



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

UK Faculty of Public Health response to *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*

Introduction

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health and wellbeing of the population through three key areas of work: health improvement, health protection and health services. In addition to maintaining professional and educational standards for specialists in public health and providing practical information and guidance for public health professionals, FPH advocates on key public health issues, influencing policy change at the highest level, and working closely with policymakers, professionals and the public to make a positive difference to people's health and wellbeing.

In addition to this overall response, FPH has responded separately to each of the individual consultations relating to the public health white paper, *Healthy Lives, Healthy People – our strategy for public health in England*. These are available at: www.fph.org.uk

What is public health?

Public health is the science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society.¹ There are three domains of public health: **health improvement** (including people's lifestyles as well as inequalities in health and the wider social influences of health), **health protection** (including infectious diseases, environmental hazards and emergency preparedness) and **health services** (including service planning, efficiency, audit and evaluation). All three domains

¹ http://www.fph.org.uk/what_is_public_health

need to be addressed actively by the public health system if the public's health and wellbeing are to be protected and improved.

Successful commissioning requires a whole system approach to procurement, based upon:

- Sound evidence.
- Population needs assessments.
- Community and stakeholder engagement.
- An holistic approach addressing pathways of care, the service landscape and the local environment.

Key messages

- The ring-fenced budget must be calculated from a realistic baseline, its uses defined clearly and the resources adequate for its defined purpose, now and in the future.
- The ring-fenced budget must include funding to support all three domains of public health: health protection, health improvement and health services.
- The funding currently available for public health in England is insufficient to meet the needs set out in *Healthy Lives, Healthy People* and will need to be increased over time.
- The director of public health should be responsible for managing the budget at a local level.
- Specialist public health expertise must be firmly embedded at all levels of commissioning, including in the NHS Commissioning Board and its hubs.
- Systems must be put in place to reduce fragmentation, and to enable and facilitate commissioning of entire seamless pathways of care.
- Commissioners must have access to timely, reliable and relevant information and analysis.

The public health ring-fenced budget

The ring-fencing of the public health budget at a local and national level is welcomed, as is the recognition that it should not be subject to “other pressures”. The ring-fenced budget must not be used to alleviate the financial pressures that local authorities may be under. The current proposals make this a real possibility. If the ring-fenced budget is transferred from Public Health England (PHE) to local authorities, authorities must be required to account for spend against each budget line and the director of public health (DPH) must manage the ring-fenced public health budget.

Public expectations of public health spend

FPH surveyed the public as part of its work on its report, *Healthy nudges: when the public wants change but the politicians don't know it*.² It found that 25-30% of the public thought 25-30% of the NHS budget was spent on preventing illness and protecting the public's health. The reality is that far less is spent – only 4% according to the white paper. This is grossly inadequate to meet the needs identified in the white paper.

Important considerations not accounted for by the budget

The scale of the changes proposed in this consultation document is placing a severe strain on the ability of the current system to account for all existing public health activity, and to ensure that the resource allocations to the new public health ring-fenced budget are capable either of delivering the current level of service or of responding to future needs. In particular, the technical definitions and accounting processes used in the financial exercise designed to capture current public health spend do not cover all current public health activity. The proposals in the consultation make no reference to the overhead costs of public health services: there is, for example, no recognition of the fact that, in order to carry out their duties effectively and efficiently, public health staff need offices, information technology, administration support, and are currently reliant on NHS human resources, finance, estates and IT services. FPH estimates that failure to acknowledge this overhead in the current financial returns exercises leaves the new public health ring-fenced budget in deficit by at least 15-20%.

Similarly, the failure to acknowledge current public health input to primary care trust (PCT) commissioning activity leaves the new public health service deficient in essential commissioning and procurement expertise, and related strategic professional input. We are also concerned that the new system will generate substantial new transaction costs which

² Available from: www.fph.org.uk

are not being accounted for, and that definitions are not being applied consistently across the country.

