Healthy Lives, Healthy People: Update on Public Health Funding

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	**Finance**
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	17695
Title	Healthy Lives, Healthy People: Update on Public Health Funding
Author	Resource Allocation Team and Public Health Policy & Strategy Unit
Publication Date	**14 June 2012**
Target Audience	SHA Cluster CEs, Directors of PH, Local Authority CEs, Directors of Finance, Local Authority Directors of Finance
Circulation List	PCT Cluster CEs
Description	This document sets out current thinking on local authority public health finance. In particular: • the next steps on moving from estimates of baseline spend published in February to actual allocations for 2013-14; • proposed conditions on the ring-fence grant; and • the health premium.
Cross Ref	
Superseded Docs	
Action Required	We would welcome feedback on the issues raised in this document.
Timing	**N/A**
Contact Details	Resource Allocation Team Strategy, Finance and NHS Directorate Department of Health 4W07 Quarry House Leeds LS2 7UE allocations@dh.gsi.gov.uk
For Recipient's Use	

First published [Month Year]
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Healthy Lives, Healthy People: Update on Public Health Funding

Prepared by

Department of Health

Resource Allocation Team and Public Health Policy & Strategy Unit

Contents

1. Introduction

1.1. *Healthy Lives, Healthy People: Our strategy for public health in England* published in November 2010 set out the Government's ambitious vision to help people live longer, healthier and more fulfilling lives, and to improve the health of the poorest, fastest. The White Paper was a response to Sir Michael Marmot's report on tackling health inequalities (*Fair Society, Healthy Lives: the Marmot Review: Strategic Review of Health Inequalities post 2010*), and highlighted the importance of taking action across the life course, with a focus on early years, children and young people, if we are to make the greatest impact on health and wellbeing. Since publication of the White Paper the Government has put in place an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives. From April 2013 there will be major changes to the public health system in England:

- local authorities will take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health. Local political leadership will be central to making this work;
- a new executive agency, Public Health England (PHE) will:
    - deliver services (health protection, public health information and intelligence, and services for the public through social marketing and behavioural insight activities);
    - lead for public health (by encouraging transparency and accountability, building the evidence base, building relationships, promoting public health); and
    - support the development of the specialist and wider public health workforce (appointing Directors of Public Health with local authorities, supporting excellence in public health practice and bringing together the wider range of public health professionals).
- as highlighted by the NHS Future Forum,[1] the NHS will continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts; and
- within Government, the Department of Health (DH) will provide leadership in promoting and protecting public health, set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities, recognising the wider determinants of health which government influence.

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132085.pdf

1.2. As set out in *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*[2], from April 2013 public health services will be funded by a new public health budget, separate from the budget managed through the NHS Commissioning Board (NHS CB) for healthcare. This will ensure that investment in public health is ring-fenced.

1.3. The principal routes through which public health functions will be funded are:

- ring-fenced grants to upper tier and unitary local authorities;
- through the NHS CB; and
- PHE commissioning or providing services itself (DH may also carry out some public health commissioning or procurement).

1.4. The Public Health White Paper, *Healthy Lives, Healthy People* gave a commitment to ensuring that local authorities are adequately funded for their future new public health responsibilities and that any additional net burdens will be funded in line with the Government's New Burdens Doctrine.

1.5. This document sets out current thinking on local authority public health finance. In particular:

- the next steps on moving from estimates of baseline spend published in February to actual allocations for 2013-14;
- conditions on the ring-fence grant; and
- the health premium incentive (the element of non-mandated expenditure that is dependent upon the local authority making progress against certain public health indicators).

1.6. It describes the interim recommendations of the Advisory Committee on Resource Allocation (ACRA), which we have accepted, but we also agree with ACRA that further development is needed before their recommendations for 2013-14 can be finalised. We are keen to receive feedback on the interim recommendations so that they can inform ACRA's continuing work.

1.7. It should be read alongside the other documents recently published by the Department on the new public health system:

- The Public Health England Operating Model[3]
- Local Government update[4]

[2] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_122916
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131882
[4] http://healthandcare.dh.gov.uk/public-health-system/

- The government's response to the NHS Future Forum's consideration of public health[5]
- The Public Health Outcomes Framework[6]
- Baseline spending estimates for the new NHS and Public Health commissioning architecture[7]

[5] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
[7] http://www.dh.gov.uk/health/2012/02/baseline-allocations/

2. From baseline to budget

2.1. On 7 February 2012 we published the first estimates of baseline spending for the new NHS and public health commissioning architecture, based on returns from PCTs of actual spend in 2010-11. This included a mapping of relevant PCT public health spend on to local authority geographies. These gave the first indication of how public health resources might potentially be distributed across local authorities in the future. We estimated that in 2012-13 around £5.2bn will be spent on the future responsibilities of the public health system, including £2.2bn on services that will be the responsibility of local authorities. To support planning, we have committed that the amount allocated to local authorities for 2013-14 will not fall below these estimates in real terms, other than in exceptional circumstances.

2.2. Understanding baseline spending is just one step in setting the level of future local authority grants. The key steps are:

- understanding the baseline;
- setting the preferred relative distribution of resources;
- setting the total resources available; and
- deciding how quickly to move local organisations from the baseline position towards the level of resource implied by the preferred distribution (pace-of-change policy).

2.3. Although the terminology varies, these steps feature in all major public sector resource allocation models, including the formula used by the Department for Communities and Local Government (CLG) for central government support for local authorities.

2.4. In February we set out our current estimates of baseline spending for each local authority, and we have received many comments and updates since then that will improve our understanding.

2.5. This update reports the interim recommendations of ACRA for how to set the preferred relative distribution of public health resources between local authorities. ACRA is an independent committee of GPs, public health experts, NHS managers and academics who make recommendations on the preferred relative distribution of resources to the Secretary of State for Health. The number of public health experts on the committee was increased to support the development of these recommendations. This update also discusses our approach to the health premium incentive scheme.

2.6. Decisions about the total resources available in the overall public health ring-fence, and so the amount available for local authorities can only be made in the context of wider decisions about resources across the healthcare system, such as the funding available to the DH, NHS CB and Health Education England.

