Title:	Impact Assessment (IA)
Mandatory public health functions for LAs to provide in improving the health of their populations **IA No:** 3095 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Date:** 03/05/2012 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries**: **Liliia Skotarenko**

Summary: Intervention and Options

RPC: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£N/Am	£0m	£0m	No	NA

What is the problem under consideration? Why is government intervention necessary?

Under the Health and Social Care (HSC) Act, as of April 2013 unitary and upper tier Local Authorities (LAs) will have a duty to take appropriate steps to improve the health of their populations. LAs will be free to commission services with the ring-fenced budget as they see fit without intervention. However, local prioritisation of these public health services would risk under-provision of services whose under-provision would result in a sub-optimal public health benefit to the national population. It is therefore proposed to mandate delivery of these services, whilst ensuring the LAs retain autonomy in commissioning decisions with the majority of the budget to target the local populations. This combination will help maximise the total public health benefit to the population.

What are the policy objectives and the intended effects?

The intended effect of the policy is to deliver an effective public health system that maximises the total health benefit experienced by each individual in England at both the local and national level. This will be achieved by:

- Ensuring LAs retain the majority of the ring-fenced public health budget to commission the services that have been locally identified as best meeting the public health needs of the local population.
- Ensuring the provision of services that meet the criteria set out, by mandating each LA to provide them

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: LAs have full autonomy in spending their ring-fenced public health budget on services that best meet identified local public health needs.

Option 2: LAs retain autonomy in spending the majority of their ring-fenced public health budget, whilst a small number of functions are mandated for all LAs to provide to their populations. The mandated functions are those that pose a serious impact if underprovided because: (i) their under-provision puts a national coherent public health system at risk, (ii) the service provides substantial additional benefits to society when provided to all and therefore national provision is optimal and/or (iii) standardised provision of the service is required by all LAs in order for the service to be effective. Mandating the functions that meet at least 2 of these criteria will ear-mark approximately 28% of the budget. This ensures that LAs retain autonomy over which services to commission locally with 72% of the ring-fenced budget. This is the preferred option.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 04/2016

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** **No**	**< 20** No	**Small** **No**	**Medium** **No**	**Large** **No**
What is the CO2 equivalent change in greenhouse gas emissions? (Million tonnes CO2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: ..... Date: Earl Howe 10.12.2012

Summary: Analysis & Evidence

Policy Option 1

Description: No change - There are no requirements on which public health services the LAs commissions.

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	N/A	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	0

Description and scale of key monetised costs by 'main affected groups'

These are defined to be zero.

Other key non-monetised costs by 'main affected groups'

These are defined to be zero.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	N/A	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	0

Description and scale of key monetised benefits by 'main affected groups'

These are defined to be zero.

Other key non-monetised benefits by 'main affected groups'

These are defined to be zero.

Key assumptions/sensitivities/risks **Discount rate (%)** N/A

This option assumes the public health needs of the local population are correctly identified, which the LAs act upon when commissioning. This option risks under-provision of services where: (i) its under-provision puts a national coherent public health system at risk (ii) the service provides additional benefits to society when provided to all and therefore national provision is optimal and/or (iii) standardised delivery of the service is required to all in order for the service to be effective.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits: 0**	**Net: 0**	No	NA

Summary: Analysis & Evidence

Policy Option 2

Description: A small number of public health services are mandated for all LAs to provide, whilst LAs retain autonomy in spending the majority of their ring-fenced public health budget

FULL ECONOMIC ASSESSMENT

Price Base Year **2013**	PV Base Year **2013**	**Time Period Years** N/A	**Net Benefit (Present Value (PV)) (£m)**		
			Low: Unknown	**High:** Unknown	**Best Estimate:** Unknown

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	Unknown	N/A	Unknown	**Unknown**
High	Unknown		Unknown	**Unknown**
Best Estimate	Unknown		Unknown	Unknown

Description and scale of key monetised costs by 'main affected groups'

There are no expected financial costs associated with prescribing LAs to deliver specified functions. The Department of Health estimates that approximately 28% of the LA's already identified public health ring-fenced budget would be required to provide the proposed mandatory functions. This equals approximately £610m. However, the £610m is not an additional cost but an earmarked amount from the ring-fenced £2.2bn. Therefore, there is no expected financial cost under option 2.

Other key non-monetised costs by 'main affected groups'

The mandated functions under option 2 may be different from those that the LAs would choose to commission under option 1. Option 2 therefore directly impacts LAs. The cost of implementing option 2 is the opportunity costs, which are the foregone benefits that would have been experienced under option 1. Whilst LAs' commissioning decisions are unknown under option 1, they would likely be similar to the mandatory functions in option 2 and therefore the opportunity cost is thought to be small.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	Unknown	N/A	Unknown	**Unknown**
High	Unknown		Unknown	**Unknown**
Best Estimate	Unknown		Unknown	Unknown

Description and scale of key monetised benefits by 'main affected groups'

No benefits have been monetised.

Other key non-monetised benefits by 'main affected groups'

The local populations benefit from LAs retaining the significant majority of the ring-fenced budget to commission services that directly target their needs. The local and national populations benefit from ensuring the provision of services that help deliver an effective national public health system. The combination of targeting local public health needs and ensuring an effective national public health system will help maximise the public health benefit experienced by the entire population.

Key assumptions/sensitivities/risks **Discount rate (%)** laN/A

This option assumes the local Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy correctly identify the public health needs of the local population, which the LAs will act upon when commissioning services. The assumption is made that the Statement of Grants Usage, which LAs will return to the Department of Health show where the budget has been spent and will therefore ensure that mandated functions have been provided.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**In scope of OIOO?**	**Measure qualifies as**
Costs: 0	**Benefits: 0**	**Net: 0**	No	NA

Problem under consideration

1. Under the Health and Social Care Act ("the Act), from April 2013 unitary and upper tier local authorities (LAs) will have the duty to take appropriate steps to improve the health of their populations. The LAs will be free to decide which services to commission that target the public health needs of the local population using their ring-fenced public health budget. However, given the local accountability structures, such as the Public Health Outcomes Framework, the LAs may not be incentivised to prioritise services that offer additional benefits at the national level. As a result, full autonomy in commissioning decisions by LAs risks sub-optimal public health outcomes at the local and national level.
2. The small number of services whose under-provision would pose a serious impact are those where:
    a. their under-provision puts a national coherent public health system at risk and therefore risks political failure
    b. the service provides additional benefits to society when provided to each individual and therefore the optimum level of delivery is uniform provision
    c. the service has operational issues in that it must be provided in a standardised manner across the board in order to be effective and accrue benefits

3. These risks are used as criteria for justification of which service areas to mandate. It is proposed to mandate the provision by each LA of services that match these criteria, whilst ensuring the LAs retain autonomy in commissioning decisions with the majority of the budget to target their local populations. This IA therefore directly impacts LAs.

4. Given that all public health services will meet at least one of the named criteria, in order to ensure that LAs retain autonomy in their commissioning decisions with the majority of the budget, the service must meet at least two of the three criteria to be mandated. The services that meet at least two of the three criteria and are therefore proposed to be mandated are:
    a. Sexual health services – confidential open access STI testing and treatment and open access contraception services
    b. Steps local authorities must take to protect the health of their population
    c. Public health advice to NHS Commissioners
    d. National Child Measurement Programme (NCMP)
    e. NHS Health Check assessments

5. The combination of LA autonomy in commissioning public health services and ensuring the uniform provision of the above named services will help maximise the total public health benefit to the population.

