



Public Health
England



Guidance on the Ringfenced Public Health Grant Conditions and Mandated Functions in England

A co-production between PHE centres and regions and the
Association of Directors of Public Health

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

About the Association of Directors of Public Health

The Association of Directors of Public Health is a Company Limited by guarantee with charity status registered in England and Wales and is the representative body for directors of public health (DsPH) in the UK. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice. More information can be found at www.adph.org.uk.

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1. Introduction

Local authorities receive an annual ringfenced public health grant from the Department of Health. The core condition of this grant is that it should be used only for the purposes of the public health functions of local authorities. This document has been developed by the Association of Directors of Public Health (ADPH) and PHE, and is intended as a working document for directors of public health and centre directors in PHE as guidance to help clarify the current public health grant conditions and mandated functions in local government. It is intended to support the broader role of local government, directors of public health and their teams as system leaders and advocates for health within the local area ('place-base').

Local authorities and directors of public health are committed to sector-led improvement as a way of ensuring that the best outcomes are delivered within the available resource. For each of the responsibilities a description is given of 'what this means in practice' against which local areas can self-assess with a view to reviewing and improving. PHE is fully committed to supporting local government's sector-led improvement through the provision of a range of tools and advice.

2. Local authority role

The local authority statutory duties for public health services are mainly outlined in the Health and Social Care Act 2012 legislation. They include the duty to improve public health through mandated and non-mandated functions. There are also existing public health duties for health protection which are not described in detail in this document.

3. The director of public health role

The most fundamental duties of a director of public health are set out in law <https://www.gov.uk/government/publications/role-of-the-director-of-public-health-in-local-authorities>. How these functions and duties translate in the local place will be shaped by local needs and priorities.

3.1 Statutory functions of the director of public health

The director of public health is a chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health.

Section 73A(1) of the NHS Act 2006, inserted by section 30 of the Health and Social Care Act 2012, gives the director of public health responsibility for:

- all of their local authority's duties to take steps to improve public health
- any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations. These include services mandated by regulations made under Section 6C of the 2006 Act, inserted by Section 18 of the 2012 Act
- exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health
- their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders
- such other public health functions as the Secretary of State specifies in regulations
- the director of public health is an independent advocate for the health of the population and for system leadership for its improvement and protection. As such, in England this is a statutory role within local authorities with close links to the NHS and PHE. The director of public health is a chief officer and pre-eminent adviser on health and wellbeing to the local authority

4. Public Health England's role

PHE is an executive agency sponsored by the Department of Health that seeks to:

- protect the country from threats to health, including outbreaks of infectious diseases and environmental hazards, in the UK and abroad
- improves the public's health and wellbeing
- improves population health through the development of sustainable health and care services
- builds capacity and capability of the public health system

PHE's role in relation to the ringfenced grant derives from the PHE chief executive's role as the accounting officer for that grant. The public health grant is accounted for in PHE's statutory annual accounts. As accounting officer, the chief executive has a duty to Parliament to ensure that the public health grant has been spent in line with the

purposes intended by Parliament, ie in line with the grant conditions. This role sits alongside the local democratic mechanisms to ensure probity and value for money in the use of the grant.

At a local level PHE centres¹ provide advice and support to directors of public health and their teams as required and requested. PHE centres advise PHE's chief executive on meeting their formal accountabilities and support local government in demonstrating delivery of the grant conditions and mandated services as part of the wider expert advice role of PHE.

5. Local authority public health responsibilities²

Local authorities' statutory responsibilities for public health services are set out in the Health and Social Care Act 2012. The Act conferred new duties on local authorities to improve and protect public health. It abolished primary care trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013. From this date local authorities have had a new duty to take such steps as they consider appropriate for improving and protecting the health of the people in their areas. (Section 5.2.5)

Furthermore, regulations made under Section 6C of the NHS Act 2006 require local authorities to take particular steps in the exercise of their public health functions, or aspects of the Secretary of State's public health functions, for example, Regulation 8 is a function of the Secretary of State delivered locally. Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (SI 2013/351) makes provision for the steps to be taken by local authorities in exercising their public health functions. These regulated functions are often referred to as the 'mandated functions' (Section 5.2).

