organisations, communities and individuals.
Stockton-on-Tees Council ¹⁸	To improve the health and wellbeing of families, communities and adults of the Borough of Stockton-on-Tees through tackling inequalities and focusing on five key priority areas.

In discharging their public health functions effectively, it will be important that local authorities have a clear understanding about what their responsibilities are, particularly given the Government’s decision to ringfence public health funding.

It is worrying that only just over half (57%) of the 109 local authorities that responded to the audit confirmed that their local authority used a definition of public health. Of the authorities that did, nearly three quarters (72%) used the definition adopted by the Faculty of Public Health and the Department of Health in *Healthy Lives, Healthy People*¹⁹. This definition is: “*The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society*”²⁰.

Figure 2 shows the local authorities which confirmed that they use a definition of public health.

Figure 2: Local authorities using a definition of public health



In total, 17 local authorities used a different definition from the definition adopted by the Faculty of Public Health and the Department of Health and, within these, there was significant variation in the scope and detail of how they defined public health. For example, Halton Borough Council defined public health as: *“To create a healthier community and work to promote well-being, a positive experience of life with good health (not simply an absence of disease), and offer opportunities for people to take responsibility for their health with the necessary support available”*²¹.

Slough Borough Council, however, merely defined public health as *“Adding life to years and years to life”*²².

Some local authorities seemed unsure as to whether they used a definition or not. North Lincolnshire Council, for example, responded by saying: *“Not sure we have ever defined public health”*²³.

Recommendation 1: As part of the public health reform process, the Department of Health should clarify the definition of public health which should be used by all those involved in commissioning and delivering public health services. Public Health England and every upper tier or unitary local authority in England should be required to use this definition.

Chapter 3: Population needs assessment

The Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a JSNA of the health and wellbeing of their local community²⁴. The JSNA is a process that aims to identify the current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements (LAA) and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities²⁵.

The Department of Health's White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England*, confirms that the JSNA will continue to have an important role in local needs assessment and healthcare planning²⁶.

The intention is that statutory health and wellbeing boards will establish a shared local view about the needs of the community and use this to support joint commissioning of NHS, social care and public health services in order to meet the needs of the local population effectively. To do this, health and wellbeing boards will establish joint strategies based on the assessment of need outlined in their JSNA. This joint health and wellbeing strategy will provide the overarching framework within which more detailed and specific commissioning plans for the NHS, social care and public health are developed.

Although JSNAs are a statutory requirement, the scope, detail and ambition of the JSNAs vary significantly. Table 4 sets out the extent to which JSNAs address key public health issue, as well as demonstrates that some JSNAs fail to make recommendations about how these issues can be addressed.

Table 4: Assessment of local authority public health priorities

Focus area	Percentage of JSNAs that mention issue	Percentage of JSNAs that refer to issue but have no recommendations in place
Healthy living, healthy eating and obesity	97%	15%
Smoking	88%	17%
Substance misuse, including drugs and alcohol	92%	18%
Sexual health, including teenage pregnancy	84%	16%
Independent living	62%	16%

Healthy living, healthy eating and obesity

The majority (82%) of local authorities identified tackling rising levels of obesity as a priority and set out recommendations for addressing the issue. Over half (56%) of these local authorities who

included obesity as a priority have action plans in their JSNA which are aimed towards addressing childhood obesity, reflecting the PSA target established under the previous government on halting the year-on-year rise in obesity among children under 11 by 2010. A quarter (25%) of the JSNAs focused on addressing obesity in adults while only a tenth (10%) of the JSNAs addressed obesity in the family.

There is also wide variation in the level of detail or recommended action included in the JSNAs. For example, Warwickshire County Council's JSNA gives details of various community based partnership interventions which have been set up to address obesity such as weight management programmes, cooking sessions, parenting groups and physical activity groups²⁷. The PCT has taken the lead in commissioning these services and holds the budget. The detail in Warwickshire County Council's JSNA is in contrast to Harrow Council's JSNA, which simply states that to address obesity the Council "*want[s] community cohesion to tackle health inequalities and to promote healthy lifestyle*"²⁸. The JSNA does not provide details on how this will be achieved.

Smoking

72% of local authorities made recommendations in their JSNA for tackling smoking rates in their area. Of this group, more than seven in ten (72%) confirmed that they want to build on their smoking cessation and support services, and 14% stated that they either have or are planning to implement a smoking strategy for their local area. For example, NHS Walsall currently commissions the Walsall Stop Smoking Service which is achieving quit rates for participants in the scheme of 47.9%²⁹. This compares with a national average quit rate of 48.7% amongst smokers setting a quit date³⁰. Walsall will also target parents of pre-adolescent children with smoking cessation support and advice and fund a programme to reduce smoking in pregnancy.

Substance misuse, including drugs and alcohol

The majority (74%) of local authorities have identified substance misuse as a key priority for action and provided recommendations for action. However, of this group, just more than a third (34%) of authorities have developed or are in the process of developing a specific strategy to address substance misuse. Cumbria County Council refers to this area as a 'top priority' and a number of authorities such as Derbyshire County Council, Suffolk County Council, Durham County Council and Hammersmith and Fulham Council have a specific strategy in place to tackle misuse of alcohol.

Despite the level of prioritisation given to the issue, only 16% of JSNAs that include recommendations for addressing substance misuse in their area make recommendations for future work for the local Drugs and Alcohol Action Team (DAAT). For example, Sheffield City Council's JSNA recommends a review of drug treatment services to identify and secure efficiency savings, disinvestment in under-performing services, and re-commissioning/re-tendering to secure best value³¹. Conversely, neighbouring Doncaster Council only notes that alcohol misuse is a key issue but fails to provide any further details on how the authority is planning to address this³².

Sexual health, including teenage pregnancy

Regarding sexual health, 68% of JSNAs contained recommendations in this area. Of this group, over a third (36%) include information on plans to address sexually transmitted infection (STI) rates in the local area, while 24% discuss education as a means of improving the sexual health of the local

population and tackling teenage pregnancy rates. Again, the plans vary in terms of the detail provided. Hackney's JSNA provides a high level of detail on sexual health, making clear that improving sexual health and reducing teenage pregnancy rates are a local priority. It describes the following methods, amongst others, as the most effective ways to improve teenage pregnancy rates³³:

- Providing accurate information through clear, unambiguous messages
- Using behavioural skills training, including self-efficacy
- Including teenagers' parents in information and prevention programmes
- School-based sex education programmes before the onset of sexual activity
- School-based, community-based, youth development and family outreach programmes
- Ring-fenced funding at the local level
- Opportunistic chlamydia screening of women under 25

Independent living

Although 62% of local authorities referred to measuring local independent living needs in their JSNA, fewer than half (47%) include detailed recommendations in this area. This is of some concern given the Government's focus on helping people to remain independent for as long as possible in order to reduce the cost burden on social care services. Typically the JSNAs referred to the importance of enabling people to have greater independence, choice and control of their conditions by the use of technology. Furthermore, telehealth and/or telecare were mentioned by eleven different local authorities as an effective tool for maintaining independent living. For example, Southampton City Council confirmed that it will continue the investment in, and use of, assistive technology such as telehealth and remote monitoring to improve disease management³⁴.

Recommendation 2: The Government should use the opportunity created by the reforms to public health and NHS structures to address the variation in quality and detail of JSNAs.