2.7. Setting national budgets is a complex process that needs to reflect the relative pressures and expectations in each part of the system to decide on the share of the available

resources each part of the system should receive. We will particularly need to consider issues that affect different parts of the health and care system differently, such as:

- pressures from a growing and ageing population;
- increased expectations, such as through new National Institute for Health and Clinical Excellence (NICE) guidance;
- new policies, such as the roll-out of the NHS Health Check programme; and
- expected efficiency gains, through initiatives like QIPP.

2.8. Until this wider process is complete we will be unable to give any firmer information on the actual levels of local authority allocations and any pace-of-change policy. However, the current restrictions on growth in public health spending will mean that, initially, progress towards the preferred distribution is likely to be slow.

ACRA's interim recommendations on the preferred relative distribution

2.9. ACRA was commissioned by the Secretary of State to develop a formula for the allocation of the public health budget to local authorities relative to population health need, to enable action to improve population wide health and reduce health inequalities.

2.10. To support ACRA we included a question in *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*, which discussed three options for the general approach that should be taken:

- a utilisation based approach (based on analysing current patterns of public health activity);
- an outcomes based approach based on population health measure(s); and
- an approach based on the cost effectiveness of different public health interventions across the country.

2.11. We also asked if there were any other plausible approaches we might use. The responses showed a strong preference for an allocation based on health outcomes measures, as the most appropriate and feasible at this time. There was concern that a utilisation approach would not be appropriate for many public health interventions and that the currently available data are not sufficiently comprehensive to support an approach based on the cost effectiveness of different public health interventions across the country.

2.12. In line with these consultation responses, ACRA's interim recommendation is based on the standardised mortality ratio (SMR) for those aged under 75 years (SMR<75). The SMR<75 is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences between the age profile of the local areas compared with the national average. A higher SMR<75 number represents a higher number of deaths.

2.13. Many of the population mortality and morbidity measures are well correlated, but SMR<75 has some important practical advantages: it is updated regularly, including at Middle-Layer Super Output Area level (MSOAs, a small geographical area defined by the Office for National Statistics (ONS), used for statistical analysis and typically covering a population of around 7,000). SMR<75 is being proposed as an indicator of the whole population's health status, and hence need for public health services; it should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 years or that morbidity is unimportant.

2.14. Having selected the appropriate measure, ACRA needed to consider the appropriate gradient, that is to say how quickly the need for public health resource increases as the SMR<75 increases. ACRA was unable to find any datasets or research to inform this decision and so convened a group of public health experts to debate the point. The judgement of this expert group, accepted by ACRA, was that, all else being equal, the decile of MSOAs with the worst outcomes (ie highest SMRs) should have a weighting that is three times greater per head than the decile with the best outcomes (ie lowest SMRs). By using the SMR data for small areas in this way, and summing across MSOAs to give local authority figures, account is taken of differences in health outcomes within local authorities as well as between local authorities.

2.15. ACRA also recommended that the formula should include an adjustment for unavoidable differences in the costs of delivering services across the country which are due to location alone, such as higher staff costs, and not need. ACRA recommended that, for consistency, an appropriate Area Cost Adjustment (ACA) based on that used in the local government funding formula should be used.

2.16. However, it is important to note that this is an interim recommendation. ACRA have already identified some areas needing further work before making its recommendations for the formula for allocations in 2013-14, including:

- an adjustment for age – much of the spend is in areas like sexual health that may suggest a weighting towards young adult populations;
- a fixed cost adjustment – some functions may need to be carried out by all authorities irrespective of size, supporting a fixed minimum allocation;
- non-resident populations – the current recommendations are based on the number of people resident in each area, but some services, most notably open access sexual health services, will be available to anybody who is in an area, whether they are residents or not; and
- updates to the latest ONS population projections based on the 2011 population census, in line with the population base used by CLG for the formula grant.

ACRA's recommendations were made before the baseline spend estimates were available and may also need to be adjusted to reflect these data. A summary of ACRA's interim recommendations is at Annex A.

Implementing ACRA's recommendations and the health premium

ACRA's recommendations

2.17. The workbook and associated technical guidance we are publishing alongside this update shows the relative distribution of resources implied by ACRA's recommendations. Although local authorities will receive a single grant that they must then prioritise, the preferred distribution is built up from three components:

- a component to support mandated services;
- a component to support non-mandated services, other than drugs services currently commissioned by Drug Action Team partnerships (DATs); and
- a component to support drugs services which are currently commissioned by DATs through the Pooled Treatment Budget (PTB) formula[8]. These drugs services are non-mandated.

2.18. The funding for non-mandated services is the 'health premium' and ultimately will include both a core allocation, targeted to allow authorities to be responsive to relative deprivation and poor health outcomes and an incentive component.

2.19. At this stage both mandatory and non-mandatory components are based on the same formula, and when grants are made to local authorities no distinction will be made between these two elements, allowing them as much flexibility as possible within the ring-fence to prioritise spending. We are making this distinction at this stage to support development over the coming years. For instance, the implications of age weighting may be different in each group of responsibilities.

2.20. The mandated services component (reflecting spend on sexual health services, the National Child Measurement Programme, the NHS Health Check programme, the provision of public health advice to NHS commissioners and resources required for ensuring health protection plans are in place) is based entirely on the interim formula recommended by ACRA, as is the non-mandated services component.

2.21. ACRA felt that, at least in the interim, the allocation of the PTB for drugs treatment should continue to follow the approach currently used and praised as effective by the National Audit Office[9]. This is currently based on a need component and an activity component, which will continue to be followed except for replacing the need component with the SMR<75, as recommended for the rest of the public health formula. We have already announced 2012-13 PTB funding will depend in part on the number of people successfully completing treatment, and this will be implemented in a future iteration of the public health ring-fence model, but the relevant data were not available for this update.

[8] For further information on the PTB for 2012/13 please see: http://www.nta.nhs.uk/news-2012-ptb.aspx
[9] http://www.nao.org.uk/publications/0910/problem_drug_use.aspx

Other parts of the core allocation component of the health premium follow ACRA's recommendation to use SMR<75.