Legislative measures for local authorities' responsibilities for dental public health are covered by separate statutory instruments (Section 5.2)

1. 8 PHE centres, plus a combined centre/region in London, provide support to the local public health system on a geographical 'place' basis across England. They are the local 'front door' to PHE services for partner organisations in a locality

2. Local authorities' public health responsibilities: House of Commons Libraries (2014). Accessible from: <http://researchbriefings.files.parliament.uk/documents/SN06844/SN06844.pdf>

This document focuses on the public health grant and mandated functions only. It is not intended to interpret all legal aspects of public health in local government such as the duties for health protection or health visiting. It is expected that local authorities would seek their own legal advice.

5.1 Duty to improve public health

Section 12 of the 2012 Act introduced a new duty at Section 2B of the 2006 Act for all upper-tier and unitary local authorities in England to take appropriate steps to improve the health of the people who live in their areas. These may include:

- carrying out research into health improvement, providing information and advice (for example giving information to the public about healthy eating and exercise)
- providing facilities for the prevention or treatment of illness (such as smoking cessation clinics)
- providing financial incentives to encourage individuals to adopt healthier lifestyles (for instance by giving rewards to people for stopping smoking during pregnancy)
- providing assistance to help individuals minimise risks to health arising from their accommodation or environment

Alongside the mandated functions are a range of public health services (for example: tobacco control, weight management, behavioural and lifestyle campaigns). The commissioning of these services is discretionary, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy. The general duty to improve public health includes the provision of facilities for the prevention or treatment of illness.

What this means in practice

Public health outcomes are maintained or improving. Local authorities use the Public Health Outcomes Framework, joint strategic needs assessment and the joint health and wellbeing strategy to guide their commissioning of all public health services. These services can be shown to be safe, effective and have a good service-user experience.

5.2 Mandated functions

The key mandated functions are defined in Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, summarised in the table below:

Regulation	Title
3	Weighing and measuring of children
4	Health check assessment
5	Conduct of health checks
6	Sexual health services
7	Public health advice service
8	Protecting the health of the local population

5.2.1 Regulation 3 – Weighing and measurement of children

The mandated element of National Child Measurement Programme (NCMP) is to provide robust public health surveillance data on child weight status: to understand and monitor obesity prevalence and trends at national and local levels, inform obesity planning and commissioning, and underpin the Public Health Outcomes Framework indicator on excess weight in 4 to 5 and 10 to 11-year-olds.

Specifically, the functions are:

- weighing and measuring of children at Reception (4-5) and Year 6 (10-11)
- parental involvement – gaining consent to carry out the measurements
- submission of data to Health and Social Care Information Centre (NHS Digital)
- to be carried out in accordance with Part 3 of the Local Authority Regulations 2013: http://www.legislation.gov.uk/ukxi/2013/218/pdfs/ukxi_20130218_en.pdf

What this means in practice

As part of a wider programme to support healthy weight during childhood, local authorities carry out the statutory public health function of weighing and measuring Reception and Year 6 children and maintain the programme's UK National Statistic status by:

- providing robust public health surveillance data on child weight status: to understand and monitor obesity prevalence and trends at national and local levels, inform obesity planning and commissioning, and underpin the Public Health Outcomes Framework indicator on excess weight in 4 to 5 and 10 to 11-year-olds

- engaging with parents and raising awareness of their child's weight status: to help them understand their child's health status, support and encourage behaviour change, and provide a mechanism for direct engagement with families who have overweight and obese children. Sharing NCMP results with parents is particularly important, as research shows that parents, and even healthcare professionals, are poor at visually judging if a child is a healthy weight. An objective measurement is therefore important
- monitoring and taking action to improve the prevalence of overweight and obese children at a local level

5.2.2 Regulations 4 and 5: NHS Health Check – assessment and conduct

The mandated function requires local authorities to provide, or secure the provision of, health checks to be offered to eligible persons in its area and ensure that all eligible persons are offered an NHS Health Check every five years and in accordance to the specified content detailed within the regulations.