Chapter 4: Funding for public health

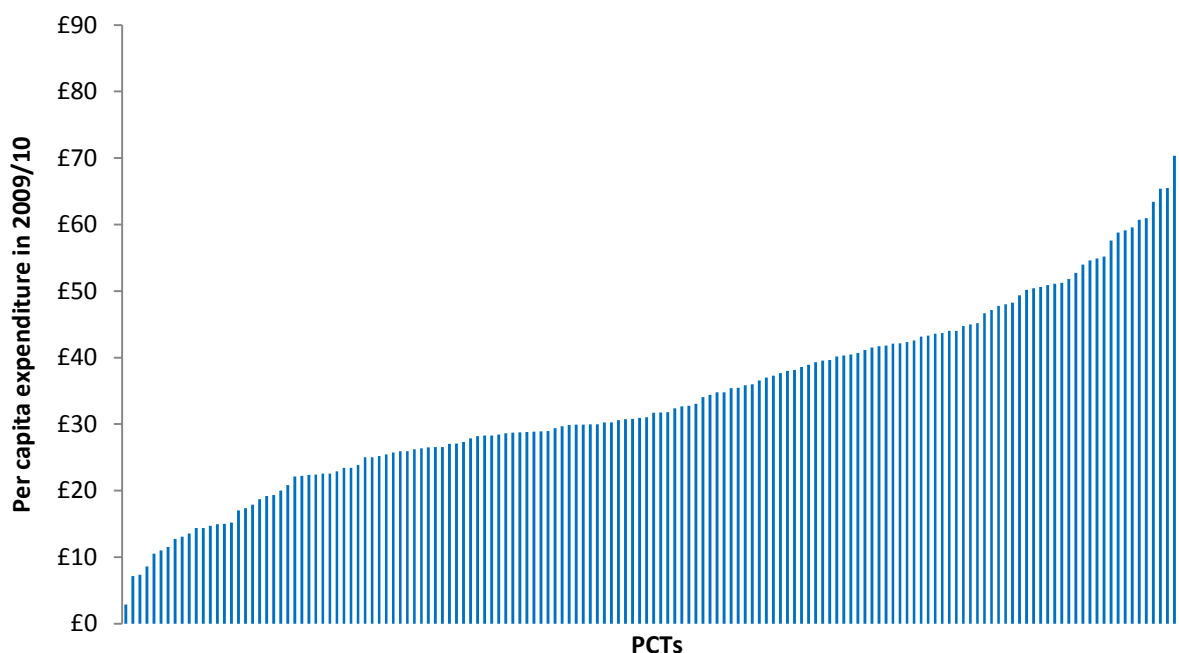
To date, the debate around public health funding has focused on the merits of the Government's proposal to ring-fence the public health budget. The Government has taken the view that local authorities are best placed to address the public health needs of their population, and ensure that the allocated funds are directed to public health initiatives and are not subsumed into wider healthcare expenditure.

Disentangling public health budgets from NHS allocations is, however, a complicated task. The Government is planning to use PCT expenditure on public health services during 2009/10 as a baseline measure of expenditure, in order to determine the relative size of the allocations received by different local authorities in 2013/14³⁵. As a result, areas that were previously 'low spenders' in public health could be disadvantaged under the new system, embedding existing variations rather than addressing them.

Anne Milton MP, the Parliamentary Under-Secretary of State for Public Health, has confirmed that any calculations on allocating public health funding are a "*work in progress*"³⁶. Early analysis of public health expenditure by PCTs suggests that there is extremely wide variation in the amount spent on services. For example, the London Borough of Wandsworth recorded expenditure of £18 per head, whereas the nearby Borough of Westminster £169 per head³⁷. Sir David Nicholson, the NHS Chief Executive, confirmed in a recent letter that the information received from PCTs on public health expenditure "*shows considerable variability between different areas, much of which might be expected, but in some cases there are unexpected values and omissions*"³⁸. It is unclear whether this variation is real or a coding issue.

An analysis of expenditure recorded under the *Healthy Individuals* category of programme budgeting data reveals significant variation, as set out in Figure 3. Variation in per capita expenditure in this category in 2009/10 was over 27-fold, with Newcastle PCT spending £79.31 and Waltham Forest PCT just £2.86³⁹.

Figure 3: Per capita expenditure on healthy individuals by PCT, 2009/10 (unified weighted population)



The situation is further complicated by the fact that the existing role and contribution of local authorities in funding public health services is variable.

Recommendation 3: In calculating the budget allocation for local authorities, the Department of Health should take into account existing local authority expenditure as well as PCT expenditure, and make an assessment of public health need.

Budget allocations from PCTs on the provision of public health services

Under the current funding system, some local authorities have been responsible for commissioning some public health services, with PCTs allocating resources to them. As part of this audit, local authorities were asked to provide details of the budget allocations received during the past three years with regards to the provision of services to address obesity (including health living and eating), smoking, substance misuse (including drugs and alcohol), sexual health (including teenage pregnancy) and independent living.

Of the 101 local authorities who responded to the audit regarding budget allocations in 2010/11, just over half (52%) were able to supply details of budget in at least one of the areas of public health covered in this report. A fifth (20%) of respondents confirmed that their local PCT holds the budget to provide all of these services, and over a quarter (27%) were unable to provide details of the funding they have received from their PCT to provide public health services for that year.

Of those who were able to respond with regard to budget allocations for specific areas of public health for 2010/11, 54% received funding to address substance misuse, just over a third to address obesity (36%), over a quarter to address sexual health (26%), under a fifth (18%) to address independent living and 17% received funding to address smoking, as set out in Figures 4, 5, 6 and 7.

Figure 4: Local authorities which received a budget allocation for substance misuse in 2010/11

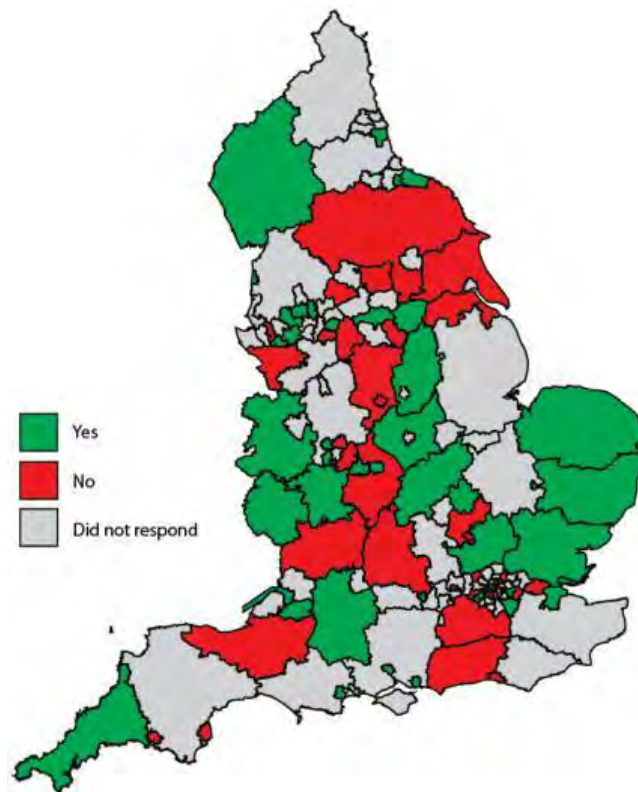


Figure 5: Local authorities which received a budget allocation for sexual health in 2010/11

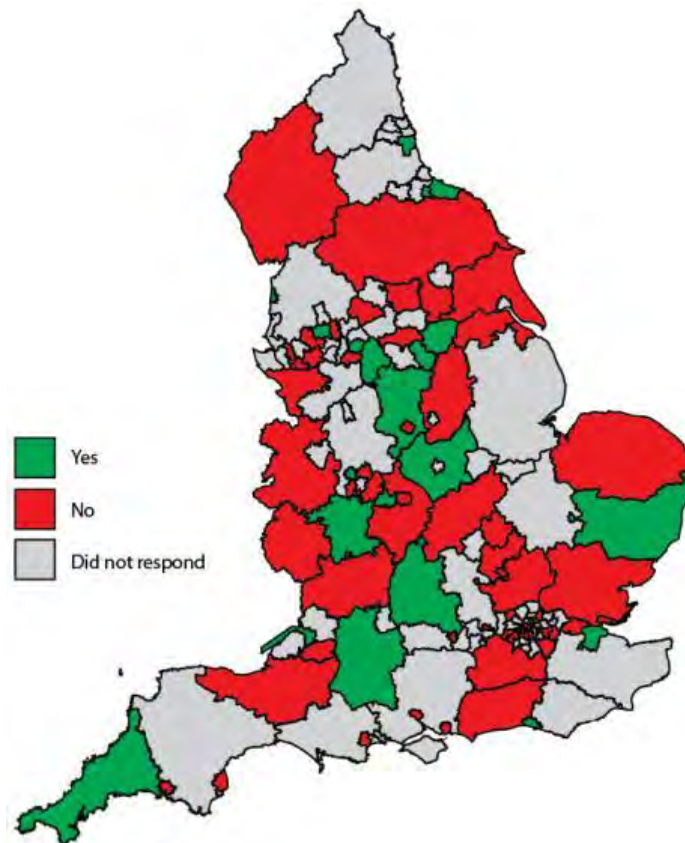


Figure 6: Local authorities which received a budget allocation for independent living in 2010/11

