DH Department of Health

Healthy Lives, Healthy People

Summary of responses to the consultations on our strategy for public health in England

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Healthy Lives, Healthy People

Summary of responses to the consultations on our strategy for public health in England

Prepared by the Public Health Development Unit

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1. Introduction

1.1 The public's health is the Government's priority. Sustaining growth and wellbeing depend on good health. On 30 November 2010, the Government published *Healthy lives, Healthy people: our strategy for public health in England*, which set out a bold vision to make wellness central to all we do – in health and across government.

1.2 Too many people die too young, spending too long suffering from preventable ill-health, and the gap between rich and poor is not improving. In the past, too little focus, too much central prescription, lack of clarity over our aims, and uncertain funding have all got in the way of making progress.

1.3 We need a new approach to fighting health inequalities, rooted in local communities and with the wider determinants of health – economic status, education opportunity, employment, housing and environment – integral to our efforts. Through the White Paper, we responded to the challenges set out in Professor Sir Michael Marmot's powerful *Fair Society, Healthy Lives* report[1].

1.4 The Government's vision for an improved public health system is focused on tackling health inequalities and the causes of ill health, helping all the people of England to enjoy longer, healthier lives. The fundamental principles of the approach are:

- empowering individuals and communities to address their own needs, giving them the tools and support to help them do so effectively
- A locally driven system, with Directors of Public Health in local authorities, influencing and driving action in partnership with local partners across the full range of services and issues, which impact on, and determine, health and well being in local populations.

1.5 Alongside the *Healthy lives, Healthy people* strategy document, we published associated consultation documents, which provided more detail on the funding and commissioning routes for public health services, and proposed how we might create a public health outcomes framework. We also asked for views on Dr. Gabriel Scally's report on the

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[1] Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, www.marmotreview.org

regulation of public health professionals. The associated documents were entitled:

a. Dr. Gabriel Scally's *Review of the Regulation of Public Health Professionals*
b. *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*
c. *Healthy Lives, Healthy People: Transparency in Outcomes, proposals for a public health outcomes framework*.

1.6 This publication is a summary of the responses we have received to the questions raised in the White Paper and associated consultation documents. Whilst its focus is on the responses to the specific questions, this summary includes also responses raised on wider issues. These are captured largely in chapter 2. We have published alongside this our policy statement, *Healthy Lives, Healthy People: Update and way forward,* which sets out the details of our plans for public health in light of the consultation, next steps towards developing policy, and a timetable for implementing our proposals and which is available on line at www.dh.gsi.gov.uk. The consultation responses will continue to inform our work as we develop our plans further.

Consultation process

1.7 We wanted to ensure that we engaged extensively on our proposals for public health and involved as wide an audience as possible. Therefore, the consultation was carried out at both the national and local level involving the public health sector, NHS organisations, local government, third sector organisations and patient representative groups. Summaries of *Healthy lives, Healthy people* were made available in accessible formats, including plain English, easy-read, alternative languages, large print and braille. Alongside this, we provided materials summarising the proposals for national stakeholders to use in running their own national and local consultation events. One such example is Regional Voices, which ran a series of events for patient representative groups, the voluntary sector and community organisations.

1.8 The Department of Health was directly involved in over 60 consultation events, with groups including the Department's Social Partnership Forum, the National Stakeholder Forum, Directors of Public Health, Local Government Group, the Public Health Taskforce, British Medical Association, Faculty of Public Health and other key partners. Regional Directors of Public Health and their teams led on engagement with local stakeholders – involving local Directors of Public Health (DsPH), and

members and senior officials in local councils. We sought to ensure that engagement and consultation events took place at the most appropriate level, were responsive to local circumstances and as far as possible worked to existing geographical footprints.

1.9 We have had feedback from stakeholders that the localised approach combined with key national events did mean that key partners felt more fully engaged than ever before.

1.10 We received over 2000 responses to the consultation documents, either in returns to the online consultation platform, by email to the public health mailbox, or by post. Many included responses to each of the documents. We received responses from a wide spectrum of individuals and organisations, including patients and the public, clinicians and NHS organisations, local authorities, pharmacists, independent providers of health care and services, professional bodies including Royal Colleges, and trade unions. A list of organisations from which we received responses, either on behalf of the organisation or from people working within it, is published alongside this document.