Background

6. Public health documents published by DH have already mentioned the possibility of mandating LAs to provide a small number of services, in conjunction with retaining the majority of the ring-fenced budget for LAs to commission local services as they see best. For example, mandatory functions were mentioned in the White Paper and in the public health reforms update fact sheets[1]. However, the policy proposal to mandate public health functions was decided upon based on high level analysis when drafting the White Paper. It was high level analysis against the baseline case of LAs having full autonomy in commissioning for their local populations with the ring-fenced budget. As this IA is outlining the full detail used in the previous high level analysis, the same baseline is used here.

[1] 'Local government's new public health functions.pdf', Department of Health (2011), http://healthandcare.dh.gov.uk/public-health-system/

7. The Public Health White Paper 'Healthy Lives, Healthy People: Our strategy for public health in England'[2] was the Public Health White Paper that proposed several changes to the way public health is delivered in England and preceded the Health and Social Care Act. The Impact Assessments[3](IAs) that accompanied the White Paper showed that LAs are best placed to deliver several of the public health functions that currently sit with NHS Primary Care Trusts (PCTs). As a result, in April 2013 the identified functions will transfer to LAs, who will take on a new duty to take appropriate steps to promote the health of their populations. The full list of functions transferring to LAs are listed in Annex 1. This IA is a secondary IA, following the IAs that accompanied the White Paper. It details the high-level analysis previously done for the proposal to mandate LAs to provide certain public health services. It is therefore a final stage IA, given that the previous IAs have been to public consultation, where there was the opportunity to comment on mandatory functions.

8. The baseline scenario for this IA refers to that which was used in the initial high level analysis and is mentioned in the 2010 public health consultation document 'Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health'. This states that "wherever possible, public health activity should be commissioned by local authorities according to locally identified needs and priorities"[4]. The consultation document also posed the questions relating to mandatory functions for the public's response: 'Which services should be mandatory for local authorities to provide or commission?'. The consultation responses ranged form the opinion that all services that LAs will be responsible for should be made mandatory, through to none of the services, in order to give LAs maximum flexibility and encourage innovation in service delivery.

9. The LAs will receive a ring-fenced public health budget in 2013/14 to deliver their new public health responsibilities, which is estimated to be approximately £2.2bn, based on 2010/11 baseline spend by PCTs[5]. This budget is referred to in the IAs that accompany the 'Healthy Lives, Healthy People' consultation[6].

10. In deciding which services to commission that best target the local population's public health needs, the LAs will be guided by the locally produced Joint Strategic Needs Assessment (JSNA) and the local Health and Wellbeing Strategy based on the JSNA, written by the local Health and Wellbeing Boards. They will assess and report on local public health needs. Both Clinical Commissioning Groups (CCGs) and LAs will be expected to base commissioning strategies on the local JSNA and Health and Wellbeing Strategy.

11. To measure improvement of their local population's public health the LAs will have to have regard for the Public Health Outcomes Framework (PHOF)[7]. PHOF is a set of indicators that sets out the desired outcomes for public health and how these will be measured. For example, the PHOF indicator that relates to 'alcohol-related admissions to

[2] 'Health Lives, Healthy People: Our strategy for public health in England', Department of Health (2011) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

[3] 'Public health elements of the Health and Social Care Bill Impact Assessment'' and 'Impact assessment B: Commissioning within the public health system', *Healthy Lives, Healthy People* Impact Assessments, Department of Health (2011), http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_126601

[4] 'Healthy lives, healthy people: consultation on the funding and commissioning routes for public health.pdf', Department of Health (2011), 'http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_122916

[5] This is an estimate and is subject to change. It is an estimate of baseline spend and not a future budget. 'Baseline spending estimates for the new NHS and Public Health commissioning architecture', Department of Health (2011), p 13, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132535

[6] 'Public health elements of the Health and Social Care Bill Impact Assessment'' and 'Impact assessment B: Commissioning within the public health system', *Healthy Lives, Healthy People* Impact Assessments, Department of Health (2011), http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_126601

[7] Public Health Outcomes Framework (PHOF), Department of Health (2012), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

hospitals' will incentivise the appropriate provision of alcohol services by each LA that are specific to their local population. The process of giving regard to the PHOF is likely to incentivise improvement in each local population's public health and to achieve the best PHOF outcomes in England.

12. It is to be noted that the responsibility for abortion services will now lie with CCGs, rather than the previous consideration for the service to sit with LAs.

Rationale for intervention

13. Under the Act, LAs will be free to decide which services to commission for their local populations using the ring-fenced budget, as of April 2013. They will prioritise commissioning services that offer the maximum benefits to their local population based on the local JSNA and the Health and Wellbeing Strategy. However, given the local accountability structures and PHOF indicators that apply to each individual LA, the LAs may not be incentivised to prioritise services that offer additional benefits at the national level. As a result, full autonomy in commissioning decisions by LAs risks sub-optimal public health outcomes at the local *and* national level.
14. The small number of services whose under-provision would pose a serious impact are those where:
    a. it's under-provision puts a national coherent public health system at risk and therefore risks political failure
    b. the service provides additional benefits to society when provided to each individual and therefore the optimum level of delivery is uniform provision
    c. the service has operational issues in that it must be provided in a standardised manner across the board in order to be effective and accrue benefits

15. These risks are therefore used as the criteria for deciding which services are proposed as mandatory.

Criteria for intervention

16. In order to assess which functions should be mandated, the risks outlined above are used as criteria for mandating. Each of the public health services that LAs will be responsible for from April 2013 are crucial to an effective and coherent public health system and are each therefore applied to these criteria. This analysis is presented as a matrix in Annex 2, which shows which of the criteria each individual function meets. The analysis that underpins the matrix in Annex 2 has been conducted by the Department of Health.

17. Each of the service areas meets at least one of the criteria, which shows that each service has reason for being mandated. However, there is a legal requirement as part of the Act, to ensure that LAs retain the majority of the ring-fenced public health budget with which to commission services that they decide best meet their local populations' public health needs[8]. This requirement means that only a small number of functions, which are clearly justified, can be mandated in order to retain LAs autonomy with the majority of the budget. To be mandated a service therefore needs to meet at least two of the three criteria. To underpin the analysis shown in Annex 2 a definition of each of the criteria follows.

Criterion 1: Any degree of under provision of the service puts a coherent and effective national public health system at risk. This also risks political failure as the Secretary of State has a duty to provide a coherent and effective public health system.

[8] The Health and Social Care Act 2012, Part 1, Item 19, The Secretary of State's Duty to Promote Autonomy, http://www.legislation.gov.uk/ukpga/2012/7/section/5/enacted

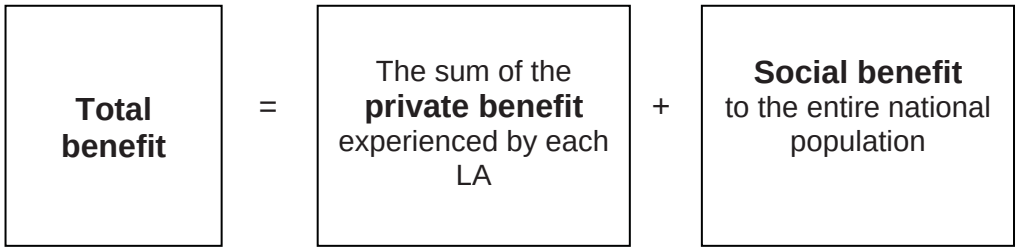
18. An effective public health system must address local and national public health risks. There are services that the LAs will be responsible for that are at risk of under provision if all commissioning decisions are made at the local level and are reinforced by local accountability structures. As a result, the local commissioning incentives may not be aligned with those for services which help provide a national effective public health system. There is a serious risk associated with full local autonomy, should services that are key to a coherent and effective national public health system be under-provided to any degree.