Healthy Lives, Healthy People describes a large public health agenda, much of which is not currently being addressed adequately. Without year on year increases in public health funding, above the level of inflation and above the level of NHS spend, the new system is unlikely to be able to deliver the necessary step-change in the public's health as envisaged by the Government in its proposals.

Risks to delivering public health activity

There is an additional risk that public health priorities will be downgraded or lost in the current financial climate, restricting the ability of public health specialists to deliver on the wider determinants of health. The public health outcomes framework could mitigate this to some extent, but its scope may be limited. DPH responsibility for the budget at a local level is therefore essential to ensure that it is spent in response to health needs rather than short-term local political – or other – demands. It is also possible that, particularly in difficult financial times, local commissioners and service providers will assume that the ring-fenced budget should be able to cover all public health activity, rather than solely the defined, focused inputs for which it is intended. These concerns are heightened by paragraphs 2.6 and Table A of the consultation document, which propose additional public health responsibilities for local authorities but do not explain how these will be funded. Clarification is urgently required on this.

Public health expertise in commissioning

Health service public health is the area of public health which specifically relates to the planning, efficiency, audit and evaluation of health services. Public health specialists working in this field provide critical expertise, skills and knowledge on the effective commissioning and delivery of health services for their local population. They have the specialist training required to interpret the huge amounts of information and data received on their local population, their health needs and the various services provided for them. Their understanding of the geography of health needs can be utilised to direct the planning and commissioning (and, where appropriate, decommissioning) of services to meet those needs. Their management training and experience enables them to inspire, lead and deliver change in systems and organisations.

However, *Healthy Lives, Healthy People* makes little reference to this critical aspect of public health. With the commissioning of health services for the local population residing with GP

commissioning consortia, under the new proposals, and recognition by GPs that they need the expert input of their public health colleagues, it is vital that specialist public health expertise is utilised to inform and support the delivery of effective and cost-effective health services. Public health expertise in this area is also used to audit and evaluate these services to understand their effectiveness and efficiency – and to inform improvements, decommission services where necessary and re-evaluate where resources should be best directed in order to meet health service needs.

Despite taking the correct definition of public health as its basis,³ the consultation does not make any realistic comment about public health input to the commissioning of general health services. The only place where it is mentioned is Section 2.17, which implies that this will happen only through health and well being boards, through the provision of data, or at the national level. This is unrealistic and will not be effective. Expert public health input must be embedded in the fabric of GP and NHS Commissioning Board commissioning, not seen as an optional extra which can ‘influence’ on request. Public health skills must be engaged in the entire commissioning process.

There is an apparent lack of overall coordination. For example, no details are provided on how data will be exchanged in the new commissioning system. The NHS has always suffered from the lack of an adequate unified information system. The move to local authorities, coupled with uncertainty about the future of information functions currently provided regionally, heightens this risk.

Commissioning of complex, multiagency services

Commissioning services such as immunisation, sexual health, mental health, safeguarding and public health services for children (including school nursing and health visiting), is often a complex, interdisciplinary and interagency process. Under the current proposals, services in each of these areas will be commissioned by multiple bodies. This raises the real danger, for example, that in the case of safeguarding, vulnerable children and adults could fall through the gaps in the system between commissioners. To minimise this risk, careful consideration should be given to how the different elements of the system will work together and where specific responsibilities should sit to ensure the efficacy of the system as a whole – particularly where, for example, GP commissioning consortia boundaries are not coterminous with local authority boundaries. Each of these services should be

³ The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society. www.fph.org.uk

commissioned as a package – and where processes are working effectively these should be retained. This must be supported by sufficient funding to cover services, commissioning and transaction costs. DPHs should have an active role in safeguarding children and vulnerable adults, including involvement in safeguarding committees, particularly with regards to developing policy, prevention strategies for the whole population and monitoring the effectiveness of service intervention. DPHs should also ensure effective partnerships with community safety agencies, drug, alcohol and domestic violence services.