Although local authorities are required through the regulations to make an offer to all eligible persons, PHE supports a proportionate universalism approach. This means that local authorities are free to target a greater extent of their resource towards higher risk and vulnerable communities, while keeping a universal offer to all eligible persons.

In agreement with ministers, PHE have introduced a content review process for the NHS Health Check, which is overseen by the Expert Scientific and Clinical Advisory Panel (ESCAP). This process includes an open call for content changes, assessment of the clinical and cost effectiveness, feasibility testing and consultation. PHE is then responsible for advising the Department of Health/ministers on possible content changes, based on our appraisal of the evidence, at which point the public health regulations may need to be revised to incorporate any changes made to the programme. ESCAP is in the process of reviewing its first wave of applications, which will be made publically available early next year.

What this means in practice

All local authorities offer all eligible persons an NHS Health Check every five years in accordance with the specified content in the regulations. Official statistics are published by PHE on a quarterly basis, including helpful data resources to compare local implementation of the programme. Local authority and NHS colleagues have also been involved in the development of programme standards, which have been introduced to promote a strong focus on quality improvement at a local level.

5.2.3 Regulation 6: Sexual health services

Sexual health services are commissioned by three separate groups of commissioners: local authorities, clinical commissioning groups (CCGs) and NHS England. This requires co-operation or collaboration in commissioning which means that sexual health services are different to other mandated services. The mandated function requires each local authority to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted infections (STIs); treating, testing and caring for people with STIs and partner notification. Local authorities should provide contraceptive services including advice on, and reasonable access to, a broad range of contraceptive substances and appliances; advice on preventing unintended pregnancy. Local authorities do not need to provide sterilisation or vasectomy services other than the giving of preliminary advice on availability and as an appropriate method of contraception for the person concerned. Local authorities are not required to offer services for treating or caring for people infected with human immunodeficiency virus.

Sexual health services comprise one of the larger areas of spend within the public health functions. While local authorities adhere broadly to their responsibilities there is variation, largely historical, as to how these services are currently provided.

Local authorities in many areas are actively recommissioning sexual health services according to specifications built on the principle of best value. In some parts of the country a collaborative approach to commissioning has developed across local authorities who have worked together to develop a joint commissioning strategy and service specification. This provides an opportunity to develop more integrated services building on the inherited range of add-on services. This will include more use of home testing, self-care, engagement of a wider voluntary sector, and potential reduction in the number of providers of more complex care.

What this means in practice

Local authorities support open access services to genitourinary medicine (GUM), which include making arrangements to cover users from outside their local authority boundary/region. Commissioners continue to value the strengths in creating and maintaining collaborative commissioning arrangements.

Recommissioned services ensure appropriately balanced provision according to need of the user, continue to use both value for money criteria and ensure equality of provision whilst appropriately balancing provision according to need of the user. Services can demonstrate they are safe, effective and have a good service user experience.

Commissioners work together across organisational boundaries to increase cohesion of such as teenage pregnancy prevention, school nursing services, community and post-pregnancy contraception services and cervical screening (carried out in community clinics for women who do not access GP services for sexual health).

Commissioners facilitate open access by making arrangements to cover users from outside of their local authority boundary.

Sexual health outcomes are maintained or improved through a combination of preventative programmes and effective services. Commissioners are encouraged to work together in an area to ensure a comprehensive range of sexual health services are commissioned and provided for the local population.