19. *Example scenario of criterion 1*: Ensuring the provision of health protection advice by all LAs to NHS commissioners is a crucial part of an effective national public health system. If an infectious disease broke out then even one LA not effectively reacting and managing the situation could lead to a serious threat to the entire population, regardless of whether all other LAs provided it. A spread of the disease within one LA puts the rest of the population, locally, nationally and internationally at higher risk of contracting the disease. The risk related to any degree of under-provision is therefore so great that it is a political responsibility to ensure the provision of such advice at a uniform level across all LAs.

Criterion 2: The service provides additional benefits to the population when provided uniformly to the entire national population.

20. Criterion 2 is met if the provision of a service provides benefits to the individual LAs who provide it and additional social benefits to the entire national population if all LAs provide it. That is, the service offers a potentially greater total benefit if all LAs commission the service (private benefit to each LA plus social benefit to the national population), which is greater than the sum of the benefits to each individual LA. Services that offer this potential greater benefit, which is also known as a positive externality, to the entire population are called 'merit goods', as shown in Diagram 1. A parallel example is that of education, where educating an individual provides a private benefit to the individual who is educated, as well as a social benefit because they can share their knowledge by educating others. The public also therefore benefits from that individual being educated. The provision of 'merit good' services is therefore desirable by all LAs.

Diagram 1. Total benefit from the provision of merit good services



21. Given the local accountability structures and PHOF indicators that apply to each individual LA, the LAs may not be incentivised to prioritise services that offer additional benefits at the national level. As a result, full autonomy in commissioning decisions by LAs risks sub-optimal public health outcomes at the local *and* national level.

22. While many public health services will cause positive externalities, this criterion is particularly looking at externalities that cross LA boundaries, not simply between individuals who may be within an individual LA. For example, a lower STI rate in one LA

will result in a reduced risk for neighbouring LAs given the high levels of movement of people between LAs.

23. *Example scenario of criterion 2*: Ensuring sexual health and contraceptive services are provided uniformly to all results in a lower rate of STIs for the entire population. That is, accessing sexual health services reduces the impact of a STI on the individual (the private benefit) and also means there is a lower risk of them passing it on to another individual who would experience health issues as a result (the social benefit). This is particularly key in sexual health because STIs are able to spread geometrically, which means one individual with an STI can infect several others, who then in turn can also infect several others. This is in comparison to, for example, obesity, where the rate of obesity changes arithmetically. That is one person cannot directly pass on obesity to multiple others. The private and social benefit of providing open access sexual health services to all is potentially therefore larger than the sum of the private benefits to all LAs.

Criterion 3: The service must be delivered in a standardised manner across all LAs in order to maximise benefits. The service therefore has operational considerations.

24. The service is required to be delivered by each LA in a standardised manner and with a required level of coverage across each LA in order for the service to provide maximum benefits. Any degree of deviation from the standardised method and the required level of coverage will result in a substantial loss of benefits, particularly in the ability to make national comparisons of locally collected data. Under-provision would result in a financial cost to the LAs who do provide it with minimal accrued benefit as a result.

25. *Example scenario of criterion 3*: The National Child Measurement Programme (NCMP) is a surveillance and monitoring programme for childhood obesity. In order for the statistics in this surveillance programme to be comparable across England and across years, all LAs must deliver the programme in a standardised way and achieve 85% coverage within their LA. In doing so, the statistics will be robust and useful in the surveillance of childhood obesity at a local and national level. It is therefore useful in policy development for how best to tackle childhood obesity. A degree of under provision by LAs and deviation from the standardised method of implementation will result in a substantial loss of benefits as the dataset would no longer be robust and the service will not be as cost effective a use of funds.

Policy objective

26. The intended effect of the policy is to deliver an effective public health system that maximises the total health benefit experienced by each individual in England and by England as a national population. This will be achieved by:
    - Ensuring LAs retain the majority of the ring-fenced public health budget to commission the service that have been locally identified as best meeting the public health needs of the local population.
    - Ensuring the provision of services that meet the criteria set out above by mandating each LA to provide them.

Description of options considered

Option 1 – No change, LAs have full autonomy in spending their ring-fenced public health budget with no requirements on which services they commission.

27. LAs have full autonomy in spending their ring-fenced public health budget on services that are locally identified as best targeting the local population's public health needs. There are no requirements on which services they are to deliver.

28. There are mechanisms that will help ensure that local needs are addressed within a national policy framework. A local JSNA and Health and Wellbeing Strategy will be written in each LA to help identify local public health needs and therefore help guide LAs in deciding which services to commission. The achievement of each LA in improving their local population's public health will be shown by the PHOF indicators, which each LA will have to give regard to. The indicators for each LA will be published annually by Public Health England (PHE). These mechanisms justify the default position of giving LAs full autonomy in commissioning services with the ring-fenced public health budget to best address local public health needs.

Option 2 – A small number of public health services are mandated for all LAs to provide, whilst LAs retain autonomy in spending the majority of their ring-fenced public health budget.

29. LAs have autonomy in spending the majority of their ring-fenced public health budget on services that are locally identified as best targeting the local population's public health needs. In conjunction with this, five service areas are mandated for each LA to provide in order to help mitigate the risk of the serious negative impact their under-provision under option 1 poses.

30. With respect to the LAs autonomy in spending the majority of the budget how they see appropriate, there are mechanisms that will help ensure that local needs are addressed within a national policy framework. A local JSNA and Health and Wellbeing Strategy will be written in each LA to help identify local public health needs and therefore help guide LAs in deciding which services to commission. The achievement of each LA in improving their local population's public health will be shown by the PHOF indicators, which each LA will have to give regard to. The indicators for each LA will be published annually by Public Health England (PHE). These mechanisms justify the default position of giving LAs full autonomy in commissioning services with the ring-fenced public health budget to best address local public health needs.

31. Table 1 shows the list of functions that meet at least two of the three criteria and shows which criteria they meet. A description of each of these mandated functions under option 2 then follows.

Table 1. LA's public health functions that meet at least two of the three criteria and are therefore mandatory for all LAs to provide

	Criterion 1	Criterion 2	Criterion 3
Mandated function	Under-provision risks an effective and coherent national public health system	Additional benefits exist if provided by each LA	Operational consideration – requires standardised delivery across the board
a) Sexual health – confidential open access STI testing and treatment and open access contraception services	Y	Y	N
b) Steps LAs must take to protect the	Y	Y	N

health of their population			
c) Public health advice to NHS Commissioners	Y	Y	N
d) National Child Measurement Programme (NCMP)	N	Y	Y
e) NHS Health Check assessments	N	Y	Y

Key: Y = Yes, the function meets the criterion. N = No, the function does not meet the criterion.

Description of the mandatory public health functions for LAs under option 2

a) Sexual health – confidential open access STI testing and treatment and open access contraception services

32. Open access sexual health services ensure that service users are provided with accessible and confidential sexual health services, regardless of whether they are registered with a GP. When they access these services their details will not be shared with anyone, including their GP, without their consent.