In summary, Table A in the consultation demonstrates the confusing plethora of interests involved, the omission of key aspects of public health and the very real risk of fragmentation. The system, as proposed, could serve to increase, rather than decrease, health needs and health inequalities.

Recommendations:

- The uses to which the ring-fenced budget is to be put must be identified clearly, and the size of the budget calculated from a realistic baseline.
- The funds available must be sufficient to meet the needs for which that budget is intended, now and in the future.
- The DPH should be responsible for managing the budget at a local level.
- Systems must be put in place to reduce fragmentation and to enable and facilitate commissioning of entire pathways of care.
- Public health expertise must be embedded fully and firmly at all levels of commissioning.
- Have an active role in safeguarding children and vulnerable adults, and in commissioning complex, multiagency services.

FPH response to individual consultation questions

Consultation question 1: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

When surveyed, 58.8 per cent of the FPH membership agreed or strongly agreed that health and wellbeing boards (HWWBs) are the right place to bring together budgets, but with some important caveats.

HWWBs have the potential power to improve population health by holding local bodies accountable for their performance, and making decisions about where budgets are spent. However, as currently described, they lack the authority to challenge central government, the national commissioning board or GP consortia and they lack the powers required to hold local providers accountable for their performance. There is a real danger that without these important powers, HWWBs may be little more than 'talking shops'. The balance would be redressed by a requirement for all GP commissioning consortia (GPCC) and local authority commissioning plans to be approved by the relevant health and wellbeing board.

It is vital that HWWBs are strong and effective committees. Weak membership is likely to result in missed opportunities to improve health, increasing health inequalities. A board with a real job to do will attract and retain the best contributors.

With those caveats outlined above, the HWWB is the right place to bring budgets together, and to explore and capitalise upon opportunities to maximise their combined impact on health. The range of budgets considered by the board should be as broad as possible, including those related to health and social care. Caution should be taken against the local authority public health budget being used to fund services provided for in other government budget allocations or the expectation that the public health budget would be the only budget being 'pooled'.

Consultation question 2: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

The independence and influence of the DPH and their teams will be essential in securing the involvement of the voluntary and independent sector. Their involvement should be coordinated by the health and wellbeing boards, and via the DPH. The annual report of the DPH is an important vehicle for engaging all sectors in the health improvement agenda, the more so if it offers a robust commentary on the efficacy, appropriateness and accessibility of local services as well as a commentary on health needs.

Robust commissioning by GPCCs, working with public health experts, will be essential to ensure that any willing provider is able to play a full part in providing health and wellbeing services.

To ensure that local authorities are able to draw upon voluntary and independent sector capacity, they must have staff in place which are able to facilitate and develop the necessary understanding and engagement. This will require funding. There is major concern that during the transition phase such capacity is already being lost and the ability to engage with these sectors is not being maintained. At the present time, many valuable skills, experience and facilities reside in the public sector. The public sector should continue to be viewed as a legitimate partner or preferred provider. Decisions concerning choice of provider must always be based on quality as well as cost and 'competitive tendering' should have quality, including outcomes and access, at its heart.

Consultation question 3: How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

The formal involvement of public health experts in all levels of NHS commissioning, including GPCC, the NHS Commissioning Board and any sub-national hubs or outposts, is essential. This will require an expert and experienced public health specialist as a board member of each decision-making commissioning body, including GPCC and the NHS Commissioning Board. In order to ensure that highly-specialised commissioning skills are developed and used to best effect across the country, health service public health specialists should be employed by Public Health England (PHE) and seconded to support local or national commissioning as necessary. (This is discussed in more detail in our response to *Healthy Lives, Health People: our strategy for public health in England* www.fph.org.uk)

Access to timely, relevant and reliable information must also be assured. The public health observatories currently play a key role in this. They are accessible, independent and well-placed to ensure that the information and analysis they provide is cognisant of the local context. For continuing public and professional confidence to be assured, the PHO function should continue to be independent of national government, resourced adequately and distributed sub-nationally, in a coordinated network. Steps must be taken to ensure that access to relevant NHS and other data is not being interrupted during the transition period or thereafter.