5.2.4 Regulation 7: Public health advice to clinical commissioning groups

This section covers Regulation 7 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 in exercise of powers conferred in Sections 6C (1) to (3) of the NHS Act 2006 (as amended by the HSC Act 2012). These duties are further described in DH Guidance “Healthcare Public Health Advice Service to CCGs” issued in June 2012:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216835/Healthcare-Public-Health-Advice-Service-Guidance-FINAL.pdf

There is a statutory duty on upper tier and unitary local authorities to give NHS commissioning a population focus to make maximum impact on population health. This is described in regulations as:

- each local authority shall provide or shall make arrangements to secure provision of a public health advice service to any CCG whose area falls wholly or partly within the authority’s area and further, that the service consists of provision of such information and advice to a CCG as the local authority considers necessary or appropriate with a view to protecting or improving the health of people in the local authority’s area.

In addition the Act gives each CCG a duty to obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in:

- the prevention, diagnosis and treatment of illness; and
- the protection or improvement of public health

The local authority public health advice service is intended to support CCGs in carrying out this duty and it is specified that this service should be free of charge. The regulations also make it clear that the provision of the public health advice service:

- should have regard to the CCG's needs
- be agreed between the local authority and the CCG; and
- be kept under review

The associated Department of Health guidance has no legal force although Section 31 of the Act require local authorities to have regard to certain documents that the Secretary of State publishes when exercising his/her public health functions, for example, in issuing guidance to local authorities about the role of their director of public health.

The June 2012 Department of Health healthcare public health guidance ('Healthcare Public Health Advice Service to Clinical Commissioning Groups') includes an estimate of the capacity required, proposing that about 40% of the specialist public health capacity in a local authority might be devoted to the healthcare public health advice function (or c1 WTE specialist per 270,000 population); an emphasis on the importance of strategic leadership of the local authority's director of public health for the service and to build collaborative relationships across the commissioning landscape; a suggested specification for the service which covers defined stages of the commissioning cycle and a clear statement that the money transferred from the NHS to the local authorities at transition was intended to cover the CCGs' needs in respect of the advice service.

Within the guidance a set of quality criteria for the service proposes that the service should:

- include input from specialists in public health as defined by the Faculty of Public Health
- meet CCG needs
- offer a timely response
- provide advice that demonstrably contributes to achieving the priorities of the joint strategic needs assessment and the joint health and wellbeing strategy.

The guidance recommends that there be a written local agreement or memorandum of understanding between the CCG and the local authority and an annual work plan agreed by the CCG and the director of public health for particular deliverables. It also recommends that there be an annual presentation to the health and wellbeing board about how the service has been provided.

What this means in practice

Local authorities provide CCGs the following (free of charge):

- demonstrable strategic leadership for the service by the director of public health to build collaborative relationships across the commissioning landscape
- input from registered specialists in public health and an agreed specialist capacity devoted to the service
- a written agreement between the local authority and each CCG in the area describing the service
- an agreed annual work plan
- arrangements to monitor and review the service at regular intervals
- a demonstrable contribution through the service to priorities in the joint strategic needs assessment and joint health and wellbeing strategies and improved outcomes
- the service must be offered free of charge to each CCG in the area covered by the local authority

Within the spirit of these key elements support should be specified for the delivery of the NHS Planning Guidance. For example this may include but is not limited to local support to implement Right Care or public health advice to sustainability and transformation plans.

5.2.5 Regulation 8: Protecting the health of the local population

The role of the local authority is to provide information and advice to relevant organisations to ensure that all parties discharge their roles effectively for the protection of the local population. This includes providing public health advice to CCGs which includes health protection. These duties are described in Department of Health guidance – Protecting the health of the local population: the new health protection duty of local authorities (2013):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf

Directors of public health will also have responsibility for the exercise of the local authority of any of its functions that relate to prevention, planning for, and responding to, emergencies involving a risk to public health. They will work with PHE who will provide specialist health protection functions, as part of the local health protection system. Unitary and lower tier authorities have existing health protection functions and powers under the Public Health (Control of Disease) Act 1984, and other legislation such as Health and Safety at Work etc. Act 1974.