33. Rapid access to STI testing and treatment services and confidential provision of these services encourages people to be honest about their sexual behaviour. Untreated infections lead to high transmission rates of STIs including HIV, which fuel further infection in others as one person can pass on an infection to multiple others who then pass on the infection further. In addition, contracting HIV in particular weakens an individual's immune system, making an individual more susceptible to further infections. Meeting STI treatment demand is very likely to lead to a cost-saving situation in which rapid treatment of a majority of new infections limits onward transmission, resulting in low infection rates and low demand for treatment. Open access STI services is particularly attractive to groups who find health services hard to access, and those who may feel embarrassed, for example, people not registered with a GP, young people, sex workers and men who have sex with men.

34. Sexual health services meet the criterion of providing positive externalities if provided by all LAs as they provide a private benefit to the individual treated and a social benefit to the rest of the population as they are less at risk on contracting a STI as a consequence of the individual being treated. Given that STIs spread geometrically, which means that an infected person can pass the infection on to multiple people, who can then pass it on to multiple people means that sexual health services meet the positive externality criterion to a large degree. Sexual health services also meet the criterion of posing a serious risk to a coherent and effective national public health system of under-provided. In addition, the Secretary of State for Health has a legal duty to supply the population with open access sexual health and contraceptive services. Mandating these services ensures that Secretary of State can fulfil his legal duty.

b) Steps LAs must take to protect the health of their population

35. Steps local authorities must take to protect the health of their population will help to ensure there are plans in place to protect the health of their populations from natural hazards, accidents, infectious diseases, terrorism and other health threats. This function is an essential service in a national public health system as it is key to the safety of the national population. Requiring LAs to provide this advice will help ensure that they play their role in addressing health threats and emergencies, through cooperating with the

NHS Commissioning Board and Public Health England. There will be a similar legal duty on these bodies to cooperate with one another.

36. Directors of Public Health will transfer from PCTs to work in LAs, together with appropriate resources, and will exercise these functions on behalf of the LAs. This will help provide the effective leadership and collaboration essential in planning for and responding to public health and other health threats. Local authorities will also continue with their existing responsibilities for planning and responding to emergencies involving a risk to public health.

37. Health protection advice meets criterion 1 because its provision helps ensure an effective and coherent public health system. Ensuring all LAs provide it means that the threat of any health protection emergency, such as an infectious disease is minimised with a consistent response by all LA. It also meets criterion 2 because it provides additional benefits when provided uniformly to the entire national population. The risk posed by a health protection emergency is substantially minimised when public health advice is provided by all LAs, as opposed to a situation where even one LA under-provides the service.

c) Public health advice to NHS Commissioners

38. The transfer of the public health functions to LAs will mean that public health teams are no longer based in the same place as commissioners of healthcare. However, public health advice will remain central to NHS commissioning when public health responsibilities transfer to LAs. Public health advice will be led by appropriately trained and accredited public health specialists (as defined by the Faculty of Public Health) and made available for use by the Clinical Commissioning Groups (CCGs) and, where appropriate, the NHS Commissioning Board. This function is an essential service in a national public health system as it is key to the safety of the national population.

39. There is a legal duty contained in the Act on NHS commissioners (both the NHS Commissioning Board and CCGs) to obtain appropriate public health advice. Whilst they are not compelled to use public health advice provided by LAs the Directors of Public Health and their team are often best placed to provide the necessary level of local intelligence pertinent to inform local commissioning decisions. The advice that they will provide will help support health and wellbeing boards to produce the Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy.

40. This advice only applies to NHS services commissioned by NHS commissioners. It does not encompass public health expertise required for those public health services that will be delivered by the NHS Commissioning Board on behalf of the Secretary of State (such as national screening and immunisation programmes).

41. Public health advice to NHS commissioners meets criterion 1 because its provision by all LAs helps ensure an effective and coherent national public health system. Ensuring all LAs provide it means that the threat of any public health emergency is minimised with a consistent response by all LA. This function also meets criterion 2 because it provides additional benefits when provided uniformly to the entire national population. The risk posed by a public health emergency is substantially minimised when public health advice is provided by all LAs, as opposed to a situation where even one LA under-provides the service.

d) National Child Measurement Programme (NCMP)

42. The NCMP provides high-quality, reliable data on child overweight and obesity levels and trends. Children are measured twice during their time at school and the findings are recorded for monitoring purposes. The results inform policy and commissioning of services that tackle local and national obesity. Coverage of the programme has to be across all PCTs in England and with at least 85% participation rate within localities for robust data collection and comparability for the programme to work.

43. Although NCMP is currently a voluntary programme for PCTs, all PCTs in England have implemented it over the past four years and child participation rates have consistently improved and now stand at 93%. This provides an extremely robust source of public health intelligence and as a result holds UK National Statistics status. The statistics have been used as key indicators in Local Area Agreements[9] and Vital Signs[10]. They are also used in conjunction with other datasets to aid understanding of, for example, the impact of active travel and children's centres. Without at least 85% coverage in each and every LA the data would not be robust enough and none of this would be possible.

44. Recent analysis of progress of the NCMP shows it is effective and is used in policy development[11].

45. The NCMP meets criterion 2 because it provides additional benefits when provided uniformly to the entire national population. It provides valuable statistics on childhood obesity at both the local level, with the added benefit of national comparability when provided uniformly to the entire population. As a result, it helps inform more effective policy development in addressing childhood obesity. This function also meets criterion 3 because it must be delivered in a standardised manner across the board in order to maximise benefits. In order for the collected statistics to be comparable across the country and across time each LA must follow the operational guidance[12] set out by the Department of Health

e) NHS Health Check assessments

46. The NHS Health Check programme[13] is designed to identify people at risk of vascular disease (eg heart disease and stroke). The burden of such conditions accounts for a significant burden of ill health and premature mortality in England. The programme was shown to be cost effective[14] and has been implemented on a phased basis across PCTs from 2009 with expected full roll out to be achieved in 2012-13.

47. The programme is analogous to a screening programme and is based on screening principles. Namely that the programme:

    a. systematically uses the same tests and measures across the eligible cohort;
    b. provides interventions/treatment to help people who are identified at risk or have disease that are proven to be both clinically and cost effective.

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[9] Local Area Agreements, Department of Health, http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Socialcarereform/Localareaagreements/index.htm
[10] Vital Signs, Department of Health, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542
[11] 'December 2011 update on NCMP results', Department of Health (2011), http://www.dh.gov.uk/health/2011/12/ncmp-2/
[12] 'Operational guidance for implementing NCMP', Department of Health (2011) http://www.dh.gov.uk/health/2011/08/ncmp/
[13] NHS Health Checks website, http://www.healthcheck.nhs.uk/
[14] 'Vascular Checks Impact Assessment', Department of Health (2008), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_090351

48. As of April 2013, a brief alcohol assessment will be included in the NHS Health Check. Over 9 million adults are drinking above the lower-risk guidelines and alcohol misuse is the third greatest contributor to ill health behind smoking and raised blood pressure, which are already addressed in the NHS Health Check. Many areas already include alcohol in their NHS Health Check, so this will not be an additional burden in those areas.

49. Within this function, resulting lifestyle interventions following a NHS Health Check will not be prescribed. This is for several reasons. It would be inconsistent with the Secretary of State's duty to promote autonomy. It would cause disparity in the system by prescribing lifestyle interventions when the provision of such services will not be mandated. In addition, some follow-up risk management activity will be provided by the NHS (e.g. prescription of drugs) where there is existing protocol to do so.