The DPH should be expected to play a key role in taking an overview of local health and well being commissioning, advising on strategic direction and drawing attention to unmet need. Their annual report should be required to review the extent to which local services are meeting the health and well being needs of the population and to make recommendations for improvement. THE DPH should also be required to ensure, with PHE's support, that the necessary advice is available

Including public health concepts and approaches in development programmes for all NHS commissioners will enable them to better identify when public health advice is needed and how it can help.

Consultation question 4: Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

Yes. Public Health England should exercise flexibility with GPCC by pooling budgets, as an incentive to deliver services for which there is currently unmet need. This might particularly be the case in health protection interventions where more needs to be done than is currently funded for through public health budgets. For example, in immunisation, in developing services to tackle Hepatitis C and other bloodborne viruses, commissioning of sexual health services and reducing tuberculosis. PHE might also encourage the pooling of GPCC's commissioning funds to meet population health objectives that are not funded by local authorities or individual GPCC, for example new population screening or immunisation programmes.

Consultation question 5: Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

The use of the Marmot review and the application of the lifecourse approach to reducing inequalities in health to underpin the objectives is welcomed, but current proposals will disadvantage the least influential in our society, particularly if they are not registered with a GP.

Mechanisms must be put in place to ensure that entire pathways of care are commissioned if resources are to be employed to best effect. For example, obesity services need to be

commissioned as a whole, not in a fragmented way by local authorities, GPs and hospital services.

Consultation question 6: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

Our response to each individual proposal is noted in the appendix. These should be read in the context of the more general comments set out earlier in this response

Consultation question 7: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:

- ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
- reduce avoidable inequalities in health between population groups and communities?

If not, what would work better?

For items commissioned through the local authority robust mechanisms must be in place to provide DPHs with appropriate levers to influence decisions for the benefit of the population. At present these levers are unclear.

Our response to each individual proposal is noted in appendix. These should be read in the context of the more general comments set out earlier in this response

Consultation question 8: Which services should be mandatory for local authorities to provide or commission?

A plethora of prevention programmes needs to be safeguarded. These include:

- Core population health programmes, which must be delivered collectively to be effective.
- Vaccination and Immunisation programmes.
- Screening programmes.
- Smoking cessation programmes.
- Water fluoridation.

Services for vulnerable people, unregistered populations and services, which have multiple adverse effects across public life: including:

- Services to prevent alcohol related harm and violence.
- Services relating to drug addiction.
- HIV and sexual health services and terminations.
- Traveller and homelessness services.
- Offender/ex-prisoner health.

Consultation question 9: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

The local authority public health grant is the responsibility of the accountable officer the chief executive of the local authority, but as with other grants it would be expected that within the council the relevant service director or chief officer would manage it. In this case, therefore, the D PH should manage the budget

The HWWB will be the principal vehicle for agreements on the spend of the public health ring-fenced budget, but such spend should be based on the recommendations of the DPH.

The HWBB should be held to account by the Secretary of State for Health through PHE, and there should be an accountability agreement against which public health spend and performance is assessed by PHE for the Secretary of State. There should be annual agreements to assess progress, but three yearly agreements for the purpose of determining the outcomes for the health premium.

The DPH should also be held to account for the delivery of services and outcomes for the public's health through their accountability to the local authority chief executive and PHE.

In relation to the local ring-fenced public health grant:

- It should be explicit what will fall within this grant, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other / existing local authority and GP commissioning consortia budgets; there are many services which local authorities currently fund that are of public health benefit, but because they are not currently NHS funded they should not be regarded as a call on the new public health ring-fenced budget.
- Within the local authority these budgets should be deployed with flexibility for DPHs to direct resources to best meet the needs of the local population based on the joint strategic needs assessment and the local health and wellbeing strategy.