Where the director of public health identifies an issue, it will be his/her duty to escalate, working with PHE, to ensure that the public's health is protected. A lead director of public health in a local resilience forum (LRF) area will be agreed to co-ordinate the public health input to planning and testing of the response to emergencies across the local authorities in the LRF area.

Local health resilience partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at LRF level, and ensure effective planning, testing and response for emergencies. LHRPs are co-chaired by the director of public health and director from NHS England, and work closely with relevant LRFs to ensure a co-ordinated health input to the LRF. PHE provides health protection services, expertise and advice at an LRF level.

In general there has been good engagement by local authorities with the emergency preparedness work and the establishment of LHRPs co-chaired by directors of public health in all LRF areas. There is variation across the country about how any wider work on this duty has been enacted by local authorities. In some areas there are health protection subcommittees of health and wellbeing boards where health protection concerns are reviewed by the director of public health, while in other places more informal arrangements are in place between the director of public health and PHE staff. The mandate to provide information and advice to relevant organisations to ensure all parties discharge their roles effectively for the protection of the population is exercised predominantly through the work of local authorities as Category 1 responders and developed with other partners of the LRF and LHRP.

What this means in practice

Health protection incidents (including screening incidents and outbreaks of infectious diseases) will be effectively managed through emergency planning and response arrangements agreed by the LHRP and LRF. The director of public health will be actively contributing to the local authority's EPRR arrangements.

5.3 Mandated functions for oral health

The Health and Social Care Act 2012 amended the Water Industry Act 1991 to transfer the responsibility for consulting residents on water fluoridation from strategic health authorities to local authorities. This includes initiation, variation and termination of fluoridation.

The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, Part 4 of the Regulations specifies

the functions to be exercised by local authorities in relation to dental public health in England. Local authorities should:

- provide or secure the provision of oral health promotion programmes as deemed necessary for the area
- provide or secure the provision of oral health surveys to:
- assess and monitor oral health needs
 - plan and evaluate oral health promotion programmes
 - plan and evaluate arrangements for provision of dental services
 - monitor and report on the effect of water fluoridation programmes
- participate in any oral health survey conducted or commissioned by the Secretary of State so far as that survey is conducted within the authority's area. The statistics are required annually for the Public Health Outcomes Framework measure. The 'oral health surveys' return is needed for the single data list, a requirement of local authorities at lower tier level. Reference 262-00.

<https://www.gov.uk/government/publications/single-data-list>

What this means in practice

In relation to duties around fluoridation arrangements (whether to introduce, withdraw or vary), local authorities consult with residents on any proposals to introduce, vary or terminate fluoridation in their patch. Likewise, that they also inform adjacent local authorities affected by virtue of the water supply zones.

Local authorities undertake, or enable surveys to assess the oral health needs for their population and implement actions to promote and improve oral health.

6. Meeting conditions of the public health grant

6.1 Non-mandated functions but 'conditions of the public health grant'

6.1.1 Drug and alcohol

Under the HSC Act 2012, local authorities have the duty to reduce health inequalities and improve the health of their local population by ensuring that there are public health services aimed at reducing drug and alcohol misuse. The ringfenced grant – with attached conditions – currently supports local authorities in the discharge of these responsibilities. The 2015/16 public health grant included a new condition that requires:

A local authority must, in using the grant, "...have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services..." In setting their spending priorities it is important that local authorities are mindful of the overall objectives of the grant, as set out in the grant conditions, and the need to tackle the wider determinants of health, for example, through addressing the indicators within the Public Health Outcomes Framework, such as violent crime, the successful completion of drug treatment, smoking prevalence and child poverty.

The publically available mechanism for monitoring the successful completion of treatment is through the Public Health Outcomes Framework, which includes the National Drug Treatment Monitoring System (NDTMS) data on recovery rates and Hospital Episode Statistics (HES) data on alcohol-related admissions.