50. Following the focus by the Coalition Government on the National Dementia Strategy[15] the NHS Health Check assessments implemented from 2013 will also include information given to the patient on Dementia. This will make use of an opportunity with each patient to raise awareness of a disease, which approximately 800,000 people in the UK suffer from[16].

51. The NHS Health Checks programme meets criterion 2 because it provides additional benefits when it's provided uniformly to the entire population. The additional benefit, alongside reducing vascular diseases, is the ability to monitor vascular disease incidence and prevalence nationally and the reduction of burden to their carers. The statistics from NHS Health Checks are monitored as a key indicator in NHS Vital Signs[17]. This function also meets criterion 3 because the Checks must be delivered in a standardised manner across the board in order to maximise benefits. The possible ways in which the Checks are provided have been analysed and the most cost-effective approach has been standardised as a result[18].

Monetised and non-monetised costs and benefits of each option

Option 1

Costs of option 1

52. There are no expected financial costs associated with option 1. Given that option 1 (no change) is the baseline case, the costs are defined as zero. The public health services will be delivered using an already identified estimated £2.2bn ring-fenced budget as detailed in the IA that accompanied the public health consultation. This estimated budget is based on 2010/11 baseline spend by PCTs.

Benefits of option 1

53. The local populations will benefit from option 1 because all of the ring-fenced public health budget for LAs will be spent by the LAs in targeting the local populations' public health needs.

[15] 'Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy', Department of Health (2010) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119827
[16] 'What is dementia?', Alzheimer's Society, http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=106
[17] Vital Signs, Department of Health (2008), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542
[18] 'Economic modelling for vascular checks', Department of Health (2008), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085869

Risks and assumptions of option 1

54. Option 1 makes the assumption that the JSNA and the joint Health and Wellbeing Board correctly assessed the public health needs of the local population. This assumption is based on the basis that local health professionals are best placed to identify their needs, which are specific to local demographics.

Option 2

55. The following section describes the expected costs and benefits of option 2 based on analysis conducted by the Department of Health. A possible method of sourcing evidence for this analysis would have been to contact LAs directly to better understand how option 2 affects them. However, given that LAs have not currently finalised which public health services they will decide to commission from April 2013 and their commissioning decisions are therefore unknown this is not information upon which to drawn estimates of more exact and quantified costs and benefits.

Costs of option 2

56. As under option 1, the LAs will receive a ring-fenced public health budget in 2013/14 to deliver their new public health responsibilities, which is an estimated £2.2bn. This is not a cost of option 2 as it is an already identified ring-fenced budget as detailed in the IA that accompanied the public health consultation. This estimated budget is based on 2010/11 baseline spend by PCTs.

57. Option 2 will ear-mark a proportion of this budget for spend on the mandatory functions. The Department of Health estimates the spend on mandated functions may be in the region of 28% of the total ring-fenced budget, totalling approximately £610m. This is detailed in Table 2, with an approximate percentage breakdown of spend of the 28% on each mandated function. The £610m will not be an additional cost but rather an allocated amount to be spent on the mandated functions form the total budget. There is therefore no direct financial cost to *mandating* the LAs to provide the identified mandatory functions and hence the monetised financial cost of option 2 is zero.

Table 2. Breakdown of the allocated amount of the LAs' ring-fenced public health budget spend on mandatory function.

Function	Estimated proportion of the 28% spent on each individual mandatory function (%)
(a) Sexual health services – confidential access to STI testing and treatment and open access contraception services	**70**
(b) Steps LAs must take to protect the health of their population, **and,** **(c) Public health advice to NHS Commissioners**	**25 (combined)**
d) National Child Measurement Programme (NCMP)	**< 5**
(e) NHS Health Check assessments	**< 5**

Please note that this is not a financial cost of option 2 but rather an earmarked amount of the already established LAs' ring-fenced public health budget.

58. With an allocated 28% of the ring-fenced budget, the LAs retain 72% of their ring-fenced public health budget to spend on services that target their local population.

59. The non-monetised cost associated with option 2 is an opportunity cost. That is, the benefits foregone by not implementing option 1. The mandated functions may be different from those that the LAs would choose to commission under option 1 with the 28% of the budget that is ear-marked under option 2. The opportunity cost is the benefits under option 1 foregone because of the decision to implement option 2. However, this displacement is thought to be small. This is because, whilst LAs commissioning decisions are unknown, they are likely to commission services similar to the mandated functions. Mandating them helps minimise the risk that any of these services are under-provided to any degree. In addition, the LAs will still be able to implement their highest priority services with the remaining 72% of the budget. The services that are no longer commissioned under option 2 compared to option 1 are likely to be those that meet local health needs by the least amount at that time. The opportunity cost of option 2 is therefore estimated to be small.

Benefits of option 2

60. The local populations' benefits from LAs retaining the significant majority of the ring-fenced budget to commission services that directly target their needs. In addition the local and national population benefit from ensuring the provision of services that help deliver an effective and coherent national public health system. The combination of these will help maximise the public health benefit experienced by the entire population.

61. The benefit of option 2 as compared to option 1 is unknown given that it is not possible to know the benefits accrued by LA commissioning decisions under option 1 compared to option 2 with the ear-marked 28%. This section therefore qualitatively describes the gross benefits under option 2 because the incremental benefits on top of option 1 are unknown. In addition, quantitative gross benefits are unknown for the same reason. Example scenarios are therefore presented to show the potential costs if these functions are not mandated.

62. Sensitivity analysis was considered on the expected opportunity cost of option 2. That is, the estimated size of displacement of alternative services that would have been commissioned under option 1 could be varied in order to show the consequence of small displacement costs compared to large displacement costs on the Net Present Value (NPV) of option 2. However, the unquatified net benefit of option 2 is not thought to be reliant on the size of this opportunity cost as the direct costs and benefits alone identify option 2 as having a positive NPV. The assumption is therefore made that the opportunity costs of mandating these functions in option 2 is small.

Benefits of each of the individual mandated functions

63. These are presented as a qualitative description of gross benefits of each function rather than the total incremental benefits as compared to option 1. This is because the local commissioning decisions of the LAs under both option 1 and option 2 are unknown. As a result the incremental benefits accrued under option 2 as compared to option 1 are unknown. In addition, a speculative scenario is described for each function to describe a possible negative impact on the population if the function were not mandated.

a) Benefits of mandating sexual health services – confidential open access STI testing and treatment and open access contraception services

64. Universal provision of confidential and open-access STI testing and treatment services extend access to groups that are not registered with a GP and to patients who are

registered with a GP but prefer to protect their anonymity. Accessible sexual health services prevent higher infection rates and therefore correspondingly higher treatment costs resulting from onward transmission, particularly if serious complications occur. It reduces the presence of untreated STIs and reduces the risk of both acquisition and transmission of HIV. Failure to provide these services would result in a considerable risk that local and national public health outcomes are highly unlikely to improve and risk deterioration. For example, along with the deterioration in the individual's health, the life-time health treatment costs of one HIV positive person are estimated to be up to £360k.

65. Contraception enables people who are sexually active to control their fertility and to avoid unintended or unwanted pregnancies. It is provided free of charge to the patient and is cost effective as it is estimated that the NHS saved £11 for every £1 spent on contraception[19], with potential for this to be an underestimation[20]. Contraception reduces unwanted pregnancies, which avoids possible adverse mental health issues for a woman[21]. GPs provide around 75-80% of contraception services and mostly offer relatively basic contraception. It is the remaining services currently provided by sexual health clinics that offer more complex reversible long-term contraception services, which have been proven to be more effective[22]. It is these remaining services that will be commissioned by LAs (Irreversible forms of contraception will be commissioned by the Clinical Commissioning Groups).

