The Department is grateful for the Committee’s interest in this subject and for the opportunity to offer written evidence to the inquiry. This submission is set out under the main headings suggested by the inquiry’s terms of reference.

A. The delivery of public health functions

Local government

The Government continues to believe firmly that local authorities (LAs) are best placed to deliver community-based public health interventions and improve the health of their residents. LAs have responded very positively to being given this role and are increasingly promoting public health across the full range of their business.

The primary public health duty of local authorities is to do what they believe is appropriate, based on their understanding of their local communities and their needs. It is not the job of central government departments to look over their shoulders unnecessarily and make these decisions for them – we are partners, each contributing what it is most qualified to contribute. However, we also accept entirely the overarching responsibility of the Secretary of State for Health for the stewardship of the comprehensive health service as a whole, of which local authorities are now a significant part.

Public Health England (PHE) continues to receive and publish data by LAs against all the indicators in the public health outcomes framework (PHOF). The latest figures show that, across the four domains of the PHOF, between 75 per cent and 87 per cent of indicators with trend data are stable or moving in a favourable direction. LAs also continue to account to PHE for their compliance with the conditions attached to their public health grant through spending returns signed off jointly by the director of public health and the chief executive or finance director.

The National Audit Office has scrutinised LAs’ performance and use of the grant, and published its report in December 2014. It found that the new system had improved transparency and accountability, but that some LAs were still in the process of aligning spending with their local priorities (rather than those they inherited from the NHS). The Department concurred with that view at the time and believes that LAs have continued to make progress in the year since.

Local government will face both challenges and opportunities as it works to improve health further in the coming years. Based on its performance since 2013 the Department has every confidence in the ability of local government to play its part successfully and we are encouraged by the level of enthusiasm and commitment for the task that LAs have shown. The Department and PHE will continue to offer practical support and national leadership.
Public Health England

In April 2013, the Government established PHE as an executive agency of the Department of Health. PHE is an expert national body which plays a leading role in delivering the Secretary of State for Health’s statutory duties to protect health and address health inequalities, and his power to take steps to improve the health and wellbeing of the nation. PHE supports local authorities (LAs) in England in taking forward their duty to improve the health of their populations, not least through providing the evidence base and advice on public health interventions. PHE also provides expertise on the population aspects of clinical commissioning and is the public health adviser to NHS England. A framework agreement between DH and PHE sets out the main elements of our relationship, including how accountability arrangements work in practice.

To carry out its remit to protect health it has been important for PHE to make use of its position as part of central government. However, the Government has accepted entirely that, to be fully effective, PHE needs an appropriate level of operational autonomy. To that end, as PHE’s Framework Agreement sets out, it is able to speak to the issues based on a professional, scientific and objective assessment of the evidence base. Since it was established, PHE has released a number of evidence-based publications, covering research and advice from scientific committees, along with peer reviewed research and advice on specific public health issues, including topics of high public interest such as shale gas extraction and sugar consumption.

PHE’s status as an executive agency has proved consistent with the Government’s fundamental objective to ensure that PHE is a credible, professional body. PHE has established a global reputation and provided expert analysis and professional judgement to help government, the NHS and the people of England to protect and improve health.

It is testament to PHE’s strong relationships with LAs, the NHS and other partners that there was a smooth transition to the new public health system. It is also encouraging to see the partnerships between PHE, the NHS and LAs being put into action, as demonstrated by the commitment to prevention and public health which is central to the NHS Five Year Forward View.

Given that PHE was established under three years ago, and the long lead time in improving public health, its major achievements relate to particular activity and to setting up strong systems and relationships that will serve it well in future. For example, PHE has:

- developed a world-leading reputation on health protection. We have been able to depend on PHE to protect the nation’s health through its expert response to the Ebola threat;
- helped drive progress in programmes locally, such as the NHS Health Check programme and on drug and alcohol recovery;
• put in place new arrangements for LAs to account for the public health grant, providing greater transparency and alignment with local needs than the previous, NHS-based, system; and
• informed national policy decisions, including through major reports on the public health impacts of alcohol, e-cigarettes and consumption of sugar and carbohydrates.

PHE will need to retain its world leading expertise so that it can continue to perform its vital role in protecting the UK and furthering its work with international partners to prevent and respond to health threats across the globe, including new infections and antimicrobial resistance. PHE is also working now to strengthen its influence on the development of key policies across Whitehall.

PHE has made a major contribution to health improvement activity, supporting LAs on local initiatives by providing the evidence, support tools, advice and through social marketing campaigns. In this challenging financial climate, it is vital that PHE can further evolve and embed its public health leadership role, including by helping local authorities understand the impact of their spending decisions, by highlighting geographic variations, and by drawing out and correlations between investment in particular services and relevant outcomes. It will also be important for PHE to continue working closely with delivery partners to support directors of public health and the NHS locally with the evidence base for health improvement activity.

As set out in the NHS Five Year Forward View, the Government recognises the importance of prevention, alongside and effective high quality treatment throughout people’s lives, as key to tackling key health risks such as obesity and the prevalence of largely avoidable diseases such as type 2 diabetes. This requires a sustained, concerted effort to make improving health a core part of what central and local government.

PHE has made a good start in its work and is delivering on the strategic priorities set out each year by the Parliamentary under Secretary of State for Public Health. It is an effective organisation and through its recent strategic review has reorganised itself to more effectively deliver its remit at the same time as making substantial efficiency savings. However, in common with the rest of the health and care system, PHE will need to create the internal capability, long-term sustainability and resilience to enable it to remain at the leading edge of public health science and live within its means in the coming years.

**The NHS**
The NHS has a critical part to play in securing good population health and preventing disease. This role includes:

• NHS England commissioning a particular set of services under the Section 7A Agreement; and
• the broader contribution of the NHS to public health and prevention
For some public health services, the Secretary of State delegates responsibility for commissioning to NHS England. These services are set out in what is known as the ‘section 7A’ agreement between the Secretary of State and NHS England (after section 7A of the NHS Act 2006). NHS England is supported by information and expert advice, capacity and support from PHE.

In practice, these services are either commissioned by NHS England as part of the primary care contract (for example childhood immunisations), primary care enhanced services, a pharmacy advanced service (for flu vaccination) or commissioned from secondary or community providers using the NHS standard contract. These services are often an integral part of NHS clinical pathways - such as cancer screening programmes, which are closely tied to cancer treatment.

The agreement is published annually alongside the NHS Mandate. In 2013/14 it focused on securing the safe transition of services and the introduction or modification of four immunisation programmes. In the second year of the new system it focused more on ambitions such as reducing the range of variation in service performance across England.

The 2015/16 agreement gives responsibility for commissioning some key programmes to NHS England:

- national immunisation programmes;
- national screening programmes;
- child health information systems;
- services for children aged 0-5 (until October 2015, when responsibility moved to LAs);
- public health care for people in prison and other places of detention; and
- sexual assault referral centres.

The agreement also sets out two over-arching ambitions intended to address health inequalities: consistent implementation of the agreement, reducing the range of variation, and improving equity of access to high quality care. The deliverables within the agreement are based largely on maintaining and improving performance against the indicators defined in the PHOF – such as percentage rates of screening coverage.

A number of new programmes have successfully been added to the agreement in response to population health needs and advice from expert advisory bodies, such as the Joint Committee on Vaccination and Immunisation and UK National Screening Committee.

Additions to the agreement since April 2013 including flu vaccination for some groups of school-age children and a Men C programme for university entrants. In 2013/14 NHS England, in partnership with PHE, introduced four new or changed immunisation
programmes; rotavirus, shingles, Men C and childhood flu for 2 and 3 year olds. The addition of this number of changes within a short time period was unprecedented. Most recently, in August 2015 a MenACWY vaccination for adolescents and young people was introduced to respond to a rising number of Men W cases, and a new MenB vaccination programme for infants was launched in September 2015.

As noted in the Five Year Forward View, there is significant role for the wider NHS to play an active part in the prevention agenda. This relates not only to specifically commissioned services under 7A agreements, but a whole range of health and care services which can support prevention and public health agenda.

There is a huge role for the NHS in tackling big public health epidemics such as diabetes and obesity, which is demonstrated by the central role of the NHS in the diabetes prevention programme. In addition, the policy of Making Every Contact Count demonstrates the importance of timely and opportunistic advice which can be given in a healthcare or a community setting. This is often a key part of health promotion, where interventions can help people to improve nutrition, quit smoking, reduce alcohol intake or to reduce social isolation.
B. The effectiveness of local authorities in delivering the envisaged improvements to public health

PHE plays the leading role in supporting and advising local government, and participating in the system of sector-led improvement that the Department funds. PHE’s own evidence submission will go into more detail about this; the Department’s position is summarised above in section A.

C. The public health workforce

Following a consultation in 2012, DH, PHE and the Local Government Association (LGA) published a joint public health workforce strategy in May 2013. The strategy contains 14 commitments that address specific issues that arose out of the consultation and aim to support and develop the workforce across the public health system. Priorities identified through the consultation included:

- support for career development across the system, particularly for public health practitioners;
- leadership and talent management throughout the public health system;
- support and development for public health academics, public health knowledge and intelligence staff and public health scientists; and
- embedding public health capacity across the system as a whole.