Furthermore, the improvement in recovery rates is a core expectation of the government's Drug Strategy. It is a focus for the Drugs Inter-Ministerial Group and for the Department of Work & Pensions-led Social Justice Committee. More frequent monthly data on drug recovery rates is available to local authorities and providers. There is an ongoing cross-government expectation that PHE will positively influence a national improvement in outcomes from drug and alcohol services, as an aggregate of improvement at local authority level.

What this means in practice

In each upper tier/unitary authority area there should be:

- an accessible drug and alcohol treatment and recovery system that includes a full range of NICE-compliant drug and alcohol interventions to treat both alcohol and drug dependence and to reduce harm, based on local authority prevalence, need and current outcomes. Recovery rates and successful completions being reviewed regularly with active measures undertaken when needed to ensure best possible service and outcomes
- evidence-based prevention activities to reduce harm and improve resilience among young people and vulnerable groups, such as homeless/hostel dwellers, offenders, men who have sex with men, and new psychoactive substance users
- compliance with NDTMS reporting
- working towards the average waiting times for treatment interventions provided to local authority residents
- improving recovery rates – or stability if performance is already in the upper quartile
- needle exchange, particularly as an entry point to treatment, widely available
- clarity on clinical governance arrangements including reporting of serious untoward incidents
- effective pathways between prison and community treatment – alcohol and drugs
- evidence-based commissioning with service reconfigurations driven by improving cost-effective outcomes

6.1.2 Children and Young People (0-19 services)

The transfer of the 0-5 Healthy Child Programme commissioning responsibility was the last part of the transfer of the public health grant commissioning responsibility from the NHS to local authority. This transfer took place on 1 October 2015 under the governance of a transition board that formed part of the Government Major Project on Health Visiting. Strong partnership work including the Local Government Association, Solace, the ADPH and the Association of Directors of Children's Services ensured that this was a smooth transition and a range of guidance on technical aspects of transition, financial allocations and broader guidance was developed.

Sustainability and benefits realisation are now governed through PHE Best Start in Life Programme Board. This is jointly chaired by the PHE chief nurse and the local authority chief executive. Benefits centre on improved service access and family experience, improved outcomes and reduced inequalities. Local authorities have the opportunity to bring together services for children in the early years and to join up 0-19 commissioning to help make local communities healthy places where children and young people can

get the best start and by building wellbeing and resilience, which evidence shows significantly affect life chances into adulthood.

At the request of, and in partnership with, local government a model service specification for Healthy Child Programme 0-19 was developed and published on 20 January 2016³. This includes the health visiting 'transformed model' HV456 and similar guidance for the school nursing services contribution from 5-19.

Both health visiting and school nursing services are 'four level' including working with communities, universal services, universal plus (extra help/early intervention), universal partnership plus (multiagency support for complex needs).

For health visiting services, five universal health reviews are mandated by Parliamentary regulation for 18 months from October 2015 (below):

Mandated elements:

- local authorities are required to commission five universal health visitor reviews delivered at 28/40 pregnancy, 10-14 days, 6-8 weeks, 1 year and 2.5 years. This mandate is in place to promote sustainability of universal services across the transition. Local authorities are required to achieve service coverage to at least the level provided at the point of transfer
- ultimately the information required on service delivery and outcomes will be collected at record level through the Children and Young People's Health Services (CYPHS) dataset: www.hscic.gov.uk/maternityandchildren/CYPHS. However, until such time as this data is fully available, PHE is managing an interim data collection based on aggregate data by local authority of residence. This enables local authorities to demonstrate coverage of the universal reviews and progress on health outcomes. This data submission is voluntary for local authorities and there has been good engagement and reporting from local authorities. The quarterly data is published at <http://www.chimat.org.uk/transfer#5>.

What this means in practice

Maintained or improving public health outcomes as measured by the early year profiles. Local authorities continue to commission mandated services that can be shown to be safe, effective and with good levels of service user satisfaction.

³ At: <https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning>