1) **Background**

1.1 Health and wellbeing and health inequalities are affected by a wide range of factors, including social, cultural, economic and environmental factors.

1.2 The main causes of premature death and illness are primarily related to lifestyles and behaviours that people adopt. Smoking, an unhealthy diet, excessive alcohol consumption and sedentary lifestyles are all key contributory factors.

1.3 Currently, efforts to target these issues are largely focused on the treatment of the illnesses resulting from lifestyle choices. For example, the NHS currently spends over £2.7 billion a year on treating smoking-related illness but less than £150 million on smoking cessation services. However, it is estimated that healthcare services only contribute around a third towards improvements in life expectancy where as changing people's lifestyles and removing health inequalities contribute the remaining two thirds.

2) **A New Approach**

2.1 The Public Health White Paper, *Healthy Lives, Healthy People*, sets out a new approach to improving health and wellbeing and reducing health inequalities. It acknowledges the need to empower people and communities to make healthier choices, and to re-prioritise funding on the prevention of ill-health.

2.2 This new approach will aim to address the root causes of poor health and wellbeing, providing support to those individuals and families that most need it. It will be:

- Responsive – so that it will be owned by communities and shaped by their needs;
- Resourced – funding will be ring-fenced and there will be incentives for areas that improve their outcomes;
- Rigorous – it will be professionally led and focused on evidence,
- Resilient – an integrated system will be developed which is best able to meet current and future threats to public health.
2.3 The paper acknowledges that responsibility for delivering improvements in health and wellbeing and reducing health inequalities does not lie solely with the NHS. While the NHS will continue to play a key role in public health (e.g. screening for disease, improving access to care and tackling health emergencies), it cannot tackle the wider impacts on health, such as the circumstances in which people live and behave. There is therefore a need to share responsibility across society, with individuals, families, local and national government, and the private, voluntary and community sectors all taking a key role in tackling the issues.

2.4 It is recognised that individuals make personal choices about the way that they live and behave but that a wide range of factors influence these decisions. The Government’s approach to this is to enable people to make healthier lifestyle choices by strengthening self-esteem and confidence and adapting the environment so that these choices are easier to make.

2.5 The ‘Ladder of Intervention’ describes a range of methods which can be used to promote positive lifestyle changes, ranging from the least intrusive approaches - giving people information - to the most intrusive, whereby personal choice is removed. The Government aims to use the least intrusive approaches possible to achieve the desired effect, with a focus on guiding people’s choices by making healthier choices easier for individuals i.e. “nudging people in the right direction”.

2.6 To support this approach, the Government outlined plans to introduce a Public Health Responsibility Deal. Through the Deal, five networks (food, alcohol, physical activity, health at work and behaviour change) will be established between the Government, business and the voluntary sector with an overall aim of creating an environment that supports health improving choices. Once the Deal has been formally launched (in early 2011), the Government expects to announce voluntary agreements on further changes to food to reduce salt, improved information for consumers about food, and the promotion of more socially responsible retailing and consumption of alcohol.

2.7 Local government will take the leadership in tackling the wider factors that affect health and wellbeing. Working in partnership with local communities, councils will
decide on the actions needed to improve health and wellbeing, and will work with the NHS to deliver them.

2.8 In order to secure better health and reduce inequalities within local communities, local authorities will be allocated a ring-fenced budget. This funding will be supported by a public health outcomes framework which the Government will be consulting on shortly. The Framework will cover five broad 'domains' of public health:

- Health protection and resilience: protecting people from major health emergencies and serious harm to health;
- Tackling the wider determinants of ill health: addressing factors that affect health and wellbeing;
- Health improvement: positively promoting the adoption of 'healthy' lifestyles;
- Prevention of ill health: reducing the number of people living with preventable ill health;
- Healthy life expectancy and preventable mortality: preventing people from dying prematurely.

2.9 Central government will continue to play an important role in public health, directly co-ordinating activity to protect people from serious health threats and emergencies.

2.10 Key to this new approach to improving health and wellbeing will be the use of innovative new approaches, robust evaluation, and the development of an evidence base of “what works”.

3) Health and Wellbeing throughout Life – the Responsibility of Local Authorities

3.1 Health and wellbeing throughout life is taking a coherent approach to different stages of life and key transitions when mental and physical health outcomes can be most strongly influenced. Mental health will be a key element, and a new mental health strategy will be published shortly.
3.2 The White Paper is the Government’s response to *Fair Society, Healthy Lives* - the Marmot Review. It adopts an partnership approach which addresses the wider factors that affect people at different stages and key transition points in their lives, and reflects the review's principle of ‘proportionate universalism’ - by which the scale and intensity of action is proportionate to the level of disadvantage.

**Starting Well**

3.3 Early intervention and prevention are key priorities for the Government, particularly strong universal public health and early education, with an increased focus on disadvantaged families. Support to meet the commitment to reduce child poverty will include increasing health visitor numbers, increasing the reach of the Family Nurse Partnership (FNP), and refocusing Sure Start Children’s Centres on families where children are most at risk of poor outcomes.