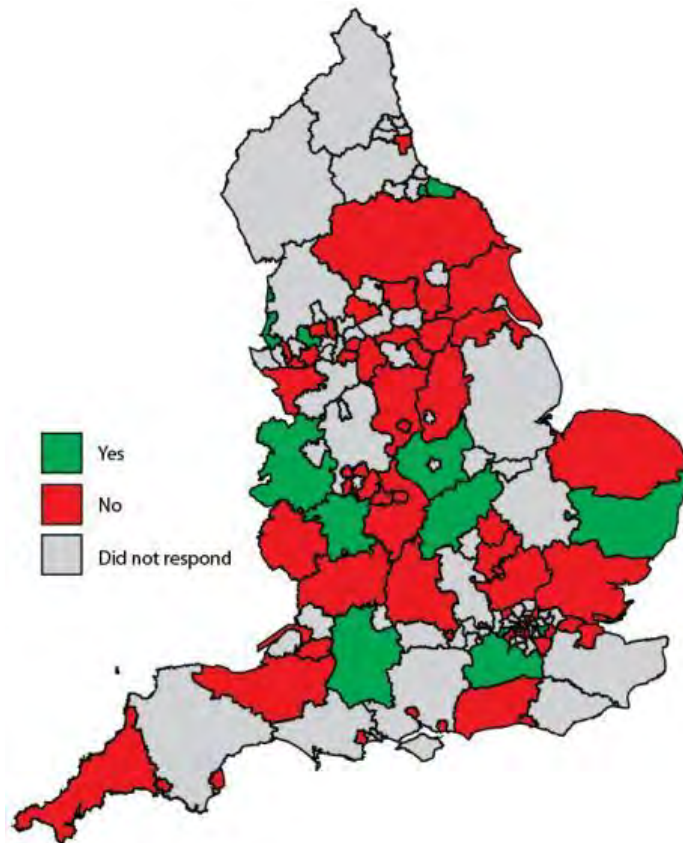
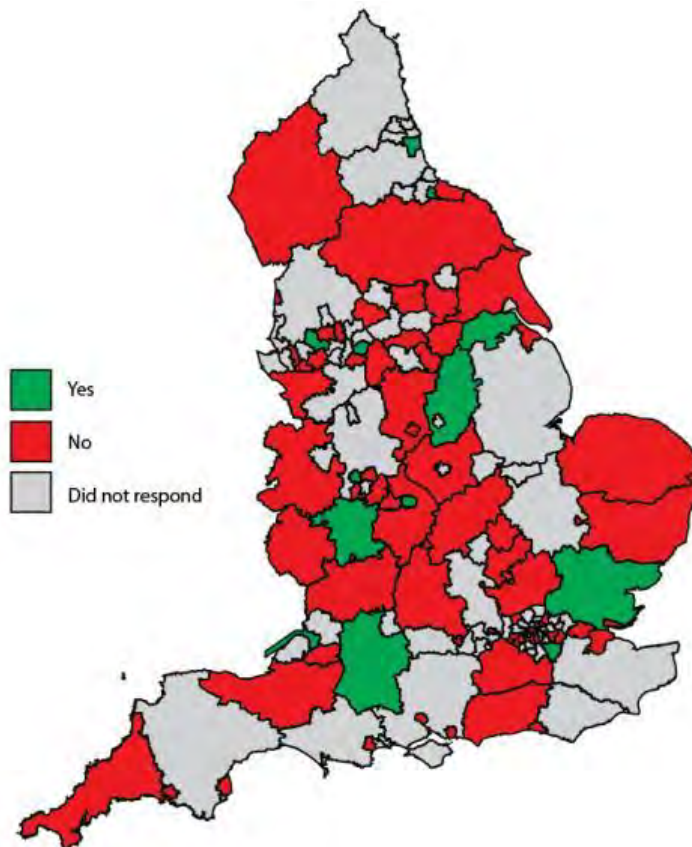


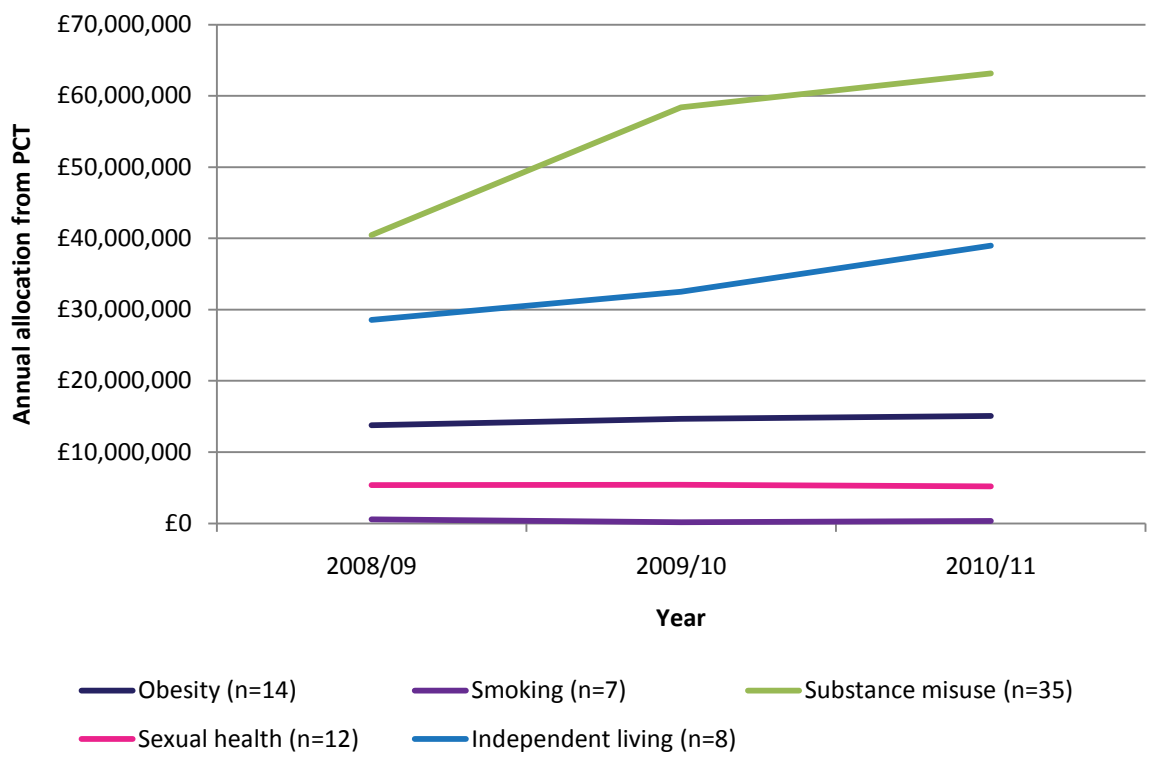
Figure 7: Local authorities which received a budget allocation for smoking in 2010/11



Eight local authorities were unable to provide a breakdown of their PCT budget allocations according to the categories specified in the audit and instead supplied a figure for their total PCT budget allocation to provide public health services over the past three years⁴⁰. The inability to provide more detail is unfortunate given the importance of public bodies accounting for the effectiveness of their expenditure decisions.

Local authorities were also asked to provide details of the level of budget allocated to each issue over the past three years. Only a small number were able to provide this information. Figure 8 sets out the total budget allocated for those local authorities that were able to respond. It appears as though funding for services addressing substance misuse and independent living has increased, although allocations for obesity, sexual health and smoking have remained flat. It is, however, difficult to draw conclusions given the small number of local authorities able to provide this level of detail.

Figure 8: PCT Budget allocations to local authorities for the provision of public health services



Chapter 5: Partnership working

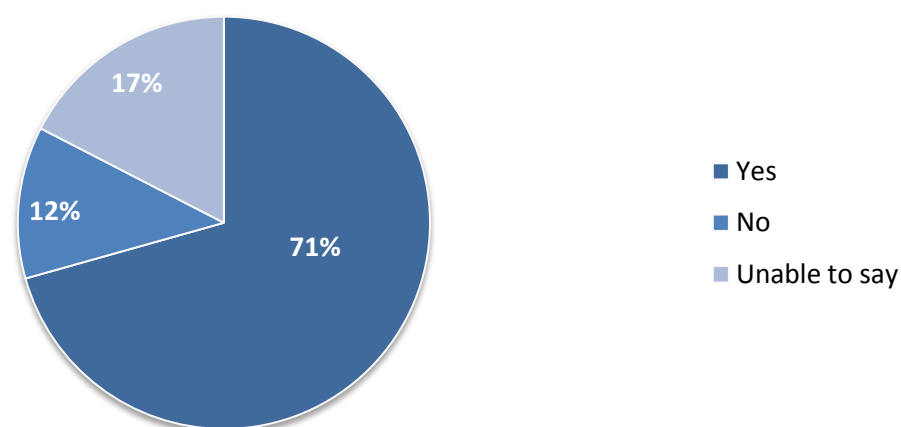
Promoting better public health effectively requires careful coordination between a variety of both statutory and non-statutory stakeholders. This chapter examines the different forms of stakeholder relationships that local authorities have already forged.