2.22. It is important to note that ACRA only made recommendations on relative shares for each local authority, not absolute monetary values. The relative shares implied by ACRA's interim recommendations are at Annex B. These are driven by each local authority's population size and a weight per head based on the SMR<75. Annex B includes also relative shares per 100,000 population.

2.23. It is only possible to convert ACRA's recommended shares into monetary values once the overall total resources available are known. Once this quantum is available it will be possible to set the pace-of-change. The pace-of-change will be consistent with our commitment to protect investment in each local authority in real terms during this Spending Review – this work does not imply a cut in resources for those local authorities over target. We would hope, however, to offer greater growth to those local authorities furthest below the preferred distribution, subject to the available resources, and delivering value for money and a smooth transition.

2.24. We would however welcome feedback at this stage on the approach taken and any factors ACRA should be considering either as part of the SMR<75 model (in which case data would need to be readily available) or for longer term work on identifying and modelling the impact of underlying drivers of need for public health.

Health Premium

2.25. Although the consultation on the new commissioning arrangements demonstrated support for the concept of an incentive scheme, a lot of concern was expressed about the precise working of any scheme. Responses highlighted the risk of perverse incentives – an area which improved its health outcomes might find its core allocation thereby reduced; the problem of time lags before the impact of public health interventions appear; and the impact of population churn in some areas.

2.26. We have reflected carefully on how best to introduce the health premium incentive. We recognise that the significant data lag on many of the indicators in the public health outcomes framework would mean that if it was paid in 2013-14 we would be rewarding local authorities for decisions taken by PCTs. We are therefore planning to delay the first payments until 2015-16, the third year of local authority responsibility for public health responsibilities.

2.27. This will also give ACRA time to develop further the public health allocation formula to be driven by the underlying drivers of need for public health services. This will be important in avoiding the perverse incentive identified above: a local area that is rewarded under the health premium incentive risks seeing a penalty in the core allocation as its SMR<75 improves.

2.28. Nevertheless, it is important that we give local authorities as much certainty about the basis of the health premium incentive scheme as early as possible. We will therefore convene an expert group to begin the task of assessing the indicators in the Public Health Outcomes Framework for their suitability as an incentive measure and, where appropriate, making recommendations on how incentives for progress should be set, ie what formulae or other approach should drive the awarding of payments. This group will need to consider a range of factors, including:

- the availability of data for local areas;
- the possible lag between local authority action and the impact on the indicator; and
- any local characteristics that would mean making progress is more challenging.

We remain committed to a formula driven model to keep bureaucracy to a minimum and maximise transparency. To manage costs, this may need to be complemented by an overall cap on the total amount paid out under the incentive scheme, but again we would be clear before the payment year about how we expected this to operate.

2.29. Drawing on the advice and recommendations from this group, the final selection of indicators and decisions about the underlying formulae to drive payments will be made by the Secretary of State for Health. Some indicators will be chosen to apply to all local authorities in support of national strategies, but we are also keen to explore ways of allowing some local choice in the measures used, so that the incentive can reflect local strategies, provided bureaucratic overheads can be kept to a minimum. Possible criteria for the inclusion of an indicator in the health premium incentive are shown in the box below.

The health premium will incentivise progress in population health outcomes and reductions in health inequalities as measured by indicators that:

- can be directly influenced by a local authority (and are not likely to be significantly affected by factors outside the control of the local authority);
- are not solely or principally linked to services that are mandated through regulations;
- are amenable to cost effective interventions that can be delivered using the available budget;
- have health as one of their principal, but not necessarily direct, impacts (rather than a wider societal impact); and will either
- benefit a significant proportion of the local population directly; or
- significantly reduce health inequalities; or
- reduce the spread of infection or risky behaviours in the wider population; or
- are linked to local authority interventions that contribute to a wider health-led programme.

An incentive will not be paid to an individual authority if any of the mandatory services (as prescribed in regulations) are not being appropriately delivered.

3. Conditions on the ring-fenced grant

3.1. The public health grant to local authorities will be made under Section 31 of the Local Government Act 2003 and, as with other ring-fenced grants, will carry conditions about how it may be used. A list of local authority public health responsibilities is attached at Annex C. This is an extract from the public health factsheets published on 20 December 2011. This list is not comprehensive, as local authorities may choose to commission a wide variety of services under their new health improvement duty.

3.2. Following consultation[10], a commitment was made in *Healthy Lives, Healthy People: Update & Way forward*[11] that, to maximise flexibility, there would be a limited number of conditions on the grant. The core conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensuring a transparent accounting process.

3.3. When developing the proposed conditions on the public health grant, we have taken account of:

- Secretary of State's duty to promote the autonomy of organisations exercising health service functions, provided this is consistent with the interests of the health service, as provided for in the Health and Social Care Act 2012. We believe the limited number of conditions on the public health grant allow local authorities the freedom to exercise their functions in the way that they consider most appropriate for their population.
- Secretary of State's duty, under the Health and Social Care Act 2012, to have regard to the need to reduce health inequalities when exercising his functions.
- The public sector equality duty under the Equality Act 2010. Local authorities (who share this duty) have been given minimal conditions so they have the flexibility to spend the grant in a way that best suits the needs of their local communities based on their Joint Strategic Needs Assessments and their joint health and wellbeing strategies. We believe the proposed conditions do not indirectly or directly discriminate against anyone with a protected characteristic and are a proportionate means of clarifying the purpose of the grant and ensuring transparency and accountability in its use.

Standard controls on local authorities' public health funding

3.4. There are some standard governance, financial management and reporting requirements on the use of public funds by local authorities which will apply equally to the public health grant. These include the Accountable Officer role of the Chief Financial Officer and the local government obligation to secure best value in delivering their duties under the Local Government Act 1999. Public health expenditure will be included in local authority financial statements, and will be within the scope of the audit of the financial statements and other more specific work carried out on grant expenditure.

[10] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_122916
[11] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120

Conditions on the grant

3.5. The grant conditions will set out how the grant may be used, to ensure that funding is spent on the public health functions for which it is given. The intention is for the grant to be spent on activities whose main or primary purpose is to impact positively on the health and wellbeing of local populations, with the aim of reducing health inequalities in local communities. Those activities include:

- improving significantly the health and wellbeing of local populations
- carrying out health protection functions delegated from the Secretary of State
- reducing health inequalities across the life course
- ensuring the provision of population healthcare advice.