**Developing Well**

3.4 Directors of Public Health will be able to work with their local authority children’s services colleagues, schools and other partners to determine local strategies for improving child health and well-being. Schools will be expected to increase their role in providing age-appropriate teaching of health issues, including relationships and sexual health, substance misuse, diet, physical activity and some mental health issues.

**Living Well**

3.5 The government is turning to local communities to devise local solutions which work for them, a key component of which is the Public Health Responsibility Deal (see 2.6).

3.6 Changes to the environment are needed so that healthier lifestyles become the norm in communities. For example, environments which promote active travel, and physical activity, and discourage smoking.
3.7 Central government will sequence social marketing for public health through the life course so that, at each stage in a person’s life, there is a meaningful and trusted voice. A social marketing strategy, setting out the plans in more detail, will be published in spring 2011.

Working Well

3.8 The Department of Health will work in partnership with employers, through the Public Health Responsibility Deal, to improve health at work. Employers have the opportunity to improve health outcomes in areas from obesity to smoking, substance misuse and physical activity in their employees, employees’ families and wider local communities.

Ageing Well

3.9 The role of Public Health services in supporting “active ageing” and “ageing well” is emphasised, with all local partners expected to support a local infrastructure that enables people to continue to be independent and active.

3.10 At local level, Directors of Public Health and Directors of Adult Social Services will be able to work together to commission specific services for older people and those who care for them.

4) National Structure – Public Health England

4.1 Nationally, the Public Health agenda will be led and supported by a new service, Public Health England. Based within the Department of Health, Public Health England will have a ring fenced budget, lead on health protection and ensure that all Government Departments work more collaboratively to improve the public’s health.

4.2 The White Paper is explicit that the establishment of this service, and the other changes to how Public Health services will be delivered locally, does not take away
from the ongoing responsibility of the NHS to continue to be a key partner in delivering the Public Health agenda.

**Areas of Responsibility**

4.3 The services funded through Public Health England will be those that contribute to the prevention of ill-health. In the main, funding for services will be devolved locally. However, where appropriate there is an intention that Public Health England will commission or deliver some services nationally. For example, vaccine purchasing, health promotion campaigns etc.

4.4 The service will take responsibility for a number of functions currently delivered by different agencies / organisations including:

- Providing public health advice, evidence and expertise to the Secretary of state;
- Commissioning or providing national-level health improvement services, including appropriate information and behaviour change campaigns;
- Jointly appointing Directors of PH and supporting them through professional accountability arrangements;
- Allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework;
- Commissioning some public health services from the NHS, for example via the NHSCB.

4.5 The service will take responsibility for a wider number of functions currently delivered by different agencies, including the National Treatment Agency, the Health Protection Agency and the Public Health Observatories.

**Outcomes Framework**

4.6 Public Health services will be delivered against a nationally agreed Outcomes Framework for Public Health. These five domains (see 2.8) will be used to assess both the national and local performance of Public Health Services. There is an intention for local budgets to have additional premiums for progress against the
outcomes framework. Further details about the Outcomes framework will be published in due course.

**Public Health Role of GPs**

4.7 Public Health England and the NHSCB will work together to support GP Consortia to maximise their impact on improving the health and wellbeing of their local populations and tackling health inequalities. As an incentive to GP practices to improve health, it is proposed that a minimum of 15% of the current value of the Quality Outcomes Framework (QOF) should be allocated to evidence-based public health and primary prevention indicators from 2013.

5) **Local Structure**

5.1 Public Health and tackling health inequalities will become the responsibility of Local Authorities. There is recognition that co-ordinated action from all local partners is needed to improve the public’s health and tackle the key causes of health inequalities.

5.2 In order to support this action locally, Directors of Public Health will be appointed jointly by the Local Authority and Public Health England, and will be supported by a team with specific public health and commissioning expertise.

**Local Leadership**

5.3 Partnership and collaboration are intrinsic themes throughout the document. At a local level the primary vehicle for leading the delivery of the Public Health Agenda is the Local Health & Well-Being Board. Another ongoing theme throughout the paper is a lack of a prescriptive expectation about how the “Five Domains” of the outcomes framework are going to be delivered locally. However, what is described is a proposed minimum membership of the Health & Well-being Boards, including:

- Elected representatives;
- GP Consortia;
- Director of Public Health (Jane Rossini);
• Directors of Adult Social Care (Sheila Downey);
• Directors of Children’s Services (Cheryl Eastwood);
• Local Health Watch (Previously LINks – Voices for Well-being);
• An option to have representative from the NHS Commissioning Board.

5.4 The paper suggests that local areas may want to open membership up to other partners including representatives from the voluntary sector, local clinicians and providers where appropriate.

**Joint Strategic Needs Assessment**

5.5 The Boards will be the strategic and commissioning leads for health and social care services. There is an expectation that a robust commissioning cycle will be used by the Board to jointly deliver effective services, supported by a clear understanding of needs as set out in a **Joint Strategic Needs Assessment** (JSNA), and evidence-based public health approaches. GP Consortia and the Local Authority, including the Director of Public Health, will have “an equal and explicit” obligation to prepare a JSNA, delivered through arrangements agreed by the Board. The legislation will be sufficiently flexible to allow the Boards to go beyond their minimum statutory duties and promote joining up of a broader range of local services – e.g. Community Budgets.