The wider context: The Health and Social Care Bill and the NHS Future Forum

1.11 The consultation on *Healthy Lives, Healthy People* took place during initial passage of the Health and Social Care Bill 2011 through the House of Commons. The Bill sets out the basic architecture of a reformed public health system by conferring new duties and powers on the Secretary of State and on local government. Many of the most important aspects of the system can be designed and delivered within the legal framework as it stands - for example, Public Health England can be established, public health outcomes defined and funding allocated to local authorities without changing the law in any way. This means that the Bill does not include every detail of the new public health system.

1.12 As part of the Bill's passage through the Houses of Parliament, the Government held a listening exercise on its plans for health care in England. The NHS Future Forum reported in early June and the Government accepted its core recommendations. Subsequently, the amended Health and Social Care Bill has resumed its passage through Parliament.

Broad summary of themes raised in consultation

1.13 Overall, there were clear endorsements from many organisations and individuals, as well as from views expressed at the consultation events, welcoming the recognition of the importance of public health, and the direction of travel. Key professional organisations, such as the NHS Confederation, the Health Protection Agency (HPA), the Royal College of General Practitioners, and the Local Government Group were broadly supportive of the vision set out in the public health white paper. Indeed, the Local Government Group reported that, *"134 of the 150 first-tier authorities have expressed an interest in joining the group of Health and Wellbeing Board 'early implementers'. This is a clear indication of the strong support from local government to be at the forefront of translating aspirations into action."*

1.14 The Institute for Health Promotion and Education said, *"The creation of Public Health England and the imminent transfer of PCT responsibilities for local health improvement to local authorities offer an opportunity to increase the quality and quantity of health improvement activity."*

1.15 There was support for incorporating the functions of the Health Protection Agency (HPA) into Public Health England. The HPA said this, "*will strengthen the new organisation and allow it to deliver, from the start, high-quality health protection services at local, national and international level*."

1.16 However, there were issues raised about lack of clarity over roles and responsibilities, including those for managing health protection incidents and emergency preparedness, resilience and response. The Local Government Group commented the relationship between health organisations has often been unclear in the past, with both gaps and duplication, *"We urge the Government to consider how national and local roles can be defined and coordinated."* The HPA raised wider issues also, including about Independence and identity, external income, and the importance of integrated research.

1.17 The Outcomes Framework received broad support in terms of the overall purpose, criteria and domains of the Outcomes Framework. We have received several campaigns proposing the inclusion of particular indicators, notably breastfeeding and sexual health indicators. A summary of consultation responses on Public Health Outcomes is in chapter 2.

1.18 Our proposals for commissioning routes also received many responses. There were some concerns that responsibility for commissioning whole programmes, or pathways of care, would be split across the system, with local authorities responsible for commissioning some public health services and the NHS responsible for others. Some respondents underlined that the division of responsibilities between commissioners would need to be clear. For a summary of consultation responses on commissioning routes please see chapter 3.

1.19 On funding for public health, *Healthy Lives, Healthy People* set out the Government's plan for a public health ring-fenced budget. Although the Local Government Group was opposed to ring-fencing the public health grant, there was wide support for the ring fence from most other stakeholders. In particular, others were concerned local government would use the public health grant in order to fund their current responsibilities. A group of sexual health commissioners from Yorkshire and the Humber commented, *"We are concerned that under the banner of localism, local authorities may not retain ring-fenced public health budgets"*.

1.20 Uncertainty about the size of the public health grant to local authorities and how the health premium will work were a source of anxiety for many stakeholders. For example, the Local Government Group requested to know details of the budget as soon as possible, and commented they were anxious about the number of unanswered questions about the health premium. A summary of consultation responses on public health funding is included in chapters 3 and 4.

1.21 On the diverse provider market, overall respondents were positive about widening the range of providers to enable diversity and effectiveness of local provision which could generate quality and innovation of services and provide service users choice and control over their care. The Voluntary, Community and Social Enterprise (VCSE) sector was of particular interest for the majority of respondents. Whilst respondents welcomed the use of VCSEs as providers of services and recognised their expertise and knowledge of their local area, they raised a number of concerns about their ability to compete in a competitive market place. This was felt particularly in the face of the public sector funding challenges and general financial constraints that may weaken the VCSE sector further and make it more difficult for them to compete against other sectors. Many argued that local authorities needed to provide financial support, access to business and development and tendering support to enable the VCSEs to compete for future service provision of

health and wellbeing services. A summary of consultation responses on the diverse provider market is in chapter 4.