Greater clarity is required as to how baseline budgets will be set. There is concern that public health resources have already and will continue to be lost through the impact of local financial savings – any baseline must not be based on reduced resources.

Consultation question 10: Which approaches to developing an allocation formula should we ask ACRA to consider?

NHS PCTs and future GP commissioners are funded for registered populations, the local authority is responsible for residents and visitors. There is a huge and fundamental difference.

The public health budget can only realistically be determined based on the resident population. During the transitional period this may create a problem with the determination of the ring- fenced budgets for those areas covered by PCTS with large registered populations but much smaller resident numbers and vice versa.

The budget should be allocated on the basis of population need – with a greater allocation for those areas with high deprivation and higher levels of premature mortality. However, there also needs to be a weighting for higher proportions of older and very young people, high fertility rates and high populations of disadvantaged ethnic minorities.

Consultation question 11: Which approach should we take to pace-of-change?

To minimise the negative impact on the health of the public, there should be a rapid pace-of- change. Uncertainty brings confusion, anxiety and reluctance to plan or initiate change.

Clarification of the pace is required as soon as possible to secure local confidence in the change management process.

In the transitional period there will need to be protection for those areas with a historically high public health budget. This will need to apply until an allocation formula has been properly established and agreed.

Local authorities will need to a risk sharing agreement for any redundancy which may become necessary at the end of the transition period. As the level of national funding of PH is acknowledged to be inadequate and specialist PH skills are currently in short supply, every effort should be made to ensure that specialist skills are not lost through redundancy. This risk will be mitigated if PHE were to employ public health specialists and second/outpost them to areas where needs are greatest and funding is available.

There is particular concern about the maintenance of health protection functions, for example in case of epidemic during the transition period; adequate provisions and plans must be put in place to account for this.

Whatever the pace-of-change, all possible steps should be taken to prevent the scenario that developed with RAWP changes, where very little real change was achieved. A definite timetable, with clear end points, is essential.

Consultation question 12: Who should be represented in the group developing the formula?

This group should include DPHs, epidemiologists, public health academics, health economists, NHS and local authority finance directors, GP commissioners and ethicists.

Consultation question 13: Which factors do we need to consider when considering how to apply elements of the of the Public Health Outcomes Framework to the health premium?

As stated in our response to the outcomes framework,⁴ the concept of a health premium acknowledges that areas with existing inequalities face some of the greatest challenges in improving health. However, the basis on which it is awarded is crucial. The premium may not

⁴ Available from www.fph.org.uk

reduce health inequities if it is paid retrospectively to areas that have made progress in health improvement. This is because some areas may have insufficient funding to start making progress in the first place. This approach may widen health inequalities if progress is more likely to be made in more affluent areas. In addition, the total budget for the premium must be at least as big as the health inequality adjustments in council and Department of Health resource allocation formulae, otherwise inequalities may widen.

The white paper states that the Department of Health will ask the Advisory Committee on Resource Allocation (ACRA) to support the development of its approach to allocating resources to local authorities. We suggest that DH refer to the recent review of the health inequalities elements of the NHS weighted capitation formula undertaken by a team of researchers led by Professor Steve Morris.⁵ On the basis of their findings, we suggest that the underlying principles of the proposed health premium are clearly delineated and that the methods used to calculate it are justified.

Consultation question 14: How should we design the health premium to ensure that it incentivises reductions in inequalities?

Our comments above refer.

Consultation question 15: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

It depends how “progress” is defined. If it refers to the achievement of simple numerical targets, then it may well have the opposite effect to that hoped for – rewarding populations who are already responsive to public health messages and for whom the challenges are relatively small. If progress is defined more flexibly, perhaps in terms of levels of involvement of partners and stakeholders, the quality of the engagement with hard-to-reach populations and other proxy measures of a “good job” then it could incentivise the right behaviours.

⁵ Morris, S. et al. Research on the health inequalities elements of the NHS weighted capitation formula. Final report. 2010. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122620.pdf

Consultation question 16: What are the key issues the group developing the formula will need to consider?

Our comments above are also relevant here, in particular, the comments relating to the pace-of-change. We would draw particular attention to the pace of change and the need to gain and maintain the confidence of all major stakeholders.

Appendix: Detailed response to questions 6 and 7: commissioning approaches and their implications

Infectious diseases

FPH supports the lead role of Public Health England. However, the DH needs to recognise that there is a substantial body of health protection work that has been built up at local level to cover healthcare acquired infection in the community, immunisation, sexual health, tuberculosis control, bloodborne virus and other communicable disease control not adequately covered by the Health Protection Agency. It remains imperative that these local health protection resources are managed and commissioned by local DPHs. The DPH and therefore the local authority also need to be able to command sufficient resource for outbreak control at a local level.

Sexual health

Sexual health services should be commissioned in an integrated and whole system model through the Director of Public Health for the local authority.

Immunisation against infectious disease

Like screening, immunisation requires coordination, commissioning, quality control and monitoring and social marketing. This should be led by PHE in partnership with the NHS commissioning board. DPHs should commission school and work vaccine programmes. DPHs should maintain their local expertise and resource for immunisation (as for the infectious disease item above) they should also exercise a fail-safe power to require more resource commitment where programmes are failing their population.

Standardisation of control of biological medicines

FPH supports the proposal that PHE should lead. FPH shares the concern of the Health Protection Agency that its current income generation through scientific programmes, biological and immunological production should not be lost as a major source of income for the benefit of public health programmes.

Radiation, chemicals and environmental hazards, including the public health impact of climate change

FPH support the proposal that PHE leads, with local authority support.

Seasonal mortality

FPH welcomes the focus at a local level under the direction of the DPH to deliver services to reduce seasonal mortality, with the exception of the seasonal flu immunisation, which should be commissioned with the rest of the immunisation programmes.

Screening

We agree that Public Health England and the NHS Commissioning Board should work together to commission all screening programmes at a sub-national level. It should be recognised that there are well-defined commissioned aspects of screening such as breast screening units. However, not all aspects of screening are 'commissioned' – population registry functions, for instance, and a whole plethora of actions and communications between different parts of the screening system which are part of quality assurance and require coordination but are not given a monetary value. It is essential that professionals continue to do their jobs in the system and do not stop these because they are not separately paid for or commissioned.

Accidental injury prevention

FPH supports the local authority focus. Much injury prevention work is already undertaken through local authorities and should therefore be regarded as outside or additional to the ring fenced budget allocation.

Public mental health

FPH agrees this should be locally commissioned and delivered, but it requires national marketing, standards and indicators.

Nutrition

Local public health nutrition programmes require local commissioning. This needs to be supported by PHE national standards, national and sub-national social marketing and campaigns and backed by regulatory and legislative measures.

Physical activity

FPH supports the model proposed: local authority commissioning. Existing local authority programmes of sport and fitness should not be included within the public health ring-fence.

Obesity programmes

FPH supports the proposal that local programmes to prevent and address obesity should be led by the local authority. However, there is potential for the commissioning of obesity services to be incoherent and disjointed. There will be contradictory local choices with some choosing to fund surgical intervention for a few ahead of preventive programmes for the many. Surgical interventions judged effective by NICE cannot be administered to the whole population, and a real and concerted national focus on reducing fat and sugar consumption is needed. Public Health England should be given the lead to establish a commissioning framework, which is procured at a local level by local government, GP commissioning consortia and the NHS Commissioning Board, according to the relevant section of the pathway. National campaigns should support this, and regulatory and legislative measures should support these. The National Children's Measurement Programme should be commissioned as part of the healthy child programme.