3.6. Local authorities will have the flexibility to pool their public health grant with other resources, where it is appropriate to do so. The grant conditions will set out the pooling arrangements. This would allow money from the ring-fenced public health grant to be pooled with local authority funds being used for similar purposes. It will be important that the pooling does not contravene any of the conditions on the public health grant; and the total amount of money to be spent is proportionate to the public health benefit to be derived, ie, it gives value for money.

3.7. A draft version of the circular letter that would accompany the grant determination is included at Annex D for illustrative purposes. A draft version of the grant determination that sets out the proposed conditions is at Annex E. Local authorities should consider these drafts in planning for 2013/14.

Reporting spend on the public health grant

3.8. The grant conditions will set out the reporting requirements that local authorities will need to adhere to, over and above the standard reporting requirements. The public health grant will be subject to the standard local authority reporting arrangements, meaning Revenue Account Budget Estimates (RA return) will be completed for the forthcoming financial year and data on year end outturn will be included in the Revenue Outturn return (RO return). In-year spend on public health will be included in the Quarterly Revenue Outturn (QRO) form from 2013/14.

3.9. Annual spend will be broken down into approximately fifteen to twenty areas and the RA and RO returns will cover the same categories; we are working with colleagues at CLG and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop this. An example of the list of categories to be reported against is at Annex F. Work is continuing on the reporting arrangements and supporting guidance.

3.10. We will continue to work closely with a range of partners during 2012 to refine the reporting arrangements and test the conditions on the grant further, before finalising them and issuing them with actual allocations for 2013/14.

4. Next Steps

4.1. Establishing the right financial underpinning for the public health system, including local authority responsibilities, is key to its success. We have already published baseline estimates. As we indicated in the baseline document, we are undertaking a further collection on the costs of termination of pregnancy, sterilisation and vasectomy so that we can correctly and consistently remove these costs from the earlier collection of public health spend; feedback suggests, as we expected, that the correction we made for this in February was probably too high.

4.2. This update is the next step, covering progress in developing the allocation formula, including the health premium, and grant conditions. We would welcome feedback on all of these.

4.3. The preferred distribution of resources is clearly going to take time to perfect and we would welcome feedback on how it can be improved in both the short and long term, taking account of available evidence and data. We have already committed to protect baseline local authority spending estimates in real terms during the current Spending Review, but we cannot commit to how quickly we will be able to move local authorities towards target until we have a clearer picture of the overall availability of resources. Our expectation that the preferred distribution will evolve over the next two to three years, which may also mean it is unwise to move local authority funding levels too quickly towards to the current targets.

4.4. We intend to publish actual allocations for local authorities before the end of 2012.

Engagement

4.5. The Department is currently undertaking a focussed engagement process with a full range of stakeholders including public health and local government representatives and the wider NHS community to ensure that there is the opportunity for interested groups to raise queries about the funding process. This process will continue and expand over the coming months to include the issues discussed in this report.

4.6. We would also welcome feedback on the issues raised direct to the Department at publichealthfinanceupdateengagement@dh.gsi.gov.uk. Early feedback would be particularly welcome but feedback by **14 August** would be in sufficient time to be taken in to account by ACRA when they finalise their recommendations.

4.7. ACRA's final recommendations will be supported by a full report on the issues raised, which we will make available at the time when ACRA's final recommendations for 2013-14 are published. We would expect ACRA's view on the issues raised during the engagement to be clear in their recommendations.

ACRA's Interim Recommendations Annex A

ACRA recommended that:

- a formula based principally on a measure of population health best meets the criteria by which resource allocation formulae are determined.

- the standardised mortality ratio (SMR) for those aged under 75 years should be used as the population health measure. This has been applied on a small area basis to take account of localised health inequalities, and aggregated to local authority level.

- to help reduce inequalities, the SMR measure be incorporated into the public health formula so that the decile of small areas with the highest SMRs have received a weight per head, three times greater that the decile of small areas with the lowest SMRs.

- the adjustment used in the local government funding formula for unavoidable differences in costs due to geographical location should be included.

- the ONS projected resident population for 2012 be used as the population base. This is the same approach as followed in the local government funding formula.

Share implied by ACRA's interim recommendations for the preferred relative distribution of resources

Annex B

Local authority	Share implied by ACRA's interim recommendations %	Share per 100,000 population implied by ACRA's interim recommendations %
Hartlepool	0.24	0.26
Middlesbrough	0.38	0.27
Redcar and Cleveland	0.30	0.22
Stockton-on-Tees	0.42	0.22
Darlington	0.21	0.21
County Durham	1.0	0.20
Northumberland	0.54	0.17
Gateshead	0.44	0.23
Newcastle upon Tyne	0.65	0.23
North Tyneside	0.40	0.20
South Tyneside	0.34	0.22
Sunderland	0.61	0.22
North East	5.6	0.21
Halton	0.28	0.23
Warrington	0.40	0.19
Blackburn with Darwen	0.36	0.25
Blackpool	0.39	0.28
Cheshire East	0.62	0.17
Cheshire West and Chester	0.57	0.17
Bolton	0.64	0.23
Bury	0.37	0.20
Manchester	1.3	0.27
Oldham	0.53	0.24
Rochdale	0.51	0.25
Salford	0.57	0.24
Stockport	0.53	0.18
Tameside	0.53	0.24
Trafford	0.40	0.18
Wigan	0.69	0.22
Knowsley	0.37	0.25
Liverpool	1.2	0.27
St. Helens	0.40	0.22
Sefton	0.58	0.21
Wirral	0.72	0.23
Cumbria	0.92	0.18
Lancashire	2.4	0.20
North West	15	0.22
Kingston upon Hull, City of	0.68	0.26
East Riding of Yorkshire	0.51	0.15
North East Lincolnshire	0.36	0.23
North Lincolnshire	0.34	0.21
York	0.33	0.16

Local authority	Share implied by ACRA's interim recommendations	Share per 100,000 population implied by ACRA's interim recommendations
	%	%
Barnsley	0.53	0.23
Doncaster	0.67	0.23
Rotherham	0.55	0.22
Sheffield	1.1	0.20
Bradford	1.2	0.23
Calderdale	0.41	0.20
Kirklees	0.85	0.21
Leeds	1.5	0.19
Wakefield	0.74	0.22
North Yorkshire	0.91	0.15
Yorkshire and Humber	10.7	0.20
Derby	0.54	0.21
Leicester	0.72	0.23
Rutland	0.04	0.10
Nottingham	0.76	0.25
Derbyshire	1.3	0.17
Leicestershire	0.96	0.14
Lincolnshire	1.3	0.17
Northamptonshire	1.2	0.17
Nottinghamshire	1.4	0.18
East Midlands	8.3	0.18
Herefordshire, County of	0.30	0.16
Telford and Wrekin	0.33	0.20
Stoke-on-Trent	0.62	0.25
Shropshire	0.48	0.16
Birmingham	2.5	0.24
Coventry	0.71	0.21
Dudley	0.58	0.19
Sandwell	0.71	0.23
Solihull	0.33	0.16
Walsall	0.57	0.22
Wolverhampton	0.58	0.24
Staffordshire	1.5	0.17
Warwickshire	0.91	0.17
Worcestershire	0.91	0.16
West Midlands	11	0.20
Peterborough	0.40	0.22
Luton	0.46	0.23
Southend-on-Sea	0.33	0.20
Thurrock	0.29	0.18
Bedford	0.28	0.17
Central Bedfordshire	0.43	0.16
Cambridgeshire	0.90	0.15

Local authority	Share implied by ACRA's interim recommendations	Share per 100,000 population implied by ACRA's interim recommendations
	%	%
Essex	2.1	0.15
Hertfordshire	1.8	0.16
Norfolk	1.3	0.15
Suffolk	1.0	0.14
East of England	9.3	0.16
City of London	0.01	0.13
Barking and Dagenham	0.44	0.23
Barnet	0.55	0.15
Bexley	0.38	0.16
Brent	0.61	0.22
Bromley	0.47	0.15
Camden	0.64	0.27
Croydon	0.65	0.18
Ealing	0.70	0.21
Enfield	0.57	0.18
Greenwich	0.64	0.27
Hackney	0.68	0.30
Hammersmith and Fulham	0.44	0.26
Haringey	0.55	0.22
Harrow	0.35	0.15
Havering	0.41	0.17
Hillingdon	0.55	0.20
Hounslow	0.54	0.22
Islington	0.64	0.31
Kensington and Chelsea	0.31	0.19
Kingston upon Thames	0.27	0.15
Lambeth	0.89	0.30
Lewisham	0.75	0.27
Merton	0.35	0.16
Newham	0.71	0.25
Redbridge	0.48	0.17
Richmond upon Thames	0.27	0.14
Southwark	0.82	0.27
Sutton	0.35	0.18
Tower Hamlets	0.82	0.31
Waltham Forest	0.55	0.23
Wandsworth	0.69	0.23
Westminster	0.52	0.21
London	18	0.22
Medway	0.51	0.19
Bracknell Forest	0.19	0.16
West Berkshire	0.23	0.15
Reading	0.33	0.23
Slough	0.30	0.23

Local authority	Share implied by ACRA's interim recommendations	Share per 100,000 population implied by ACRA's interim recommendations
	%	%
Windsor and Maidenhead	0.23	0.16
Wokingham	0.19	0.11
Milton Keynes	0.45	0.18
Brighton and Hove	0.57	0.22
Portsmouth	0.43	0.21
Southampton	0.49	0.21
Isle of Wight	0.24	0.17
Buckinghamshire	0.74	0.15
East Sussex	0.78	0.15
Hampshire	1.8	0.14
Kent	2.3	0.16
Oxfordshire	1.0	0.16
Surrey	1.6	0.14
West Sussex	1.2	0.14
South East	14	0.16
Bath and North East Somerset	0.28	0.16
Bristol, City of	1.0	0.24
North Somerset	0.33	0.16
South Gloucestershire	0.37	0.14
Plymouth	0.54	0.21
Torbay	0.25	0.19
Bournemouth	0.37	0.22
Poole	0.22	0.15
Swindon	0.37	0.18
Cornwall	0.89	0.16
Isles of Scilly	0.0020	0.10
Wiltshire	0.64	0.14
Devon	1.04	0.14
Dorset	0.54	0.13
Gloucestershire	0.92	0.15
Somerset	0.77	0.14
South West	8.6	0.16
England	100.0	

Annex C

Local Authority Commissioning Responsibilities from April 2013

Local authorities will be responsible for:

- 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)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public 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
- 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

Annex D

NOTE: THIS DOCUMENT IS A DRAFT TO BE CONSIDERED IN ADVANCE OF REAL ALLOCATIONS IN 2013/14

GRANT CIRCULAR

RING-FENCED PUBLIC HEALTH GRANT

Summary

1. This [draft] circular sets out the funding that will be available to upper tier, London boroughs and unitary local authorities in England to discharge their new public health responsibilities, and the conditions that will govern the use of the grant. The grant is administered under Section 31 of the Local Government Act 2003, which allows Ministers, with the consent of the Treasury, to pay grants to any local authority for any expenditure.

2. The circular contains 2 annexes:

- Annex E comprises the grant determination and conditions, which set out the detailed arrangements for administering the grant.

- Annex F lists the categories of public health spend against which local authorities will need to report to the Department.

Introduction

3. The public health White Paper, *Healthy lives, Healthy People: Our strategy for public health in England* set out a bold vision for a reformed public health system in England - with localism at its heart. The bold changes proposed in the White Paper are a response to the challenges we face to the public's health; challenges that require a new approach, systematically underpinned by public health expertise and given real political priority. The Health and Social Care Act 2012 will transfer substantial health improvement duties to local authorities from 2013/14. Local authorities will be given a ring-fenced public health grant, which the government intends to target for health inequalities, to improve outcomes for the health and wellbeing of their local populations.

4. In the *Consultation on the funding and commissioning routes for public health* we consulted on the conditions that should be attached to the public health grant. As stated in *Healthy Lives, Healthy People, Update and way forward*, it was confirmed that to maximise flexibility in local decision making, there should be a limited number of conditions which would clearly define the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensure a transparent accounting process.

5. Alongside this, we consulted on proposals for a Public Health Outcomes Framework. This consultation set out how we might realise a focus on outcomes rather than on targets, and setting out a more comprehensive and whole systems understanding of public health.

6. The Health and Social Care Act 2012 will promote the principle of integrated working by stating that in exercising their respective functions NHS bodies (on the one hand) and

local authorities (on the other) must cooperate with one another in order to secure and advance the health and welfare of the people of England and Wales. This confers a duty of co-operation between Directors of Public Health, clinical commissioning groups (CCGs) and the wider NHS when carrying out their respective functions.

Use of the grant

7. The public health grant is being provided to give local authorities the funding needed to discharge their new public heath responsibilities. It is vital that these funds are used to:
   - improve significantly the health and wellbeing of local populations
   - carry out health protection functions delegated from the Secretary of State
   - reduce health inequalities across the life course
   - ensure the provision of population healthcare advice.

8. The grant will be made to upper-tier and unitary local authorities in England and paid in quarterly instalments, in accordance with an allocation formula, from 2013/14.

9. The grant has been made under Section 31 of the Local Government Act 2003 and we have set down some conditions to govern its use. The primary purpose of the conditions is to ensure that it is spent on the new public health responsibilities being transferred from the NHS to local authorities, that it is spent appropriately and accounted for properly.

10. The expectation is that funds will be utilised in-year, but if at the end of the financial year there is any underspend this can be carried over, as part of a public health reserve, into the next financial year. In utilising those funds the next year, the grant conditions will still need to be complied with. However, where there are repeatedly large underspends the Department will consider whether allocations should be reduced in future years.

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)

11. In drawing up their priorities, local authorities, as members of health and wellbeing boards will have a duty to work with CCGs and other partners to prepare and conduct Joint Strategic Needs Assessments (JSNAs) – an assessment of the local health and social care needs and assets. Based on these they will have to develop Joint Health and Wellbeing Strategies (JHWSs) – a strategy for meeting the identified needs in the local area based on evidence in JSNAs.

12. Performance information supporting the Public Health Outcomes Framework alongside the Adult Social Care Outcomes Framework, NHS Outcomes Framework and eventually the NHS Commissioning Outcomes Framework could also inform JSNAs; however, national measures should not overshadow local priorities based on evidence of local needs.

Reporting of grant expenditure: Statement of Grant Usage

13. In giving funding for public health to local authorities, it remains important that funds are only spent on activities whose main or primary purpose is to improve the health and wellbeing of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities.

14. The Department has therefore worked with colleagues in the Department for Communities & Local Government (CLG) and the Chartered Institute of Public Finance & Accountancy (CIPFA) to agree the requirements for reporting on spend from the grant.

15. Instead of sending in a separate Statement of Grant Usage, local authorities will be able to use existing reporting tools to report on spend from the grant. Existing Revenue Account (RA) and Revenue Outturn (RO) forms from CIPFA and CLG will be updated to reflect the new public health responsibilities. Local authorities will need to forecast and report against the sub-categories in these returns to the Department of Health. This can be achieved by writing separately to the DH when submitting the returns, confirming that the reporting conditions have been adhered to. A draft list of the proposed sub-categories has been provided at Annex F.

16. The proposed reporting categories are sufficiently flexible to allow local decisions about what services are commissioned to be reflected sensibly and the Department will engage further during 2012/13 to refine it if necessary. Guidance will be provided to local authorities in the Service Reporting Code of Practice (SeRCOP) on how activity should be recorded against the sub-categories. This guidance will be developed during the shadow year.

17. Authorities should be aware that the section on Public Health in the Revenue Outturn form is going to be used as a way of monitoring the usage of the ring-fenced public health grant. It is therefore important that the contacts responsible for this section of financing are content with the figures submitted. Authorities will need to ensure that the figures are verified and in line with the purpose set out in the grant conditions.

In-year reporting

18. Local authorities will need to submit quarterly returns of spend on public health as part of the existing Quarterly Revenue Outturn reports. At the end of the financial year they will need to return a more detailed RO return.

19. For the detailed list of grant conditions please refer to the Grant Determination and conditions in Annex E.

Charging

20. Under new section 2B of the National Health Service Act 2006 (as inserted by section 12 of the Health and Social Care Act 2012) , each local authority has a duty to take steps, as it considers appropriate, for improving the health of the people in its area. A local authority may also be required by regulations under new section 6C of the NHS Act (as inserted by section 18 of the Health and Social Care Act 2012) to take steps to protect the public in England from disease or other dangers to health. These steps are services which form part of the comprehensive health service and are therefore subject to the general prohibition on charging under section 1(3) of the NHS Act unless exempted through regulations.

Guidance

21. Local authorities will have to have regard to other forms of guidance when discharging their public health responsibilities such as:
    - guidance issued by the Department e.g. the Public Health Outcomes Framework;

- the revised Best Value statutory guidance issued by the Department of Community & Local Government (2011), which is equally applicable to local authorities new public health functions. The duty to secure best value under the Local government Act 1999 will also apply to these public health responsibilities.

22. Local authorities might also want to consider other forms of guidance e.g. from the National Institute for Clinical Excellence in discharging their public health duties.

Clinical Governance

23. In commissioning services using funds from this grant, local authorities should also ensure that appropriate clinical governance arrangements are put in place.

Mandatory Functions

24. As set out in *Healthy Lives, Healthy People: Update and way forward*, the Health and Social Care Act 2012 provides for regulations that will allow the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken.

25. The services and steps that will be prescribed are set out in *Public Health in Local Government – factsheets*[12]*.*

Outcomes Framework

26. These reforms are aimed at improving the health and wellbeing of the nation and delivering better outcomes. We have therefore put in place a new strategic outcomes framework for public health at national and local levels, based on the evidence of where the biggest challenges are for health and wellbeing, and the wider factors that drive it. The outcomes framework sets out a high-level vision for public health outcomes, focused on increasing healthy life expectancy and reducing inequalities in health.