1.22 On the role of GPs and the role of the NHS, there was widespread recognition of the critical role of GPs and general practices in improving public health. A number of respondents highlighted that GPs are also in an ideal position to tackle health inequalities by systematically monitoring patients to encourage a greater focus on prevention. A summary of responses on this issue is provided in chapter 5.

1.23 On Information and Intelligence, there was broad support among a range of stakeholders for our proposal that Public Health England might play a role in drawing together existing sources of public health evidence and making it more easily available to all through a single, accessible and authoritative web-based evidence system. Respondents were keen to see better signposting of existing information on public health as well as opportunities to share learning across different localities. Respondents were keen to see such a web portal signposting information clearly, providing accessible summaries and drawing out key messages for public health commissioning.

1.24 We also received many useful suggestions as to how Public Health England could address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities. In general respondents identified the following key gaps:

- Cost-effectiveness of public health interventions
- Mental health
- Children and young people
- Behaviour change science

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1.25 There was also general support for the proposal of partnership-working on information and intelligence across services in relation to public health. For a summary of consultation responses on information and intelligence please see chapter 2.

1.26 In response to the question in Dr Gabriel Scally's report on the regulation of public health professionals, there was generally more support for statutory regulation rather than voluntary, but no consensus on the best organisation to provide this. A summary of consultation responses on this issue is set out in chapter 7.

1.27 Many equalities groups, including Mencap, Men's Health Form, Zacchaeus Trust, Age UK, Catch 22, and Stonewall endorsed the vision of the White Paper, the focus on The Marmot Review and the wider determinants of health. For example, Afiya Trust and Rota commented, *"We welcome the Coalition Government's strategy for public health, Healthy Lives, Healthy People. We particularly welcome the attention paid to taking a life course approach to public health, the focus on social determinants of health inequalities, and the linkages made between health, wellbeing and mental health. The idea that local communities have a key role to play in determining the agenda for and ways of promoting public health is in line with the argument we have consistently made that local knowledge needs to be at the heart of policy development and practice".* Nevertheless, some respondents felt that the White Paper overlooked Marmot's focus on minimum incomes for healthy living. Equalities responses are summarised in chapter 8.

1.28 As mentioned above (paragraph 1.6) a range of additional or cross-cutting issues was raised which will inform our work to create a robust public health system. These Include:

- the future status of the Health Protection Agency;
- fragmentation of the wider public health system;
- public health advice to NHS Commissioning;
- responding to health protection incidents and emergencies; and
- risks to the system through the transitional period.

These responses are incorporated into chapter 2.

2. A robust public health system to improve public health outcomes

2.1 *Healthy Lives, Healthy People* set out a vision for a new approach to public health, supported by an improved system and structure. Many respondents made general points about these plans, which we detail in the second half of this chapter. We start, however, with the focus on outcomes.

2.2 In *Healthy Lives, Healthy People: Transparency in Outcomes*, we proposed that we should establish a public health outcomes framework taking a life-course approach. This outcomes framework will have three purposes:

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

2.3 The consultation responses were broadly supportive of the proposed overall purpose, criteria and domains of the Outcomes Framework. Key points were made in relation to:

- the integration and alignment between the public health, NHS and adult social care outcomes frameworks;
- the focus on health inequalities;
- the life-course approach (including the emphasis on child and maternal health measures); and
- the relationship between local authorities (and Directors of Public Health) with Public Health England and their respective roles in improving outcomes for public health.

2.4 For example, on the issue of alignment, the British Dental Association said, *"We welcome the recognition that close alignment between these*

frameworks is essential to prevent fragmentation of care systems, and that there must be input from all three frameworks into the JSNA."

2.5 On health inequalities, Breast Cancer Care said, "*We were pleased to see the White Paper make a commitment to reducing the inequalities that currently exist in public health*." An individual respondent said "*I support the ambition to improve public health and reduce health inequalities. I am pleased that the key findings of the Marmot Review, Fair Society, Healthy Lives are being adopted.."*

2.6 On the life-course approach issue, Oxford City Council said, *"The indicators provide a good reflection on the life course approach to public health."* North Warwickshire Borough Council said, "Those indicators identified above include people at all life stages and, therefore, should ensure that a whole-life approach is adopted."