66. The benefits of contraception can only be realised if people are able to go to services they feel happy about attending, and are able to select a method of contraception, which works best for them. Prescribing these services is therefore necessary to ensure that open-access contraception services are provided in all areas, and that there is reasonable provision of all methods of contraception.

Example speculative scenario to illustrate the benefits of mandating sexual health services

67. There have been unexpected outbreaks of syphilis throughout England during the past decade, following the infection re-establishing itself in the UK[23]. This included an outbreak in heterosexual men in East London in 2002, where 103 new cases were identified, 30% of which were also co-infected with HIV[24]. This outbreak was only noticed as a result of retrospective surveillance data. An additional outbreak was in November 2011 where multiple outbreak were found across England and Scotland. Should this situation not be contained by each and every LA there is a high risk that syphilis, and other STIs will spread further. The Government of Alberta in Canada currently have a sustained outbreak of syphilis where infection has spread to the general population, outside the high risk groups, including babies being born with congenital syphilis[25]. This is a highly preventable situation but once established it is very difficult to stop. This is an example to show that mandating the provision of sexual health services by all LAs is crucial.

b) Benefits of mandating steps local authorities must take to protect the health of their population

[19] McGuire, D and Hughes, A. The cost effectiveness of family planning service provision. *Journal of Public Health Medicine*, (1996) Vol. 18, (2) p.189-196
[20] Contraception Atlas 2011, Bayer HealthCare
[21] Induced Abortion and Mental Health (2011), Academy of Medical Royal Colleges
[22] Long Acting Reversible Contraception (CG30) (2005); National Institute for Health and Clinical Excellence
[23] Infectious syphilis in young heterosexuals: responding to an evolving epidemic, Simms, Bell and Hughes (2011) International Journal of STD & AIDS, 22: 481–482 http://www.iusti.org/sti-information/Journals/pdf/IJSA-11-206.pdf
[24] Lessons from the syphilis outbreak in homosexual men in east London, Hourihan, Wheeler, Houghton and Goh (2012), Sex Transm Infect (2004), 80:509-511
http://bmj-sti.highwire.org/content/80/6/509.full.pdf
[25] The syphilis outbreak in Alberta, Office of the Chief Medical Officer of Health, December 2010,
http://www.health.alberta.ca/documents/STI-Syphilis-Report-2010.pdf

68. Prescribing this function will ensure that plans are in place for effective responses to health protection incidents and emergencies. For example, in the event of an outbreak of an infectious disease, a consistent degree of readiness and response across the country will help to reduce significantly an otherwise serious risk to the population from the spread of the disease. Providing health protection will mean that the service is provided in line with the Cabinet Office identification of health resilience as one of the nine core elements of the National Resilience Capabilities Programme[26].

69. The transfer of Directors of Public Health from PCTs to LAs will ensure effective leadership of health protection advice and coordination and cooperation between LAs, the NHS Commissioning Board and Public Health England.

Example speculative scenario to illustrate the benefits of mandating steps local authorities must take to protect the health of their population

70. In 2009 there was an outbreak of e-coli from Godstone Farm in Surrey, England. The outbreak began in August 2009 and in the space of 3 months there were 93 cases in the UK. The outbreak was contained as a result of staff from PCTs, LAs, the Surrey and Sussex Health Protection Unit, the Health Protection Agencies Local and Regional Units and others, coordinating and managing the outbreak[27]. As a comparison, an outbreak of e-coli in Europe is estimated to have resulted, in Germany alone between May and June 2011, 838 Hemolytic Uremic Syndrome cases (a severe complication that can cause blood and kidney infection) and 3,063 verocytotoxin-producing E.coli cases (severe diarrhoea which can lead to a HUS case), of which 47 people died[28]. Whilst values of the financial burden posed by each of these outbreaks vary substantially, it is clear that without a coherent, coordinated and effective approach to health protection threats such as a communicable disease such as e-coli the result is high costs to the individuals affected, a high risk of infection to the entire population and a cost to the economy. The risk posed by under-provision of these services is therefore substantial. The proposed spend on health protection and public health advice equates to 25% of the 28% of the estimated £2.2bn spend on mandatory functions. An alternative use of these funds might be on functions that are a local priority for the LA. However, whilst each local population would accrue benefits from this local service the risk posed from it's under-provision is substantially smaller compared to the risk posed by the under-provision of health protection and public health advice nationally.

c) Benefits of mandating public health advice to NHS Commissioners

71. The transfer of the public health functions to LAs will mean that public health teams are no longer based in the same place as commissioners of healthcare. Prescribing the provision of public health advice will ensure that public health advice to NHS commissioners continues to be available. Otherwise public health advice may become fragmented or at worst, nonexistent. The uniform provision of such advice helps to ensure clinical commissioning reflects adequately the needs of the whole population. Mandating this advice will ensure that public health advice remains central to NHS commissioning when public health responsibilities transfer to LAs.

72. There is a legal duty contained in the Health and Social Care Act 2012 on NHS commissioners (both the NHS Commissioning Board and clinical commissioning groups)

[26] National Resilience Capabilities Programme, Cabinet Office, http://www.cabinetoffice.gov.uk/content/capabilities-programme
[27] 'The e-coli E0157 independent Griffin Investigation' (2010), Chapter 5, http://www.griffininvestigation.org.uk/report/P_B/default.htm
[28] 'Joint rapid risk assessment on the *E. coli* outbreak', European Food Safety Authority and European Centre for Disease Prevention and Control (2011), http://www.ecdc.europa.eu/en/publications/Publications/2011June29_RA_JOINT_EFSA_STEC_France.pdf

to obtain appropriate public health advice. They are not compelled to use public health advice provided by Local Authorities. However, Directors of Public Health and their team are often best placed to provide the necessary level of local intelligence pertinent to inform local commissioning decisions. The advice that they will provide will help support health and wellbeing boards to produce the Joint Strategic Needs Assessment (JSNA) and health and wellbeing strategy. Public health advice will be led by appropriately trained and accredited public health specialists (as defined by the Faculty of Public Health) and made available for use by the Clinical Commissioning Groups (CCGs) and, where appropriate, the NHS Commissioning Board.

Example speculative scenario to illustrate the benefits of mandating public health advice to NHS Commissioners

73. In 1988, Camelford in Cornwall, England experienced an accidental contamination of their drinking water supply. The concentration of aluminium sulphate was raised to 3,000 times the advisable level by accident and resulted in "considerable damage to cerebral function" in 55 people[29]. Those affected complained of short term memory loss and impaired concentration. As a result of the incidence 148 individuals were paid a total of £400,000 in compensation in 1994. The appropriate and coordinated efforts to deal more effectively with a public health situation such as this would have helped contain the contamination, reducing the negative health impacts on the individuals and helping them gain any due compensation in a timely manner.

d) Benefits of mandating the National Child Measurement Programme (NCMP)

74. Prescribing the NCMP will secure continuation of the collection of robust statistics on childhood obesity and therefore the continuing ability to monitor levels and trends in obesity that informs policy and commissioning decisions. National policy decisions and local commissioning of services will continue to be based on evidence and thus will be more likely to be effective at helping to reduce child obesity.

75. The NCMP data can also be used in conjunction with other national data sets such as education or travel to aid our understanding of child health; detect the impact of services such as active travel, children's centres and other early years settings; and to inform the policy of other Departments of State.