27. The Public Health Outcomes Framework presents a broad spectrum for public health. These outcomes will be measured through a range of indicators grouped into four domains that provide a focus on tackling the wider determinants of health, health improvement, health protection and healthcare public health. Some of these indicators reflect the contribution local authorities already make to public health whilst others reflect new areas of responsibility. Local authorities will want to have regard to the Public Health Outcomes Framework in deciding how to use their public health funding.

28. 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.

29. The new health premium will be designed to reward communities for improving or reducing inequality in selected health outcomes. Further detail has been provided in the main document.

Enquiries

30. Enquires about this Circular should be addressed to the Public Health Policy and Strategy Unit, Department of Health at publichealthpolicyandstrategy@dh.gsi.gov.uk

[12] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

[SIGNED BY……..]

Annex E

NOTE: THIS DOCUMENT IS A DRAFT TO BE CONSIDERED IN ADVANCE OF REAL ALLOCATIONS IN 2013/14

DETERMINATION UNDER SECTION 31 OF THE LOCAL GOVERNMENT ACT 2003 OF A RING-FENCED PUBLIC HEALTH GRANT TO LOCAL AUTHORITIES FOR 2013-2014

RING-FENCED PUBLIC HEALTH GRANT DETERMINATION 2013/14: No 31/xx

The Secretary of State for Health ("the Secretary of State"), in exercise of the powers conferred by section 31 of the Local Government Act 2003, makes the following determination:

Citation

1) This determination may be cited as the Ring-fenced Public Health Grant Determination 2013/14 [No31/xx].

Purpose of the grant

2) This grant can be used for both revenue and capital purposes.
3) The purpose of the grant is to provide local authorities in England with the funding required to discharge the public health functions detailed in paragraphs 2-4 in Annex 'X' .

Grant conditions

4) Pursuant to section 31(4) of the Local Government Act 2003, the Secretary of State determines that the grant will be paid subject to the conditions set out in Annex 'X'.

Determination

5) The Secretary of State determines as the authorities to which the grant is to be paid and the amount of grant to be paid, the authorities and the amounts set out in Appendix 1.

Treasury consent

6) Before making this determination the Secretary of State obtained the consent of the Treasury.

Signed by authority of the Secretary of State for Health.
[A senior civil servant within the (name of government department)]
[xx xxxx] 2012

NOTE: THIS DOCUMENT IS A DRAFT TO BE CONSIDERED IN ADVANCE OF REAL ALLOCATIONS IN 2013/14

GRANT CONDITIONS

1. In this Determination:

"the Department" means the Department of Health**;**

"financial year" means a period of twelve months ending 31st March XX.

"NHS body" means an NHS body within the meaning of section 75 of the National Health Service Act 2006;

"grant" means the amounts set out in [insert appropriate reference **2013/14: No 31/xx**]

"upper tier and unitary local authorities" means: a county council in England; a district council in England, other than a council for a district in a county for which there is a county council; a London borough council, the Council of the Isles of Scilly; and the Common Council of the City of London.

Use of the grant

2. Pursuant to Section 31 of the Local Government Act 2003, the Secretary of State hereby determines that the public health grant shall be paid towards expenditure incurred, or to be incurred, by upper tier and unitary local authorities from the financial year 2013/2014. The relevant authorities are listed in Appendix 1.
3. Subject to paragraph 5, the grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities in the exercise of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the 2006 Act").
4. The functions mentioned in that subsection are:
   (a) functions under section 2B, 111 or 249 of, or Schedule 1 to, the 2006 Act
   (b) functions by virtue of section 6C of the 2006 Act,
   (c) the Secretary of State's public health functions exercised by local authorities in pursuance of arrangements under section 7A of the 2006 Act,
   (d) the functions of a local authority under section 325 of the Criminal Justice Act 2003 (local authority duty to co-operate with the prison service with a view to improving the exercise of functions in relation to securing and maintaining the health of prisoners), and
   (e) such other functions relating to public health as may be prescribed under section 73A(2)(e).

5. A local authority may use the grant to contribute to a fund made up of –
   (a) contributions by the authority from both the public health grant and other sources of funding;
   (b) contributions by the authority and one or more other local authorities; or
   (c) contributions by one or more local authorities and one or more NHS or other public bodies.

   Provided the conditions specified in paragraph 6 are met.
6. The conditions referred to in paragraph 5 are that –
   (a) the fund must be one out of which payments are made towards expenditure incurred in the exercise of the functions described in paragraph 3;

(b) if payments are made out of the fund towards expenditure on other functions of a local authority or the functions of an NHS body or other public body, the authority must be of opinion that those functions have a significant effect on public health or have a significant effect on, or connection with, the exercise of the functions described in paragraph 3;

(c) the authority must be satisfied that, having regard to the contribution from the public health grant, the total expenditure to be met from the fund and the public health benefit to be derived from the use of the fund, the arrangements provide value for money.

7. A local authority must, in using the grant, have regard to the need to reduce inequalities between the people in its area with respect to the benefits that they can obtain from that part of the health service provided in exercise of the functions referred to in paragraph 3.
8. The public health grant will only be paid to local authorities to support eligible expenditure.

Eligible expenditure

9. Eligible expenditure means expenditure incurred by an authority or any person acting on behalf of an authority, between 1 April 20XX and 31 March 20XX, [for the purposes of carrying out the new public health functions referred to in paragraph 3-4 above].

10. If an authority incurs any of the following costs, they must be excluded from eligible expenditure:
    a) contributions in kind
    b) payments for activities of a political or exclusively religious nature
    c) depreciation, amortisation or impairment of fixed assets owned by the authority
    d) input VAT reclaimable by the authority from HM Revenue & Customs
    e) interest payments or service charge payments for finance leases
    f) gifts, other than promotional items, with a value of no more than £10 in a year to any one person subject to the exception in paragraph [9].
    g) entertaining (Entertaining for this purpose means anything that would be a taxable benefit to the person being entertained, according to current UK tax regulations)
    h) statutory fines, criminal fines or penalties.

11. Expenditure on promotional items in fulfilment of the local authority's health improvement duty under Section 2B of the 2006 Act such as products goods or services which are given for health improvement purposes may form part of eligible expenditure. This could include for example, vouchers for gym or fitness classes, nicotine patches or other expenditure which corresponds with the health improvement objectives of the public health grant.