2.7 Finally, on respective roles, Stockton on Tees Health and Wellbeing Partnership Board said, *"The connectivity of all partners in addressing the public health outcomes is important."*

2.8 There were contributions also on the range and scope of indicators proposed within each of the five domains, including some proposals for new and additional indicators. Please see Annex A for further information on the five domains and details of specific suggestions for indicators and improvements.

How well do the indicators promote a life-course approach to public health?

2.9 The majority of respondents clearly believed the chosen indicators broadly reflected a life course approach. A typical response came from North Warwickshire Borough Council, which said "*Those indicators identified above include people at all life stages and, therefore, should ensure that a whole-life approach is adopted."* A number of respondents urged closer alignment to themes from 'the Marmot Review' and in particular a stronger emphasis on the early years and young people.

2.10 Four themes emerged in relation to this question:

- more emphasis on indicators of wellbeing in very young children
- more emphasis on indicators of wellbeing in the elderly

- the importance of developing measures of population physical activity in both the young and in elders.
- a stronger emphasis on mental health, including maternal mental health.

2.11 There was concern that because key indicators life stage indicators are distributed throughout the five domains, the balance between life course indicators and other indicators was sometimes lost.

Do you agree with the overall framework and domains?

2.12 There was overwhelming support for the publication of an outcomes framework for public health that was broad in its scope across the whole range of public health. On the whole there was also support for the five domains for public health, although some public health stakeholders pointed out the potential for confusion with the *three pillars (sometimes called the domains) of public health*[2]. A number of respondents also felt that the rationale for dividing Domains 3 and 4 as an artificial and unhelpful split. On this point the Faculty of Public Health (FPH) said, "*For example, the distinction between 'Domain 3 (Health improvement)' and 'Domain 4 (Prevention of ill health)' seems unnecessarily artificial, particularly as there is some overlap between the two: non-accidental injury (NAI) in children aged 5-18 year olds appears in Domain 3, whilst NAI in the under 5s is placed in Domain 4".*

2.13 There was recognition that the five domains recognised the journey of people's health from the causes of ill health (in Domain 2), right through to the long term impacts of poor public health resulting in premature mortality (in Domain 5).

2.14 Many respondents believed that equality considerations should be at the heart of each domain and recommended that public consultation on indicators be carried out from the very beginning of the development of the indicator set to ensure that equality issues can be measured appropriately in the final set.

[2] The three pillars are health improvement, health protection and population healthcare, or healthcare public health.

2.15 The vast majority of responders were pleased that DH had proposed indicators that were not seen traditionally as 'health' measures, and welcomed the increased focus on the wider determinants of health. For example, Cambridgeshire County Council "*agree[s] with the overall framework and domains and find the way they are presented helpful and logical. We welcome the focus on the wider determinants of health and health inequalities*." Others partly agreed, for example, St Mungo's said "*Yes, however, we would like to see greater concentration of addressing the needs of the most deprived and those experiencing the worse health inequalities*." Gateshead council said, "*Yes, we support the concept, although integrated outcomes frameworks would be preferable*."

2.16 However, NHS Wiltshire disagreed, "*No. It is widely accepted by public health practitioners that their work falls in to 3 domains. We see no reason why these domains should be further subdivided in the way that has been done for this new outcomes framework. We are concerned that within the 5 domains proposed there is too much focus on the health improvement aspects of public health, to the detriment of other areas in particular improving healthcare services*."

Indicators for public health

2.17 We asked specific questions about public health indicators. How should we select them? Are there ones we should omit or include? Should we incentivise any, and if so, which ones and by which criteria? The responses on these detailed issues are summarised in Annex A and will help to inform the further development of the Public Health Outcomes Framework.

How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

2.18 We proposed that whatever the outcomes framework includes, an essential principle for public health is joint and partnership working. We want to make sure the final framework enables and encourages partnership working, and does not hinder it.

2.19 The following themes emerged in the responses:

- there should be shared indicators across the public health, NHS and adult social care outcomes frameworks reflecting those priorities that all parts of the system have a shared responsibility to achieve.;
- the need for clarity on responsibility and accountability; and
- the need for a much stronger emphasis on outcomes for children and young people – both to respond more fully to the Marmot Review recommendations on early years, and also to ensure the current lack of a children's outcomes framework should not be a barrier to focusing on outcomes for them.

Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

2.20 There was an overwhelming view that there needed to be greater integration between the public health, NHS and adult social care outcome frameworks, including perhaps a single framework for health and well-being with the local health and wellbeing boards leading a joined up approach. Citizen's Advice said, "*We believe that the future direction of travel is a single outcomes framework that reflects overlapping needs and responsibilities across the three sectors to support integrated working and an overlapping of needs and responsibilities..".* NHS Hertfordshire stated that "*We believe the most effective delivery of the three sets of outcomes (NHS, Public Health, And Social Care) requires integration both nationally, and also locally…"*

2.21 In addition, some responders – mainly those interested in child health issues – wanted to see the introduction of a children's outcomes framework.

2.22 There was interest in the way that the domains took a 'cause to care' approach to achieving improvements in people's health and wellbeing. For example, some respondents welcomed the potential for the outcomes framework to demonstrate the impact of wider determinants, such as fuel poverty, on high-level indicators of premature mortality and excess seasonal mortality. Some respondents saw an opportunity to relate these measures to indicators within the NHS or Adult Social Care Outcomes Frameworks.

What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

2.23 All respondents who felt able to comment on this proposal agreed with our idea to align the public health and NHS outcomes framework by sharing a specific domain on preventable mortality. Respondents pointed out that preventable mortality was an outcome of the whole health system rather than local authorities' responsibility alone.

2.24 This shared domain was seen as essential to:

- co-ordinate preventive activity for public health across sectors
- ensure that NHS services supported preventative action
- engage the wider NHS in prevention.

2.25 A number of respondents such as Wolverhampton City Council and PCT raised the issue of accountability for shared indicators or domains, including the need for clarity over responsibility and how this would relate to democratic accountability.

2.26 Respondents were clear on the need to adopt a longer time scale in the approach to and influence on mortality. For example, Cancer Research UK said. "*Whilst we appreciate the greater impact achieved by a focus on mortality, many chronic conditions such as cancer have a long lag time between successful prevention interventions and any measurable changes in mortality.*"

How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

2.27 The focus on wider determinants (in Domain 2) was seen as a positive step forward on health inequalities and as the most effective way to respond to Professor Sir Michael Marmot's recommendations in *Fair Society, Healthy Lives*. There was support for the intention to provide analysis of each of the measures within the outcomes framework by geographical and social deprivation, although there was recognition that for many indicators this would be difficult to do without further development on data availability and

analysis. Respondents recognised that disaggregating data by equalities characteristics for all of the proposed indicators would be very challenging.

2.28 There was a suggestion that the Public Health Outcomes Framework should adopt the indicators developed by London Health Observatory and Marmot Review Team, which demonstrate the extent of inequality at Local Authority level. Others also suggested that the OECD (Organisation for Economic Cooperation and Development) could be explored as a source of information for calculating the health premium. Some respondents recommended the inclusion of inequality dimensions such as ethnicity, age, gender and disability.

2.29 Groups such as the Afiya Trust, Race on the Agenda (ROTA), Mencap and others suggest that the final framework needed to make clear to local authorities, the NHS and wider public services that they had clear duties under the Equality Act to ensure that outcomes are improved for all.

2.30 Key additional concerns raised were:

- the White Paper overlooked the Marmot Review's focus on minimum incomes for healthy living;
- the potentially detrimental impact of local government cuts, with services under the greatest risk being those that best support the needs of the most deprived;

A robust new system - general issues

2.31 Beyond the questions we posed in the consultation exercises respondents raised a number of additional concerns, the most important of which we discuss below. Whilst supporting the aim of creating an enhanced new public health system at national and local level, respondents highlighted the risks they perceived to achieving this vision. These risks included a lack of independence at national and local level; the possibility that public health staff would not be appropriately qualified; and a lack of clarity around roles and responsibilities, in particular for outbreaks and emergencies. Each of these concerns features strongly in the policy statement *Healthy Lives, Healthy People: Update and way forward,* which we published on 14 July 2011, and we will continue to take these issues into account as we further develop and implement our new public health system.

Public Health England (PHE)

2.32 At the national level, a number of respondents were concerned that bringing the functions of the Health Protection Agency (HPA) into a central government department would threaten the ability of public health professionals to give authoritative independent scientific advice. Thus, the HPA argued that PHE should have a *"strong separate identity as an expert body"* and that there should be *"proper arrangements to safeguard the independence of its staff in providing expert scientific and public health advice at local, national and international levels."*

2.33 The Faculty of Public Health argued that PHE "*should be established either within the NHS as a special health authority or, if that is not accepted, as an executive agency of the Department of Health, employing the existing public health specialist workforce currently working within primary care trusts (PCTs) and strategic health authorities (SHAs).*" PHE would provide support to the local public health system through PHE teams seconded to work with DPHs in local authorities and NHS commissioning through local agreements.