The commitments in the strategy are being delivered by a range of partner organisations including Health Education England (HEE), PHE, the Faculty of Public Health and the LGA. The Department has a co-ordination and oversight role and has worked closely with partner organisation to identify and agree proposals for the development of the public health workforce.

Taken together the commitments in the strategy aim to:

- help us better understand our public health workforce across the system;
- promote leadership skills appropriate to the new public health system;
- focus on the workforce development role of local authorities and PHE;
- provide support for career and skills development across the system;
- give assurance on the competence and professionalism of all public health specialists; and
- embed public health knowledge and capacity across the healthcare workforce

In addition to delivering the commitments in the strategy further work has been undertaken in the past two years to enable the Department, PHE and others to better understand the scale and scope of the public health workforce and its development needs in the new system. This includes a series of projects commissioned jointly by the Department, HEE and PHE from the Centre for Workforce Intelligence (CfWI).
The Department, and the other three health departments in the devolved administrations, are being advised on public health workforce issues by the People in UK Public Health (PiUKPH) group, which is chaired by Shirley Cramer, Chief Executive of the Royal Society of Public Health. Membership is drawn from a wide range of organisations including the Local Government Association, the Faculty of Public Health, the Royal College of Nursing, Manchester Fire and Rescue, the Chartered Institute of Environmental Health, Association of Directors of Public Health and the UK Public Health Registry.

We intend to review the workforce strategy this year and expect an update to be published shortly. We will then consider the outcome of a series of projects being conducted by PHE and CfWI, together with advice from PiUKPH, to identify and prioritise any further developmental needs for the workforce across the public health system.

D. Public health spending

The Department allocated over £8 billion to local authorities over the three years 2013/14 to 2015/16, ring-fenced exclusively for public health. The initial allocations were based on historic public health spend by the NHS. The independent Advisory Committee on Resource Allocation (ACRA) has developed a formula sets a target allocation based more closely on need, and the Department determines the pace of change from current spend towards target allocation, taking account of the available resources and the need to ensure system stability. In 2013/14 and 2014/15, LAs furthest from their target allocation benefited from a 10 per cent increase in their public health grant allocations.

The Government believes that taking action to reduce the deficit is vital to the long-term health of our economy and to all of the public services that it supports. To support that objective, the Department of Health asked LAs to deliver an in-year saving of £200 million during 2015/16. Following consultation, this was applied as a uniform reduction of 6.2 per cent to all LAs’ public health allocations.

A strong economy is in itself a contributor to good public health. To reflect this, the Department has joined with DWP to create a joint Work and Health Unit, showing the Government’s strong commitment to halving the disability employment gap.

In 2013/14, £2.51 billion was reported as spent by LAs on public health duties and a total of £207 million placed in reserves. Provisional figures for 2014/15 shows that £2.70 billion was reported as spent on public health duties with £302 million carried forward in reserves.

The Chancellor announced in his autumn statement on 25 November that the ring-fenced grant will remain in 2016/17 and 2017/18 and will be reduced by an average of 3.9% in real terms in each of the next five years. However, local authorities will still receive over £16 billion to spend on public health over that period. This is in addition to what NHS England will continue to spend on vaccinations, screening and other
preventative interventions, including the world’s first national diabetes prevention strategy.

The Chancellor’s statement also announced the decision to move PHE’s headquarters and its science facilities in Colindale to Harlow in Essex. This follows on from the announcement in September that PHE’s laboratories at Porton will move to Harlow and completes the plan to bring all the public health laboratories onto a single integrated campus. This investment in our critical infrastructure will ensure we have public health science facilities capable of meeting current and future needs for decades to come.

The Government will consult on options to fully fund local authorities’ public health spending from their retained business rates receipts, as part of the move towards 100 per cent business rate retention.

The Department has recently concluded a consultation on a package of updates proposed by ACRA to the fair shares formula, including:

- routine data updates;
- an adjustment to increase the weighting of the most challenged populations;
- estimating sexual health and substance misuse services need using a predicted utilisation model rather than mortality data; and
- a new component for children’s 0-5 services, based on consultation evidence gathered in March 2015.

The responses to this consultation are currently being considered by ACRA before it provides final advice on a revised formula.

E. Conclusion

We remain committed to protecting and improving public health. While efficiencies need to be made we will continue to invest in the public health grant alongside supporting councils’ local efforts and taking bold national action to tackle obesity as a leading cause of ill-health. Local government has demonstrated some excellent examples of delivering better health for local people and better value for the taxpayer. We are confident that this partnership between national and local Government will continue to find ways of improving health outcomes.

14 December 2015