Partnership working with NHS commissioners

The Government's health reforms set out an important new role for local authorities in helping to join up public health services with the NHS, social care and other local services. As well as being given responsibility for the commissioning of public health services, local authorities are tasked with using local health and wellbeing boards to encourage integration between public health, the NHS and social care services.

Although most local authorities reported regular contact with NHS commissioners, over a quarter stated that they have had no communications with their local PCT or commissioning groups in the last year. This is clearly an issue that local health and wellbeing boards will need to address to ensure effective and joined-up working between the outgoing and incoming commissioning bodies. The area which has been the greatest focus for communication was substance misuse, including drugs and alcohol and it is encouraging to see that there is already some dialogue between local authorities and health service commissioners.

Figure 9: Percentage of local authorities which had communications with their PCT and/or commissioning groups on public health issues



Metropolitan district councils appear to have less well developed relationships with NHS commissioners on public health issues, with only 58% reporting communication with NHS bodies compared to 77% of unitary authorities. This is particularly concerning as metropolitan and urban areas often have greater problems with public health issues such as obesity and teenage pregnancy, which would benefit from greater co-operation between service providers.

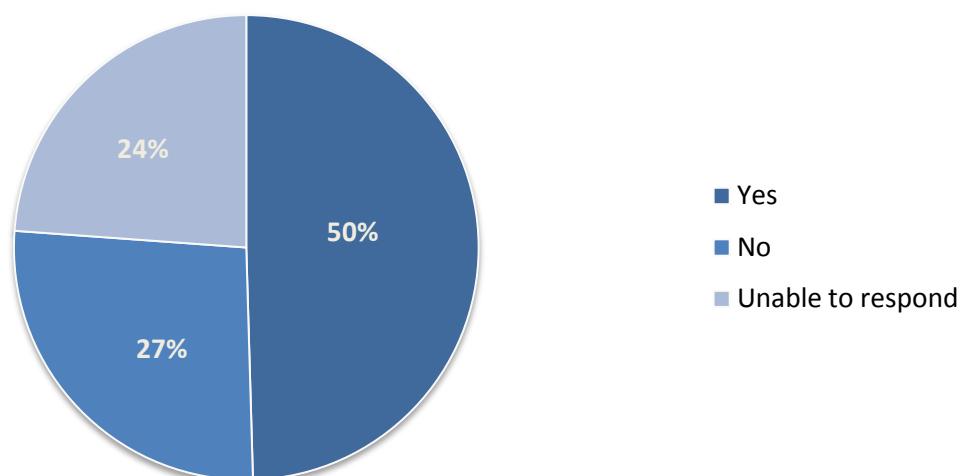
Much of the communication between local authorities and PCTs or commissioning groups appears to have arisen through formal mechanisms, for example through working groups, as the result of joint commissioning arrangements or through the sharing of a Director of Public Health. For example, Derbyshire County Council developed a local action plan based on the Young People's Sexual Health Needs Assessment in partnership with the local PCT⁴¹. Meanwhile, North Yorkshire Council sits on a number of working groups including a Substance Misuse Board, North Yorkshire and York Sexual Health Network and the local Risky Behaviour Strategy Group, through which it has regular dialogue with its PCT⁴². Some areas already have working groups in place across all areas of public health which will develop into health and wellbeing boards within the new health system. For example, Oldham Council responded that it engaged with the local PCT through a Joint Working Programme Board which considers public health issues and will become the basis of the local health and wellbeing board⁴³.

Tackling substance misuse, including drugs and alcohol, appears to be the area where there is currently most dialogue between local authorities and health commissioners. This is possibly explained by the fact that local authorities share joint statutory responsibility for reducing substance misuse under the Crime and Disorder Act 1998, in partnership with the police and fire authorities⁴⁴. Therefore, in most areas of the country the commissioning and performance management of drug and alcohol treatment services is undertaken by a Drug and Alcohol Action Team (DAAT) which is part of a Community Safety Partnership. For example, North East Lincolnshire Council reported that the DAAT organises a multi agency Joint Commissioning Group (JCG) which is 'hosted' by the local PCT, North East Lincolnshire Care Trust Plus (CTP), and manages a pooled treatment budget made up of contributions from national government, the local authority, PCT, police authority and probation service⁴⁵. Similar arrangements were described in other local authorities including Cornwall Council⁴⁶ and Derby City Council⁴⁷.

Partnership working between local authorities

Public health often requires coordination over larger geographical areas and this can also create opportunities for sharing good practice. Half of local authorities reported discussing public health issues with each other, as set out in Figure 10.

Figure 10: Percentage of local authorities which had discussed public health issues with other local authorities



Unitary authorities and metropolitan districts were much more likely to have spoken to other local authorities about public health issues, with 65% and 69% respectively having engaged in such dialogue. Meanwhile only 42% of upper tier councils and 47% of London boroughs had had conversations with other local authorities. This is particularly surprising in London where borough councils operate in close proximity to each other, serve very mobile populations and interact with other authorities such as PCTs which operate across the boundaries of London boroughs.

Of those local authorities which did report regular discussions with other local authorities, many stated that these took place through the membership of health and wellbeing partnerships, which form part of county level strategic partnerships. The first local strategic partnerships were established in 2000 to help prevent 'silo working', and focused on regeneration and renewal within the most deprived local authorities⁴⁸. Most areas of the country now have a strategic partnership in place and many also cover health and wellbeing. Other areas have partnerships or alliances on specific public health issues, for example, East Riding of Yorkshire Council reported being a member of the Humber Alliance on Tobacco⁴⁹ and Wigan Council participated in meetings of the Great Manchester Alcohol Commissioners Group⁵⁰.

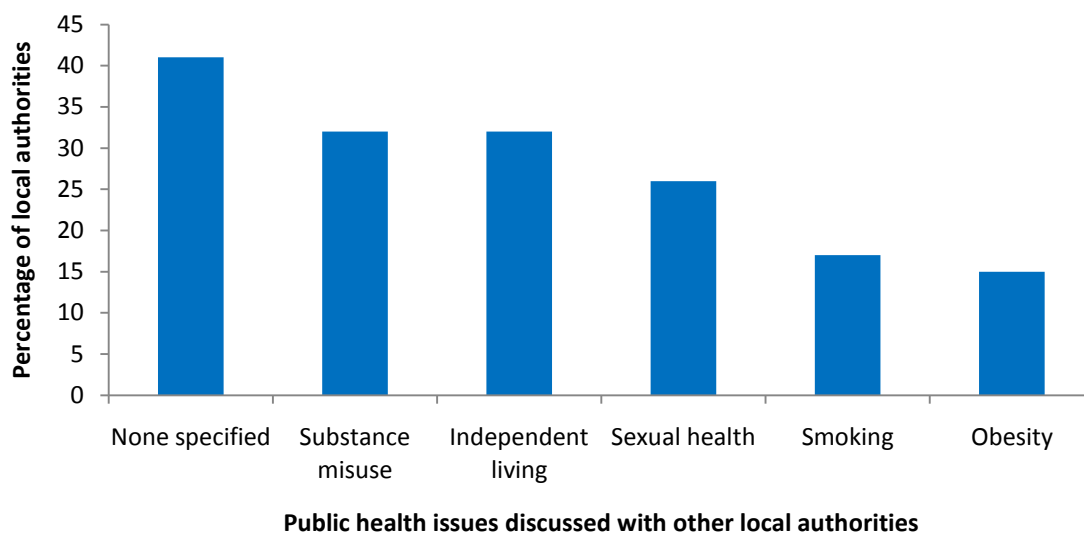
Conferences remain a key forum through which local authorities are able to share experiences of commissioning or providing public health services for obesity, smoking, substance misuse, sexual health and independent living. Organisations such as the Association of Directors of Adult Social Services (ADASS) and the Core Cities Group also play an important role in facilitating dialogue.

There are examples of joint commissioning and lead commissioner models being used by local authorities to commission public health services. For example, authorities in East Berkshire have formed a Joint Commissioning Board made up of PCT commissioners, directors of public health and directors of children's and adult social care from the three local authorities⁵¹. This group meets every six weeks and agrees areas of shared priority needs for joint strategic development, such as obesity services. Meanwhile, Swindon Borough Council reported acting as the lead commissioner in the region for sexual health, involving for example the development of a 'pan- region' service specification and contract for the commissioning of the Medi+Vend Kiosk service, which dispenses a range of products including condoms, and chlamydia and pregnancy test kits⁵².