12. An authority must not deliberately incur liabilities for eligible expenditure before there is an operational need for it to do so.

13. For the purpose of defining the time of payments, a payment is made by an authority when money passes out of its control (or out of the control of any person acting on behalf of the authority). Money will be assumed to have passed out of such control at the moment when legal tender is passed to a supplier (or, if wages, to an employee), when a letter is posted to a supplier or employee containing a cheque, or an electronic instruction is sent to a bank to make a payment to a supplier or employee by direct credit or bank transfer.

Payment arrangements

14. Grants will be paid in quarterly instalments.

Reporting: Statement of Grant Usage

In-year reporting

15. Local authorities will need to submit three high-level public health returns (Quarterly Revenue Outturns) at quarterly intervals during the year; in June, September and December.

End-of year reporting

16. Each authority shall prepare a Statement of Grant Usage at the end of the financial year; the first to be submitted to the Department on or before [Insert date] covering the period 1 April 2012 to 31 March 2013. A (draft) list of the lines of expenditure (categories) that will need to be reported on is attached at Annex F. The Statement of Grant Usage must provide details of eligible expenditure in the period, against each relevant category. The returns must be certified by the authority's Chief Executive that, to the best of his or her knowledge, the amounts shown on the Statement are all eligible expenditure and that the grant has been used for the purposes intended, as set out in this Determination.

Auditing

17. The Statement of Grant Usage submitted to the Department must be accompanied by a report from the authority's Chief Executive or Chief Finance Officer setting out whether he or she has received an audit opinion from the authority's chief internal auditor that he can provide reasonable assurance that the Statement of Grant Usage, in all material respects, fairly presents the eligible expenditure in the period 1 April 2012 to 31 March 2013 in accordance with the definitions and conditions in this Determination.

18. Local authorities can use the RO return to meet the end of year reporting requirements set out in paragraph 16, as long as the condition in paragraph 17 is met.

19. The Secretary of State [to amend as appropriate] may require a further external validation to be carried out by an appropriately qualified independent accountant or auditor of the use of the grant where the annual audit report referred to in paragraph 16 above fails to provide sufficient assurance to the Secretary of State.

20. Each authority must inform the Department promptly of any significant financial control issues raised by its internal auditors.

21. If a local authority identifies any overpayment of grant, the authority must repay this amount within 30 days of it coming to their attention.

22. In accordance with existing practice, local authorities should place a copy of the end of year statement on their website.

Financial Management

23. Each authority must maintain a robust system of internal financial controls.

24. If an authority has any grounds for suspecting financial irregularity in the use of any grant paid under this funding agreement, it must notify the Department immediately, explain

what steps are being taken to investigate the suspicion and keep the Department informed about the progress of the investigation. For these purposes "financial irregularity" includes fraud or other impropriety, mismanagement, and the use of grant for purposes other than those for which it was provided.

Records to be kept

25. Each authority must maintain reliable, accessible and up to date accounting records with an adequate audit trail for all expenditure funded by grant monies under this Determination.

26. Each authority and any person acting on behalf of an authority must allow:
    a) the Comptroller and Auditor General or appointed representatives; and
    b) the Secretary of State or appointed representatives;
    c) free access at all reasonable times to all documents (including computerised documents and data) and other information as are connected to the grant payable under this Determination, or to the purposes for which grant was used, subject to the provisions in paragraph 27.

27. The documents, data and information referred to in paragraph 26 are such which the Secretary of State or the Comptroller and Auditor General may reasonably require for the purposes of his financial audit or any department or other public body or for carrying out examinations into the economy, efficiency and effectiveness with which any department or other public body has used its resources. An authority must provide such further explanations as are reasonably required for these purposes.

28. Paragraphs 25 and 26 do not constitute a requirement for the examination, certification or inspection of the accounts of an authority by the Comptroller and Auditor General under section 6(3) of the National Audit Act 1983. The Comptroller and Auditor General will seek access in a measured manner to minimise any burden on the authority and will avoid duplication of effort by seeking and sharing information with the Audit Commission.

Breach of Conditions and Recovery of Grant

29. If an authority fails to comply with any of these conditions, or any overpayment is made under this grant, or any amount is paid in error, or if an authority 's chief internal auditor is unable to provide reasonable assurance that the Statement of Grant Usage (or, alternatively, the RO), in all material respects, fairly presents the eligible expenditure, in the relevant period, in accordance with the definitions and conditions in this Determination, or any information provided is incorrect, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority. Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from central government.

Underspends

30. If there are funds left over at the end of the financial year they can be carried over into the next financial year as part of a public health reserve. All the conditions that apply to the use of the grant will continue to apply to any funds carried over. However, where there are large underspends DH reserves the right to reduce allocations in future years.

Appendix 1: To be completed

Authorities to which grant is to be paid	**Amount of grant to be paid**
XXXXX	**XXXXX**
XXXXX	**XXXX**

Annex F

Proposed categories for reporting local authority public health spend

Prescribed functions:

1) Sexual health services - STI testing and treatment
2) Sexual health services – Contraception
3) NHS Health Check programme
4) Local authority role in health protection
5) Public health advice
6) National Child Measurement Programme

Non-prescribed functions:

7) Sexual health services - Advice, prevention and promotion
8) Obesity – adults
9) Obesity - children
10) Physical activity – adults
11) Physical activity - children
12) Drug misuse - adults
13) Alcohol misuse - adults
14) Substance misuse (drugs and alcohol) - youth services
15) Stop smoking services and interventions
16) Wider tobacco control
17) Children 5-19 public health programmes
18) Miscellaneous, which includes:
    - Non-mandatory elements of the NHS Health Check programme
    - Nutrition initiatives
    - Health at work
    - Programmes to prevent accidents
    - Public mental health

- General prevention activities
- Community safety, violence prevention & social exclusion
- Dental public health
- Fluoridation
- Local authority role in surveillance and control of infectious disease
- Information & Intelligence
- Any public health spend on environmental hazards protection
- Local initiatives to reduce excess deaths from seasonal mortality
- Population level interventions to reduce and prevent birth defects (supporting role)
- Wider determinants