**Joint/Coherent Commissioning**

5.6 The Department of Health has also proposed a new role for local government to encourage coherent commissioning strategies, promoting the development of integrated and joined up commissioning plans across the NHS, social care, public health and other local partners.

5.7 The National Institute for Health & Clinical Excellence (NICE) will have a broadened remit, including the development of guidance relating to social care and also work on specific commissions from Public Health England. The use of Information and Intelligence to support surveillance, monitoring and evaluation is focused on, with
**Briefing on the Public Health White Paper: Healthy Lives, Healthy People**

December 2010

Public Health England drawing together the information and intelligence sources currently in place.

**Local Funding Agreement**

5.8 A ring fenced budget allocation will be made to each local authority from Public Health England. There is going to be flexibility in the local commissioning approaches, but there will need to be a clear focus on activities that will directly improve the public’s health. There will be some weighting of budgets to areas with high level of health inequalities and a new health premium to reward progress made locally against the outcomes framework.

**Role of Director of Public Health**

5.9 The local DPH will be the local leader for Public Health. The DPH will have a number of critical tasks including:

- Promoting health and wellbeing within local government;
- Providing and using evidence relating to health and wellbeing;
- Advising and supporting GP consortia on the population aspects of NHS services;
- Developing an approach to improving health and wellbeing locally, including promoting equality and tackling health inequalities;
- Working closely with Public Health England, health protection units (HPUs) to provide health protection as directed by the Secretary of State for Health:
- Collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

**Localism**

5.10 Local Authorities will be given freedom to decide what action is needed to take in order to shape their environments. For example, local planning authorities already have the ability to regulate the development of new fast food restaurants, and to impose conditions on such development, for example, to specify the operating hours. In addition, the proposed new 'general power of competence' will provide them with much greater freedom and flexibility to act in the interest of their
communities. The paper encourages innovative solutions and anticipates most services will be commissioned rather than delivered in house, with incentives for those organisations that deliver the best outcomes.

6) Public Health Workforce

6.1 The Paper states that there is going to be a work force strategy published by autumn 2011 that will provide details concerning the anticipated workforce and transition arrangements. There is an emphasis on retaining current skills in relation to providing public health services.

7) Timeline

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<th>December 2010 – March 2011</th>
<th>The Department of Health will consult on:</th>
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<tr>
<td></td>
<td>• The Public Health White Paper;</td>
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<td>• Public Health Outcomes Framework;</td>
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<td>• Funding and Commissioning of Public Health.</td>
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<th>By early 2011</th>
<th>The Government will publish a series of documents setting out the proposed structure of the new health system and the proposals for managing the transition to this new system. Publications will include:</th>
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<td>• A detailed roadmap for the system as a whole (the NHS, Public Health England and the Department of Health);</td>
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<td>• Further details on the public health system, based on responses to the White Paper consultation and others;</td>
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<td>• Human resources frameworks setting out the approach for managing people moving between each of the organisations in the new health system;</td>
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<td>• The Health and Social Care Bill which will set out the detail on the structural and delivery implications of the system-wide reforms;</td>
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<td>• The NHS Operating Framework and PCT allocations for 2011/12, setting out expectations for public health delivery through PCTs in the first transition year.</td>
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<p>| 2011/12 | During the transition period, accountability for the delivery of services |</p>
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<th>Transition Year</th>
<th>will remain with PCTs and SHAs.</th>
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<td>Public Health England will be set up in shadow form within the Department of Health.</td>
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<td></td>
<td>Regional Directors of Public Health will lead the transition to the new public health system at a regional and local level. The transition will be developed alongside changes to PCTs and SHAs, and the establishment of the NHS Commissioning Board (NHSCB).</td>
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<td>During this period, the Department of Health will continue on the design of the new public health system, including setting up working relationships with local authorities.</td>
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<td>A public health workforce strategy, covering staff who will form part of Public Health England, will be developed and consulted upon.</td>
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<tr>
<td>2012/13 – 2013</td>
<td>Public Health England will be formally established, taking on the responsibilities of the Health Protection Agency and the National Treatment Agency.</td>
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<td>Consolidation</td>
<td>Shadow ring-fenced allocations for local authorities will be published.</td>
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<td>April onwards</td>
<td>The new public health system will be in place and formal commissioning arrangements between Public Health England, the NHSCB, GP consortia and local authorities will be established.</td>
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<tr>
<td>2013 onwards</td>
<td>Ring-fenced budgets will be allocated by the Department of Health to upper-tier and unitary local authorities.</td>
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8) Supporting Documents

8.1 A number of other key documents that link to the White Paper will be published by the Department of Health:

- Winter 2010/11
  - Health Visitors
  - Mental Health
  - Tobacco Control

- Spring 2011
  - Public Health Responsibility Deal;
  - Obesity;
  - Physical Activity;
  - Social Marketing;
  - Sexual Health and Teenage Pregnancy;
  - Pandemic Flu.

8.2 Other government departments will also be launching a number of other documents that relate to public health.