There were also encouraging examples of local authorities asking for advice from others when commissioning public health services. Wigan Council reported that it examines the approach of other local authorities as a matter of course as and when it reviews a service⁵³. For example, when recently reviewing its approach to Community Equipment Services, officials visited Stockport Council to see the approach that had been taken there. Surrey County Council also mentioned that they asked for specialist advice from another local authority when agreeing their contract for HIV services with Surrey PCT⁵⁴.

An analysis of the issues discussed by those local authorities which did engage in dialogue with other local authorities about public health issues reveals that once again substance misuse was the most discussed issue, along with independent living, as set out in Figure 11. This is perhaps not surprising given that local authorities currently have statutory responsibility for the provision of services to tackle substance misuse and for the provision of social housing. It is, however, concerning that so few local authorities have shared learning on tackling obesity and smoking with other local authorities, given that these will become important areas of responsibility for local authorities under the proposed health reforms. Several responded that they had not discussed areas such as healthy weight, smoking or sexual health with local authorities because these were the responsibility of the local PCT. Given the transfer of responsibilities, this is a mindset which will need to change.

Figure 11: Public health issues discussed with other local authorities



Recommendation 4: Public Health England and the Local Government Association should establish mechanisms to encourage the sharing of good practice in public health commissioning between local authorities.

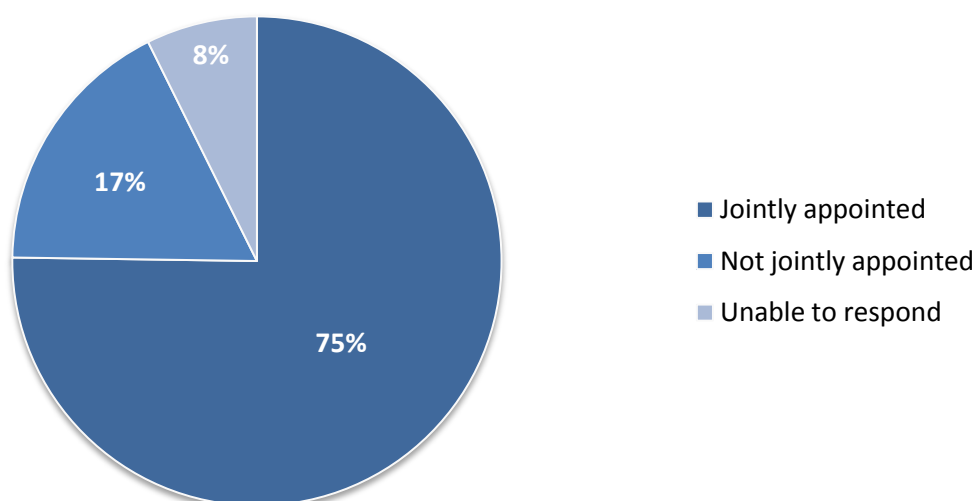
Recommendation 5: Local authorities should explore effective lead commissioning models and look to replicate these through their local health and wellbeing boards.

The role of joint directors of public health

In 2006 the Association of Directors of Public Health issued new guidance recommending that all new director of public health posts should be joint appointments between the NHS and local government where possible⁵⁵. The White Paper, *Our Health, Our Care, Our Say: A New Direction for Community Services*, also published in 2006, further championed the importance of joint appointments⁵⁶. Such guidance was a precursor to the proposal made by the Coalition Government that under the new system public health would be overseen by directors of public health within local authorities, helping to join up public health initiatives with other areas of local authority responsibility such as housing, policing, transport, children’s services and social care, as well as promoting joint working with NHS authorities through the health and wellbeing board⁵⁷.

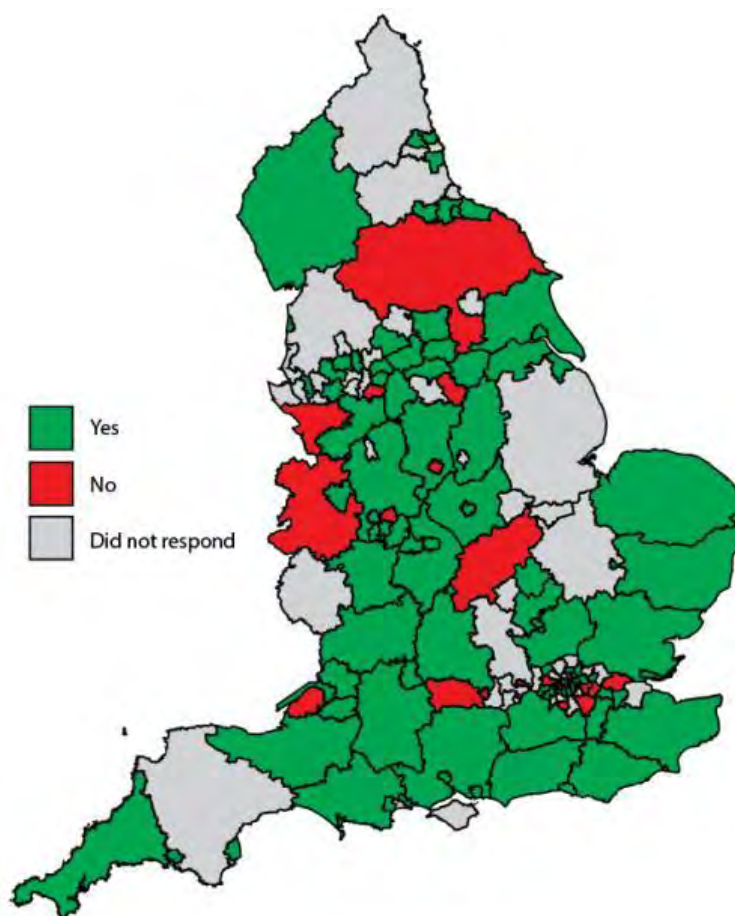
Of the 109 authorities who responded, 82 confirmed that they had jointly appointed a Director of Public Health with their PCT. This equates to just over 75% of respondents, as set out in Figure 12.

Figure 12: Number of jointly appointed directors of public health



Upper tier local authorities had the highest rate of jointly appointed directors of public health at over 83%, whilst London boroughs had the lowest at 68%. Meanwhile, 70% of unitary authorities and 80% of metropolitan boroughs had jointly appointed directors of public health. Figure 13 shows the location of local authorities with a joint director of public health.

Figure 13: Local authorities which have a jointly appointed director of public health



The earliest joint appointment of a Director of Public Health was in the London Borough of Barking and Dagenham in 1992⁵⁸. However the vast majority (84%) of posts were established after the Association of Directors of Public Health guidance was issued in 2006. Many local authorities were able to provide a job description for the director of public health role, responding that their local PCT held it.

Recommendation 6: Every local authority should develop a job description for the Director of Public Health role. This should be based on the Faculty of Public Health's model job description.

Contracts with external organisations

A range of organisations have always been involved in delivering public health services, including state organisations, charities and private sector companies. The Government's White Paper emphasises the need for more personalised and preventive public health services that are focused on delivering improved outcomes to citizens⁵⁹. Nearly two thirds (57%) of the local authorities who responded to the audit confirmed that they already had contracts in place with external organisations. Table 5 summarises the issues on which contracts with third parties are held.

Table 5: Local authority contracts with third parties to provide public health services

Policy area	Percentage of local authorities who hold contracts in this area with external parties
Substance misuse, including drugs and alcohol	84%
Independent living	39%
Healthy living, healthy eating and obesity	29%
Sexual health, including teenage pregnancy	29%
Smoking	2%

In some areas, such as substance misuse, local authorities already work with a number of commercial and voluntary sector organisations to provide services to the local population. However, in other areas where the PCT has traditionally taken the lead in commissioning services, such as smoking cessation, there are fewer examples of such contractual arrangements with third parties.