Drug misuse

FPH supports the local authority as lead, as proposed. Existing Drug and Alcohol Action Team (DAAT) arrangements for pooled and additional budgets should continue to apply.

Alcohol misuse

FPH supports the local authority lead role but considers this underfunded area needs additional funding from budgets pooled by GP commissioners, social services and criminal justice agencies.

Tobacco control

FPH supports local authority as lead commissioner.

NHS Health Check programme

The NHS Health Check programme is principally within the province of the NHS service providers and is an NHS constitutional commitment. Most of the work is undertaken in primary care, including that undertaken by pharmacists. It should be jointly commissioned between GP commissioners and local authority DPH.

Health at work

Health at work services should be commissioned by local authorities with Public Health England support and through the work of the Department of Work and Pensions. The

inclusion of occupational health expertise in the DPH's team would strengthen this commissioning function

Reducing and preventing birth defects

FPH supports the proposed model for interventions at population level: local authority and PHE. There are essential national and regional surveillance systems in place for this work, which should not be interrupted through organisational change. PHE should play a key role in overseeing this system and, for example, informing local DPHs and NHS commissioners about the quality standards required in maternity contracts to maintain and improve information quality.

Prevention and early presentation

FPH supports the proposal of local authority as lead. Specialist public health teams at a local level may not have adequate social marketing resource to deliver the campaigns described. The budget at a local level must reflect the specialist skill set required for social marketing and at a national level it should be supported by Public Health England social marketing arm.

Dental public health

This scarce resource is best delivered at a sub-national level through Public Health England with local co-ordination of all health promotion through the teams of the DPH. Local authorities will be the only public bodies in a position to advocate fluoridation programmes and will need to be encouraged and supported by national bodies to undertake further public consultations.

Emergency preparedness and responses to pandemics

PHE should provide the expert support for emergency and pandemic preparedness. It will also need to lead and coordinate, the response to national and sub-national /supra-local emergencies. In general, however, local authorities should be responsible for protecting the health of their population, supported by PHE. At local level only DPH management on behalf of the local authority can ensure that good professional advice is translated into an effective local response. Memoranda of understanding between PHE and local authority DPHs will be needed to recognise these different scenarios.

Health intelligence

FPH supports the approach outlined: PHE and local authority. However there must be sufficient capacity at local level to deliver the outputs described. Health intelligence at local level is essential: high quality reports and data supplied from higher supra local or national bodies require local interpretation and implementation.

Children's public health under 5 years and 5-19 years

FPH recognises that the NHS commissioning board is being proposed as lead commissioner for 0-5s in the first instance, as it builds up the new health visiting programme. However, in the medium term FPH believes that the healthy child programme, which should include school nursing and mental health and well-being, should be delivered from 0-19 years in its entirety through a single commissioning framework, which should be established by Public Health England. The budget should be held by local authority DSPH and commissioned locally.

Community safety

Local authority leadership is essential. With the demise of primary care trusts as responsible bodies in community safety partnerships, the public health component is also assimilated into the local authority role. The commissioning of community safety via this route is therefore supported. However, NHS partners, especially GP commissioners must be partners in the community safety partnerships and must be able to contribute additional pooled budget towards major health damaging crime problems such as alcohol harm, domestic violence and offenders with mental ill-health. Sexual assault response centres (SARCs) are best commissioned at a sub-national level. It should be noted that SARCs have not generally received NHS mainstream funding and that funding such centres will become a new, additional call on the public health ring-fenced budget – and therefore appropriate funding should be included in the budget to ensure this vital service continues to be supported.

Social exclusion

FPH supports the local authority as lead commissioner. Funding currently applied by the NHS for services for non-registered populations needs to be redirected into the public health ring-fenced budget for this purpose.

Prison health

FPH supports the proposal of the NHS Commissioning Board as lead. There should be identified specialist public health support for this important and specialised commissioning.