76. Participation by every local area in England is essential as public health responsibilities LAs assume their new public health responsibilities. Without robust data (85% coverage) from each LA, none of this would be possible.

77. An additional benefit of the NCMP is the availability of data to inform parents in living healthier lifestyles. Providing the individual feedback to parents is not a proposed prescribed part of the function, it will be at the discretion of the LA. Prescribing the NCMP and thereby having the access to robust, comparable data makes this possible and creates an additional tool in tackling local child obesity.

78. If NCMP is not prescribed, it is possible that the areas that do choose to continue to implement NCMP are likely to be less economically deprived areas, whereas more economically deprived areas may choose to divert resources elsewhere. Prescribing the NCMP will help national and local understanding of health inequalities, as the less and more economically deprived areas have information with which to tackle obesity.

[29]Disturbance of cerebral function in people exposed to drinking water contaminated with aluminium cuplahte: retrospective study of the Camelford water incident http://www.bmj.com/content/319/7213/807.full

Example speculative scenario to illustrate the benefits of mandating the NCMP

79. In 2010, 62.8% of the adult population and 30.3% of children aged 2-17 years were classed as obese or overweight in England. The total estimated annual cost of obesity is £55.1billion in England[30], as a result of 1.1 million obesity related prescriptions in 2010[31] and a higher risk and incidence of type 2 diabetes, cancer and heart disease. These costs will continue to rise and will require a larger health budget if obesity is not targeted with direct and effective policy. In order to help ensure such policies are implemented, robust and reliable data sources are crucial in doing so. Evidence based policy is required in tackling obesity.

e) Benefits of mandating NHS Health Check assessments

80. The programme is proven to be clinically and cost effective[32] and has been identified as one of the most ambitious public health programmes in the world. Prescribing the assessment part of the NHS Health Check will facilitate further improvements being made in preventing and delaying the onset of heart disease, stroke, diabetes and kidney disease. These improvements will build on the advancements that have already taken place in this area and ensure that the progress is not undermined.

81. The programme is due to reach full roll out across PCTs in the same year that the responsibility for it will transfer to local authorities. Prescribing the local authorities to provide it will ensure the continued provision of the programme to all eligible throughout England.

Example speculative scenario to illustrate the benefits of mandating NHS Health Check assessments

82. Type 2 diabetes affects 2.5million people in the UK[33]. The cost of drugs and treatment for diabetes rose from £458.6million in 2004/5 to £649.2 million in 2009/10, which is a 40% increase in costs of drugs and treatment alone[34]. This does not include further costs such as absenteeism from work, which further adds to the cost of diabetes. An estimate of absenteeism as a result of diabetes is £8.4billion per year[35]. In order to raise awareness and to improve prevention and treatment of diabetes it is crucial for LAs to offer NHS Health Check assessments, which also help do the same for heart disease, strokes and dementia.

Risks and assumptions of option 2

83. Prescribing the specified public health functions reduces the flexibility for the LAs to commission services that directly address locally determined priorities from 100% to 72% of their public health ring-fenced budget. The estimated 28% that is earmarked from the ring-fenced budget for mandated functions is a figure across all LAs. The assumption is made that the allocation of the ring-fenced budget is 28% for each individual LAs. This option assumes the JSNA and the joint health and well being strategy correctly identify the public health needs of the local population, which the LAs will act upon when

[30] Obesity, Department of Health, http://www.dh.gov.uk/health/category/policy-areas/public-health/obesity-healthy-living/
[31] Statistics on obesity, physical activity and diet: England 2012, NHS Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity/statistics-on-obesity-physical-activity-and-diet-england-2012
[32] 'Economic Modelling for Vascular Checks', Department of Health (2008) http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085917.pdf

[33] Diabetes, type 2, NHS Choices, http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Introduction.aspx
[34] Prescribing for Diabetes in England 2004/5 to 2009/10, NHS Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions/prescribing-for-diabetes-in-england-2004-05-to-2009-10
[35] Diabetes expenditure, burden of disease and management in 5 EU countries, Kanavos, van den Aardwag and Schurer, (2012), London School of Economics, http://www2.lse.ac.uk/LSEHealthAndSocialCare/research/LSEHealth/MTRG/LSEDiabetesReport26Jan2012.pdf

commissioning services. This assumption is made on the basis that local health professionals, who assist with the JSNA and the Strategy are best placed to assess the local population's needs.

Rationale and evidence that justify the level of analysis used in the IA

84. The mandated functions in option 2 are not those that are the most cost effective or deemed more important. Each of the public health functions that will be LAs responsibility from April 2013 are considered cost-effective. In addition they are all considered important but will be to a varying degree depending on the public health needs of the local population. The mandated functions are those whose under-provision would pose a significant negative impact on the national public health system and as a consequence, result in sub-optimal pub health benefits to the population. The risks posed by the potential under-provision of these services are described qualitatively because there is no definite quantitative evidence available about the cost. However, the potential costs described qualitatively in this IA are considered substantial.

85. The qualitative descriptions of expected costs and benefits of option 1 and option 2 are based on previous implementation of a service area, previous costs as a result of their under-provision or on qualitative economic reasoning. An alternative method of collecting evidence would have been to contact LAs directly to see how option 2 would affect them. However, the commissioning decisions they make locally aren't currently finalised and therefore would not be able to inform the IA further.

86. Sensitivity analysis could be conducted on the expected opportunity cost of option 2. That is, the estimated size of displacement of alternative services that would have been commissioned under option 1 could be varied in order to show the consequence of small displacement costs compared to large displacement costs on the Net Present Value (NPV) of option 2. However, the unquantified net benefit of option 2 is not thought to be reliant on the size of this opportunity cost as the direct costs and benefits alone identify option 2 as having a positive NPV. The assumption is therefore made that the opportunity costs of mandating these functions in option 2 is small.

87. Alternative policy options have not been considered in this IA because option 2 already presents the key criteria by which the mandated functions have been chosen and therefore the decision making process behind which functions are to be mandated.

Evaluation

88. The policy objectives will be evaluated and reviewed as outlined in the PIR outlined in Annex 3.

89. The policy objectives will be indirectly assessed against achievement of the Public Health Outcomes Framework (PHOF) indicators. Checks on services provision, achievement of improving health outcomes and any under-provision of services will be picked up indirectly by:
    - Local scrutiny and transparency through the JSNA and Health and Wellbeing Boards
    - The annual reports written by each LA's Director of Public Health
    - The return of Statement of Grant Usage (SoGU) to the Department of Health on what the LA has spent their ring-fenced Public Health budget on

Coalition agreement

90. Option 2 is in line with the Coalition agreement. It allocates the significant majority of the LAs ring-fenced public health budget to LAs to commission services as they see best fit the local public health needs. Their commissioning decisions are therefore held to account by local accountability structures such as the local JSNA and Health and Wellbeing Boards, the LA's Director of Public Health reports and the LA's improvements of the local PHOF indicators. As a result the services are more accountable to the patients that they serve as set out in the Coalition's programme for Government[36]. The policy also ensures the provision of services that help ensure an effective and coherent national public health system that help maximise the public health benefit to the entire population. This will help LAs achieve improvements in relevant indicators as set out in the Coalition's document.

Direct costs and benefits to business calculations (following OIOO methodology)

91. There are no direct impacts on businesses under option 2. The OIOO implication is therefore zero.

92. There will be an indirect impact on businesses given that option 2 will impact on the services that are commissioned by the LAs. Whilst commissioning of the mandated services will be ensured across years, the other services delivers are decided by each individual LA and are currently unknown. The impact on local businesses is therefore indirect and unknown.