Table 6: Examples of the type of contracts local authorities hold with external organisations

Name of the local authority	Policy area	Name of the organisation
Medway Council, North Lincolnshire Council ⁶⁰	Obesity	MEND
North East Lincolnshire Council ⁶¹	Obesity	WeightWatchers
West Sussex County Council, Cornwall Council , Luton Borough Council, North East Lincolnshire Council ⁶²	Substance misuse	Addaction
Coventry City Council ⁶³	Smoking	Coventry and Warwickshire Partnership
Oxfordshire County Council, Nottinghamshire County Council ⁶⁴	Sexual health	Terrence Higgins Trust
Islington Council, Westminster Council, Slough Borough Council, Hounslow Council ⁶⁵	Substance misuse	Equinox
Slough Borough Council, Waltham Forest Council, Bury Council, Tameside Metropolitan Borough Council, Dorset County Council, Kent County Council, Bedford Council ⁶⁶	Substance misuse	Turning point
East Sussex County Council, Blackpool Council, Bristol City Council, Derby City Council ⁶⁷	Independent living	Anchor Trust
Blackpool Council, Bristol City Council, Luton Borough Council, Portsmouth City Council, Slough Borough Council, Shropshire Council, Coventry City Council ⁶⁸	Independent living	Age Concern

In any contractual arrangement it is important that processes are in place to ensure value for money, irrespective of who the provider of the service is. It is concerning that Norfolk County Council, who currently holds contracts with external organisations to provide public health services was unable to confirm that they had set any specific performance criteria to monitor the effectiveness of their contracts⁶⁹.

Recommendation 7: Local authorities should publish details of their contractual relationships with third parties in an open and transparent way. Local authorities should also ensure they have appropriate arrangements in place to enable effective performance management of contracts.

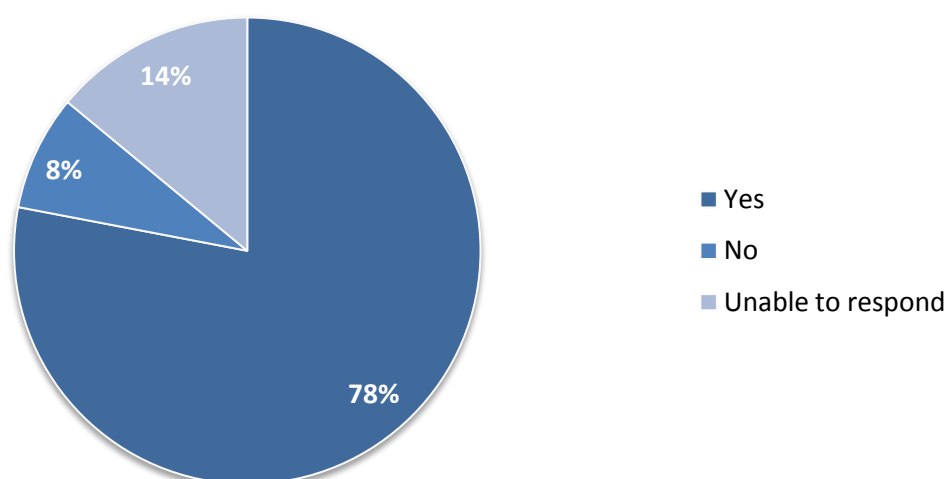
Chapter 6: Preparing for the new world

The reforms to health and social care will represent a significant increase in the powers and responsibilities of local authorities in relation to public health, as well as the overall integration of services. This chapter examines the current levels of preparedness of local authorities to assume these functions.

The role of PCTs in the transfer of public health responsibilities to local authorities

The majority of local authorities (78%) reported that they have received communications relating to their new responsibilities, as set out in Figure 14. Nine councils denied having received any communications. Of these, seven – Barnsley Council, Kent County Council, Southampton City Council, Hampshire County Council, Coventry City Council, Greenwich Council and Cheshire West and Chester Council – are listed as early implementers of health and wellbeing boards.

Figure 14: Percentage of local authorities which had communications about assuming public health responsibilities



Barnsley Council stated that its Director of Public Health had not received any communications from the Department of Health, the local PCT or SHA about assuming responsibility of public health “as this is dependent on the passing of the Health and Social Care Bill and its content and intention is still undergoing consultation and review”⁷⁰. This is contrary to the letter sent to all local councils in January 2011 from the Department of Health’s Director General for Social Care, Local Government and Care Partners, David Behan, inviting them to join “a network of early implementers” of health and wellbeing boards⁷¹.

However, a number of local authorities confirmed the establishment of working groups within the council to oversee the transition of public health responsibilities. Suffolk County Council also provided a timetable for the transition which had been agreed with the local PCT⁷².

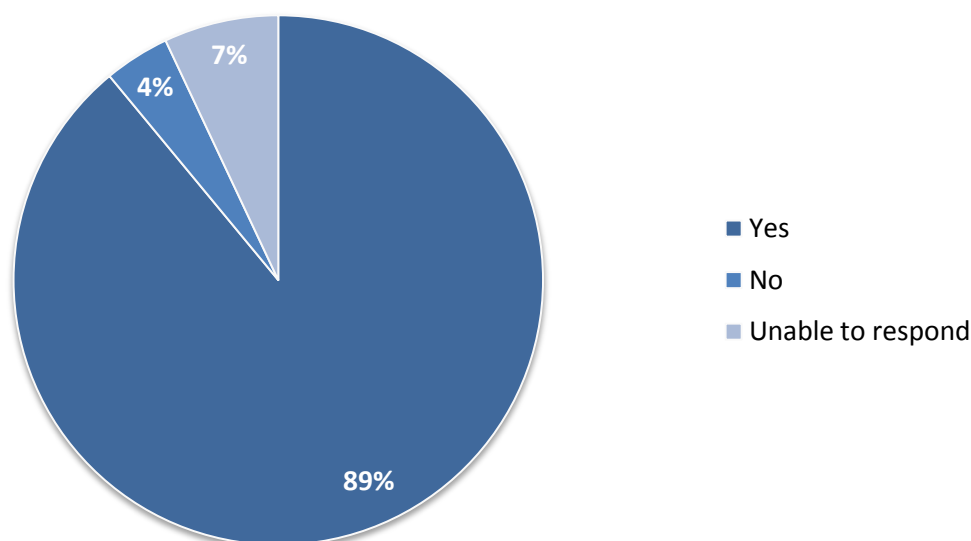
Recommendation 8: The Department of Health should reissue advice to local authorities about the transition. It would be good practice for all local authorities to publish a local transition timetable.

Establishment of local health and wellbeing boards

Local health and wellbeing boards will sit at the heart of the new public health, NHS and social care architecture. They will be responsible for maintaining oversight of local commissioning decisions, aided by their role in drawing up local JSNAs, joint health and wellbeing strategies and promoting integration between local NHS, public health and social care services.

Local authorities have responded to the proposed changes with enthusiasm and 134 have signed up to become 'early implementers' of health and wellbeing boards⁷³. These early implementers will begin working with the emerging clinical commissioning groups, testing new approaches to coordinating care and ensuring integration across public health, NHS and social care pathways. Figure 15 shows that the vast majority of local authorities have begun communications with the NHS about assuming these responsibilities.

Figure 15: Percentage of local authorities which had communications with their PCT, SHA and the Department of Health about the establishment of health and wellbeing boards



Notable exceptions included Cumbria County Council, Southampton City Council and Greenwich Council, which all denied having any communications about the establishment of a health and wellbeing board, despite all being early implementers themselves⁷⁴.

A number of local authorities were able to provide extensive details of communications they had had with local PCTs and regional SHAs about the establishment of their local health and wellbeing board. Somerset County Council, for example, confirmed the establishment of a Health Developments Steering Group which seeks to “respond to the emerging Government policy position for health and wellbeing services, and oversee the effective transition of commissioning, governance, service delivery and support arrangements to new structures”. Membership of the steering group includes representatives from the local PCT⁷⁵.

Slough Borough Council confirmed meetings with the Director of Public Health and PCT Chief Executive to discuss the implications of the proposals, including the establishment of a health and wellbeing board. The Council also confirmed meetings with the South Central SHA and the PCT's Director of Public Health to *"discuss the implementation plan and work streams for the public health transfer and new responsibilities of councils"*⁷⁶.

Brighton and Hove City Council also confirmed that, following the local council elections in May 2011, the Council had agreed not to become an early implementer. Instead, the Council has held consultative events on the future of public health based on the Government's White Paper⁷⁷.

Recommendation 9: Local authorities should publish updates on their progress in establishing local health and wellbeing boards.

The Department of Health has stated that it aims to have functioning shadow health and wellbeing boards in place in every top-tier local authority by April 2012⁷⁸. Despite this, over a third (37%) of local authorities who responded to the audit were unable to confirm that they had undertaken an assessment of their current preparedness. The response was varied, with some local authorities already well underway in terms of planning for the development of a board, or indeed stating that a shadow board was already in place. For example, Wigan Borough Council stated⁷⁹:

"A stakeholder event was held in March 2011 to engage with key partners from across the Borough and to introduce the background and vision for the new Board and seek their involvement from the outset. The first meeting of the new Board will be held on 13 May 2011."

Stockport Metropolitan Borough Council on the other hand did not believe it was necessary to undertake an assessment of developing a health and wellbeing board, despite being an early implementer, stating *"It is generally not the norm for Local Authorities to 'assess' DH guidance or the pending legislation to implement a statutory body"*⁸⁰.

Although 92% of respondents were able to provide the name of the responsible officer leading the development of the local health and wellbeing board, only 84% were able to provide details of the lead councillor involved. Within upper tier (two tier) councils the latter figure was significantly lower, with only 74% of respondents able to provide the name of a responsible councillor. A major purpose of local health and wellbeing boards is to increase the democratic legitimacy of health service commissioning and therefore it is concerning that not all local authorities have established a mechanism for ensuring democratic involvement in the design of their local process⁸¹.

It is important to note that a good deal has been left to local discretion in the way in which local health and wellbeing boards have been developed. This does, however, have resource and capacity implications for local authorities. Unsurprisingly, given the current pressure on council finances, only 3% of respondents identified a budget which is being used in this area, which ranged from £6,000 to £40,000. Many respondents stated that the resource being utilised to run engagement workshops and other preparatory activities was taken from within existing allocations.

The Department of Health has announced almost £1million in additional funding to support the development of health and wellbeing boards, in order to *"create a learning programme to develop solutions on key challenges around joint working between local government and the NHS; develop an interactive online forum, tools and events to show-case and share this learning; and support councillors working on Health and Wellbeing Boards"*⁸².

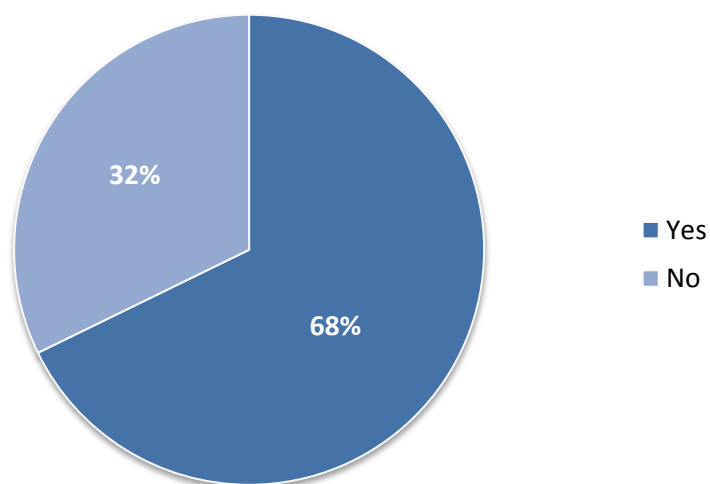
The funding is intended to enable the Department of Health, alongside partners such as the Local Government Association to work with early implementer areas, bringing together local partners from across the country to identify how councils, the NHS and local communities can best use the boards to make genuine improvements to the health and wellbeing of local communities.

Recommendation 10: As part of its learning network on local health and wellbeing boards, the Department of Health should identify examples of good practice which can be used as models by other local authorities. It should also create a capability assessment framework to enable the benchmarking of local authority preparedness.

Patient and public voice

A key principle underpinning the reforms is to encourage greater public and patient involvement in commissioning. A key duty for local authorities will be to commission local HealthWatch services, ensuring a strong patient voice⁸³. Local HealthWatch organisations will be the successor bodies to Local Involvement Networks (LINKs) and it would therefore be hoped that LINKs are closely involved as local authorities develop their health functions. However, as set out in Figure 16, only 68% of responding local authorities stated that they had been involved in communication with their LINK, and only 70% had been involved in communications with other stakeholders such as voluntary groups.

Figure 16: Percentage of local authorities which have had confirmed communication with LINK



Recommendation 11: Local authorities should take steps to involve LINKs in the development of local health responsibilities, including the development of the local health and wellbeing board.

Recommendation 12: In setting out the next steps for public and patient involvement in health through the development of HealthWatch England, the Department of Health should set out how local HealthWatch should be involved in local health and wellbeing boards.

Conclusion

Local authorities have a critical and underexplored role to play in the new public health, NHS and social care commissioning and delivery system. In addition to assuming responsibility for commissioning many public health services, they will have the power to coordinate local health delivery through the local health and wellbeing board. Although they will have no power of veto over the plans of clinical commissioning groups, the power to refer proposals to the NHS Commissioning Board could be a powerful lever for driving up quality.

Yet, much of this power is not automatically granted from the centre, either through legislation or through performance management. Instead it will come from the way in which local authorities choose to discharge their responsibilities. In many ways, the role will be what they make of it.

In this sense the extent of local authority preparedness for their new powers and responsibilities will be a critical determinant of the success of the new system. Local authorities are already involved in public health commissioning to varying degrees, and it is also clear that they have made varying levels of progress in preparing for their new role.

This report reveals that preparedness is uneven. Some local authorities have a sophisticated understanding of what effective public health commissioning entails, a long heritage in public health and well established systems of monitoring and control. Others do not. Some have made impressive strides in preparing to assume their new powers. Others have barely begun.

Anyone seeking to engage with, influence or secure contracts from the next generation of public health commissioners will have to understand this variation in capacity and approach. Equally, anyone who wishes to work with local health and wellbeing boards to improve the quality of integrated commissioning will need to understand that there will be significant local variations in the new landscape.

The process of transition has begun, but there is a lot of work to do before local authorities are ready for their new responsibilities.

References

- ¹ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ² Department of Health, *Healthy Lives, Healthy People: update and way forward*, July 2011
- ³ Department of Health, *Healthy Lives, Healthy People: update and way forward*, July 2011
- ⁴ MHP Health Mandate, *Commissioning in the New World: an analysis of the impact of prioritisation on quality, expenditure and outcomes in the health service*, September 2010
- ⁵ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ⁶ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ⁷ UK Parliament, *National Health Service Reorganisation Act 1973*
- ⁸ UK Parliament, *Crime and Disorder Act 1998, Health Act 1999, Criminal Justice and Policy Act 2001, and Crime and Security Act 2010*
- ⁹ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ¹⁰ McKee M et al, "Public health in England: an option for the way forward?", *The Lancet*, Vol 378, Issue 9790, 536-539, 6 August 2011
- ¹¹ Health Select Committee, *Public Health – corrected transcript of oral evidence*, 17 May 2011, to be published as 1048-i, <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/c1048-i/c104801.htm>, accessed on 19 August 2011
- ¹² Health Select Committee, *Public Health – corrected transcript of oral evidence*, 17 May 2011, to be published as 1048-i, <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/c1048-i/c104801.htm>, accessed on 19 August 2011
- ¹³ Department of Health, *Healthy Lives, Healthy People: update and way forward*, July 2011
- ¹⁴ Department of Health, *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*, December 2010
- ¹⁵ Department of Health, *Healthy Lives, Healthy People: update and way forward*, July 2011
- ¹⁶ Communication from Wiltshire Council, dated 19 April 2011
- ¹⁷ Communication from Portsmouth City Council, dated 9 May 2011
- ¹⁸ Communication from Stockton-on-Tees Council, dated 27 May 2011
- ¹⁹ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ²⁰ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ²¹ Communication from Halton Borough Council, dated 31 May 2011
- ²² Communication from Slough Borough Council, dated 16 May 2011
- ²³ Communication from Lincolnshire Council, dated 26 May 2011
- ²⁴ Local Government and Public Involvement in Health Act 2007, s5(116)(4)
- ²⁵ Department of Health, *Guidance on Joint Strategic Needs Assessment*, December 2007
- ²⁶ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ²⁷ Warwickshire County Council and NHS Warwick, *Warwickshire Joint Strategic Needs Assessment*, April 2009 [http://www.warwickshireobservatory.org/observatory/observatorywcc.nsf/0/9AB7B4E6C6CBF043802572CE003DB345/\\$file/JSNA%20Final%20Draft.pdf](http://www.warwickshireobservatory.org/observatory/observatorywcc.nsf/0/9AB7B4E6C6CBF043802572CE003DB345/$file/JSNA%20Final%20Draft.pdf), accessed on 19 August 2011
- ²⁸ Harrow Council and Harrow PCT, *Harrow's JSNA: A story of success, complexity and diversity*, November 2008 http://www.harrow.gov.uk/site/scripts/download_info.php?downloadID=1701&fileID=6044, accessed on 19 August 2011
- ²⁹ NHS Walsall and Walsall Council, *Joint Strategic Needs Assessment*, 2009 <http://www.walsall.gov.uk/observatoryindex/wpo-current-initiatives/wpo-jsna.htm>, accessed on 19 August 2011

-
- ³⁰ NHS Information Centre, *Statistics on NHS Stop Smoking Services: England, April 2010 – March 2011*, 16 August 2011, <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2010-march-2011>, accessed on 19 August 2011
- ³¹ Sheffield Director of Public Health Report, *Summary of Recommendations for Commissioning*, 2008 <http://www.publichealthsheffield2008.nhs.uk/recommendations/>, accessed on 19 August 2011
- ³² Doncaster PCT, *Joint Strategic Needs Assessment*, 2008 <http://www.doncasterpct.nhs.uk/documents/JSNA-DoncasterPCT.pdf>, accessed on 19 August 2011
- ³³ Hackney Council, City of London, NHS City and Hackney, *The health and wellbeing profile for Hackney and the City: our joint strategic needs assessment*, 2009, http://cityandhackney.org/Documents/JSNA_2009.pdf, accessed on 19 August 2011
- ³⁴ Southampton City Council and Southampton Primary Care Trust, *Southampton's Joint Strategic Needs Assessment for Health and Well-being 2008 to 2011*, July 2008, <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/jsna-final-report/>, accessed on 19 August 2011
- ³⁵ Sir David Nicholson, NHS Chief Executive, *Dear Colleague letter*, Gateway reference 16440, 12 August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129401.pdf, accessed on 19 August 2011
- ³⁶ Health Select Committee, *Public Health – corrected transcript of oral evidence*, 19 July 2011, to be published as 1048-v, <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/c1048-v/c104801.htm>, accessed on 19 August 2011
- ³⁷ Sally Gainsbury, "What price public health?", *Health Service Journal*, 21 July 2011, <http://www.hsj.co.uk/comment/opinion/sally-gainsbury-what-price-public-health/5032707.article>, accessed on 19 August 2011
- ³⁸ Sir David Nicholson, NHS Chief Executive, *Dear Colleague letter*, Gateway reference 16440, 12 August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129401.pdf, accessed on 19 August 2011
- ³⁹ Department of Health, *2009-10 Programme Budgeting reference cost based PCT benchmarking workbook v1.00*, January 2011, http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_1, accessed on 19 August 2011
- ⁴⁰ The local authorities were Essex County Council, Wolverhampton City Council, Worcestershire County Council, Medway Council, Wiltshire Council, London Borough of Bromley, Wigan Council and Sunderland City Council
- ⁴¹ Communication from Derbyshire County Council, dated 20 May 2011
- ⁴² Communication from North Yorkshire County Council, dated 13 May 2011
- ⁴³ Communication from Oldham Council dated, 24 June 2011
- ⁴⁴ UK Parliament, *Crime and Disorder Act 1998, Section 17*
- ⁴⁵ Communication from North East Lincolnshire Council, dated 10 May 2011
- ⁴⁶ Communication from Cornwall Council, dated 18 May 2011
- ⁴⁷ Communication from Derby City Council, dated 12 May 2011
- ⁴⁸ Department for Communities and Local Government, *Impacts and Outcomes of the Neighbourhood Renewal Fund*, November 2008
- ⁴⁹ Communication from East Riding of Yorkshire Council, dated 25 May 2011
- ⁵⁰ Communication from Wigan Council, dated 4 May 2011
- ⁵¹ Communication from Slough Borough Council, dated 16 May 2011
- ⁵² Communication from Swindon Borough Council, dated 26 May 2011
- ⁵³ Communication from Wigan Council, dated 4 May 2011
- ⁵⁴ Communication from Surrey County Council, dated 13 May 2011
- ⁵⁵ The Association of Directors of Public Health (ADPH), *Public Health: Fully engaged, Directors of Public Health jointly appointed across local authorities and the health sector*, July 2006, http://www.adph.org.uk/files/ourwork/dphrole/adsph_joint_appointments_guidance.pdf, accessed on 19 August 2011
- ⁵⁶ Department of Health, *Our health, our care, our say: a new direction for community services*, 30 January 2006 http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453, accessed on 19 August 2011

-
- ⁵⁷ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ⁵⁸ Communication from London Borough of Barking and Dagenham, dated 4 July 2011
- ⁵⁹ Department of Health, *Healthy Lives, Healthy People: Our Strategy for public health in England*, November 2010
- ⁶⁰ Communication from Medway Council, dated 8 June 2011 and communication from North Lincolnshire Council, dated 26 May 2011
- ⁶¹ Communication from North East Lincolnshire Council, dated 10 May 2011
- ⁶² Communication from West Sussex County Council dated 21 June 2011, communication from Cornwall Council, dated 18 May 2011, communication from Luton Borough Council, dated 8 June 2011 and communication from North East Lincolnshire Council, dated 10 May 2011
- ⁶³ Communication from Coventry City Council, dated 7 June 2011
- ⁶⁴ Communication from Oxfordshire County Council, dated 17 May 2011 and communication from Nottinghamshire County Council, dated 5 July 2011
- ⁶⁵ Communication from Islington Council, dated 19 May 2011, communication from Westminster Council, dated 24 May 2011, communication from Slough Borough Council, dated 16 May 2011 and communication from Hounslow Council, dated 3 June 2011
- ⁶⁶ Communication from Slough Borough Council, dated 16 May 2011, communication from Waltham Forest Council, dated 13 May 2011, communication from Bury Council, dated 24 May 2011, communication from Tameside Metropolitan Borough Council, dated 3 June 2011, communication from Dorset County Council, dated 17 May 2011, communication from Kent County Council, dated 13 May 2011 and communication from Bedford Council, dated 3 June 2011
- ⁶⁷ Communication from East Sussex County Council, dated 12 May 2011, communication from Blackpool Council, dated 10 May 2011, communication from Bristol City Council, dated 9 May 2011 and communication from Derby City Council, dated 12 May 2011
- ⁶⁸ Communication from Blackpool Council dated 10 May 2011, communication from Bristol City Council, dated 9 May 2011, communication from Luton Borough Council, dated 8 June 2011, communication from Portsmouth City Council, dated 9 May 2011, communication from Slough Borough Council, dated 16 May 2011, communication from Shropshire Council, dated 11 May 2011 and communication from Coventry City Council, dated 7 June 2011
- ⁶⁹ Communication from Norfolk County Council, dated 12 April 2011
- ⁷⁰ Communication from Barnsley Council, dated 17 July 2011
- ⁷¹ David Behan CBE, *Invitation to be an early implementer for health and wellbeing boards*, 27 January 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123863.pdf, accessed on 19 August 2011
- ⁷² Communication from Suffolk County Council, dated 20 April 2011
- ⁷³ Department of Health, *More cohesive care promised as councils back Health and Wellbeing Boards*, 16 March 2011, http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_125156, accessed on 19 August 2011
- ⁷⁴ Communication from Cumbria County Council, dated 7 June 2011, communication from Southampton City Council, dated 13 May 2011 and communication from Greenwich Council, dated 12 May 2011
- ⁷⁵ Communication from Somerset County Council, dated 21 June 2011
- ⁷⁶ Communication from Slough Borough Council, dated 16 May 2011
- ⁷⁷ Communication from Brighton and Hove City Council, dated 8 June 2011
- ⁷⁸ David Behan CBE, *Invitation to be an early implementer for health and wellbeing boards*, 27 January 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123863.pdf, accessed on 19 August 2011
- ⁷⁹ Communication from Wigan Borough Council, dated 4 May 2011
- ⁸⁰ Communication from Stockport Metropolitan Borough Council, dated 17 May 2011
- ⁸¹ Department of Health, *Equity and excellence: Liberating the NHS*, 12 July 2011
- ⁸² Department of Health, *£1 million boost for health and wellbeing boards*, 30 June 2011, http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_127967, accessed on 19 August 2011
- ⁸³ Department of Health, *Equity and excellence: Liberating the NHS*, 12 July 2011



Health Mandate

**In health, evidence is everything.
And the evidence for MHP Health
Mandate is overwhelming.**

**If you would like to find out more,
please get in touch.**

publichealth@mhpc.com

**MHP Health Mandate
60 Great Portland Street
London
W1W 7RT**

T: 44 (0)20 3128 8100

F: 44 (0)20 3128 8171

www.mhpc.com/health

MHP is part of Engine

©MHP September 2011