The Local Public Health System

2.34 With regard to the local public health system, the Faculty of Public Health commented: *"in order to influence effectively throughout the local authority, the DPH [Director of Public Health] must be appointed at corporate or strategic director level (accountable directly to the local authority chief executive) and have direct access to the authority's cabinet, councillors, CEO and executive directors."* The Faculty argued that the DPH must have the skills to do the job effectively. They said, *"the need for training and registration at specialist level in public health must be made explicit and a requirement by primary or secondary legislation . . . a statutory appointments process, along similar lines to the Advisory Appointments Committee process currently used for all DPH and other consultant/specialist appointments in the NHS, must be implemented by all organisations employing public health specialists at this level."*

2.35 Accordingly the Faculty recommended that the DPH:

- *"Provide strategic leadership for all three domains of public health at local level*
- *Be trained and registered to specialist level in public health.*

- *Be required to produce an independent, public annual report on the health and health needs of their population.*
- *Be a statutory member of the Health and Wellbeing Board.*
- *Be directly accountable to the local authority CEO and have direct access to the authority's cabinet and councillors.*
- *Have responsibility for managing the ring-fenced public health budget and public health staff, which should be appropriate and adequate to support them in delivering the health and wellbeing of their population.*
- *Not be sacked for any reason without the approval of both the local authority and the Secretary of State for Health.*
- *Have appropriate contractual relationships with PHE and the local authority.*
- *Be appointed jointly by the local authority and PHE, through a statutory appointments process, accredited by the FPH, which mirrors the existing process for DPHs and consultants/specialists in public health.*
- *Have an active role in safeguarding children and vulnerable adults, and in commissioning complex, multi-agency services."*

2.36 The Faculty also argued that local authorities should be accountable for protecting and improving the health of their populations, including outbreak and emergency situations. A large number of respondents supported the Faculty's approach.

2.37 The need to ensure public health expertise is available to NHS commissioners was a general theme of the consultation. NHS Swindon and Swindon Borough Council in a joint response noted that the local DPH was already a member of the authority's board and could already influence and develop corporate policies. They said, "*We believe this to be a good model that ensures credibility of the DPH function and contributes to whole organisational decisions that ultimately impact upon the health and wellbeing of the local population".*

2.38 However, some respondents called for a more localist approach. Brent Council for example was "*disappointed that the Government has been so prescriptive in the proposed transfer of public health services to local authorities"*. They said, *"Brent Council believes there needs to be flexibility in the way that public health staff are integrated within councils. We would not support any centrally or regionally transfer of public health staff from the NHS to the local authority as this could have serious financial implications at a time when we are reducing our staff and costs."* They opposed the idea

of split accountability for the DPH to PHE and the local authority and argued that they should be accountable to the Chief Executive and elected members, as other local government employees are.

Emergency Preparedness, Resilience and Response

2.39 A number of respondents were concerned about a lack of clarity around roles and responsibilities for planning for, and responding to, health protection incidents and to emergencies. The Local Government Group commented that the relationship between health organisations has often been unclear in the past, with both gaps and duplication, *"We urge the Govt to consider how national and local roles can be defined and coordinated."* Respondents also raised the need to ensure that the response to public health emergencies remained robust through the transition to the new system.

3. Funding and commissioning routes for public health

3.1 The consultation on funding and commissioning routes for public health sought views about our proposals for commissioning and funding arrangements for delivery of public health services. This chapter summarises the responses to questions on what activity should be funded from the new public health budget and the division of commissioning responsibilities between local authorities, Public Health England and the NHS.

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) 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?

3.2 Many respondents answered these two consultation questions together. They explored combinations of what should be considered ‘public health’, what should be public health funded, or which part of the new system should become responsible for commissioning different services/activity. Of those who responded specifically on what should be public health, most were broadly content that we had labelled the right activities as ‘public health’ for the purposes of funding. Responses relating to individual areas of activity are summarised in the thematic paragraphs which follow the general responses below.

3.3 The answers to both of these questions are pivotal in ensuring that future public health budgets and allocations are of an appropriate size. One frequently expressed concern was whether local authorities would be appropriately funded to deliver their new functions, or whether the grant to local authorities would be adequately ring-fenced. The concerns are