Wider impacts

Equality Assessments (EAs)

93. Equality Assessments have been conducted for each of the mandated functions, which sit alongside this IA.

Small and medium enterprises (SME)

94. Under option 1 it is unknown what the impact on SMEs will be because it is not yet known what services each individual LA will decide to commission compared to what is already being delivered by PCTs.

95. Under option 2 there will be a degree of secured commissioning across the country, within each LA. The functions that are prescribed as currently being delivered nationally, under commissioning by PCTs. Ensuring the continued delivery of the prescribed functions therefore makes it more likely that the small and medium organisations that currently provide them will continue to do so. (There may be some competing providers that the LA will choose to deliver the services.)

Environmental impacts

96. There are not expected to be any impacts on greenhouse gas emissions, energy use, C02 changes or wider environmental issues as a result of this policy.

Health impacts

97. The combination of locally commissioned services and a small number of mandated services across all LAs under option 2 will help maximise the total public health benefits to the population.

[36] 'The Coalition: our programme for Government.pdf', Cabinet Office (2010), http://www.cabinetoffice.gov.uk/news/coalition-documents

Summary and preferred option with description of implementation plan

98. The preferred option is option 2. Option 2 helps maximise the total public health benefit of the population. It does so by providing LAs with considerable autonomy in commissioning services that best meet the public health needs of the local population, whilst ensuring uniform provision of services that provide an additional benefit when provided nationally. The LAs retain 72% of the ring-fenced public health budget, whilst 28% of the budget is allocated to the mandated functions.

99. This policy would be implemented by mandating LAs to provide the services stated as mandatory from when they assume their public health responsibilities in April 2013.

100. The policy objectives will be evaluated and reviewed as set out in the Post Implementation Review detailed in Annex 3.

Annex 1 - List of public health functions transferring to Local Authorities in April 2013[37]

Under the Health and Social Care Act 2012, from April 2013 unitary and upper tier local authorities (LAs) will be responsible for the following functions. Except where a service is mandated, local authorities will be free to invest the public health budget in services that best reflect local needs, based on the Joint Strategic Needs Assessment and the joint health and wellbeing strategy. The list below is therefore not a comprehensive list of public health services that may be commissioned at the local level.

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5 – 19 (including Healthy Child Programme 5 – 19) (and in the longer-term all public health services for children and young people)
- National Child Measurement Programme
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasingly levels of physical activity in the local population
- NHS Health Check assessments
- Public mental health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- The local authority role in dealing with health protection incidents, outbreaks and emergencies[38]
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks

[37] 'Commissioning responsibilities.pdf', Public health system fact sheet, Department of Health (2012), http://healthandcare.dh.gov.uk/public-health-system/

[38] The service areas 'The LA role in delaying with health protection incidents, violence prevention and response' and 'Public health aspects of promotion of community safety, violence prevention and response' are now combined to make ''Core offer' for health protection and general public health leadership'.

Annex 2 – Local Authority Public Health mandatory functions matrix

	Criteria for mandation			
Public health functions the Local Authorities are responsible for from April 2013	**Under-provision puts a coherent and effective national public health system at risk**	**Additional benefits exist when provided by all LAs**	**Operational issues - it must be implemented in a standardised way with required coverage levels in each LA**	Number of criteria met
Tobacco control and smoking cessation services	N	Y	N	1
Alcohol and drug misuse services	Y	N	N	1
Public health services for children and young people aged 5 – 19 (including Healthy Child Programme 5 – 19) (and in the longer-term all public health services for children and young people)	N	N	N	0
National Child Measurement Programme	N	Y	Y	2
Interventions to tackle obesity such as community lifestyle and weight management services	N	N	N	0
Locally-led nutrition initiatives	N	N	N	0
Increasing levels of physical activity in the local population	N	N	N	0
NHS Health Check assessments	N	Y	Y	2
Public mental health services	N	Y	N	1
Accidental injury prevention	N	N	N	0
Population level interventions to reduce and prevent birth defects	N	N	N	0
Population level interventions to reduce and prevent birth defects	N	N	N	0
Behavioural and lifestyle campaigns to prevent cancer and long term conditions	N	N	N	
Local initiatives on workplace health	N	N	N	0
Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes	Y	N	N	1
Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)	Y	Y	N	2
Local initiatives to reduce excess deaths as a result of seasonal mortality	N	N	N	0
The local authority role in dealing with health protection incidents, outbreaks and emergencies	Y	Y	N	2
Public health aspects of promotion of community safety, violence prevention and response	Y	Y	N	2
Public health aspects of local initiatives to tackle social exclusion	N	N	N	0
Local initiatives that reduce public health impacts of environmental risks	N	Y	N	1

Annex 3 - Post Implementation Review (PIR) Plan: Mandatory public health functions for local authorities

Basis of the review

The Public Health Policy and Strategy Unit in the department will keep all public health legislation under review to ensure it remains relevant and effective. Ministers have a duty to promote local autonomy so far as that is consistent with the interests of the health service. With that in mind they have committed to prescribing the minimum necessary amount of activity, and so periodically will want to consider the potential for removing functions from these regulations as well as any evidence of a need to add new ones. This policy will be reviewed as part of this, 3 years after implementation in April 2016.

Review objective

The review objectives are to ensure each of the following mandatory public health functions are provided to the appropriate level and to analyse their effectiveness (based on success criteria, identified in the sections below):

- open access to confidential sexual health services, including testing, prevention and treatment of sexually transmitted infections and provision of contraception;
- public health advice from local authorities to the NHS commissioners;
- steps local authorities must take to protect the health of their populations through ensuring appropriate plans are in place;
- National Child Measurement Programme (NCMP);
- NHS Health Check assessments.

Review approach and rationale

To ensure the appropriate level of provision of each of the mandated functions, the LA annual financial outturn reports provide one means checking that appropriate levels of funding are being spent on each function.

For cost saving reasons, the review in relation to the effectiveness of each mandated function will be based on routine analysis of existing monitoring data, for example the Public Health Outcomes Framework, and the routine Public Health England and Office of National Statistics (ONS) data.

DH programme leads may consider commissioning in-depth evaluations of their programmes/workstreams (e.g. NHS Health Check) to inform further programme development and policy making. This review will attempt to draw on the results of these where possible.

Baseline

The baseline for all future data comparisons will be data outlined in the impact assessment, submitted in each of the LAs' annual financial outturn reports and the Public Health Outcomes Framework.

Success criteria

The success criteria for ensuring provision of the mandatory functions:

- the LAs' annual financial outturn reports provide evidence of appropriate levels of funding on each mandatory function

The success criteria for effectiveness of the mandatory functions:

- the improvements in coverage by the NHS Health Checks and by the National Child Measurement Programme;
- improvements in the relevant Public Health Outcomes (e.g. reduction in the rate of late HIV diagnosis, plans in place to protect the health of the local population);
- general improvements in public health outcomes as a result of public health advice to NHS commissioners.

Monitoring information arrangements

- Data submitted in the LAs' annual financial outturn reports will be held by the Department of Health, who will check that appropriate levels of funding have been spent on each mandated function, which ensures their provision.

- Data for the NHS Health Checks and the National Child Measurement Programme will be held by local authorities and will also be available through the Public Health Outcomes Framework.

- Data for other prescribed and non-prescribed functions will be available through the Public Health Outcomes framework as well as general Public Health England surveillance data, and ONS.

Reasons for not planning a review

Not applicable.