EMBARGOED UNTIL 20.10.11

Joint statement on the future of public health in England by the Local Government Association, British Medical Association, Faculty of Public Health, Association of Directors of Public Health, NHS Confederation and Royal College of Midwives

This joint statement sets out the conclusions of our joint work to date to prepare for the reform of public health in England and areas of agreement. It is intended to shape future national discussion on legislation, guidance and implementation of the reforms.

The new national public health system

1. It is important that Public Health England (PHE) is not considered or developed in isolation. The design for England's new public health system should cover all three domains: health protection, health improvement and improving health services and the role and contribution of each component at all levels: the Chief Medical Officer and the Department of Health; National Commissioning Board; Public Health England; public health in local government; clinical commissioning groups; clinical senates and provider services. We favour an integrated approach with roles and responsibilities defined clearly and distributed across the system.

2. The funding to be provided and its distribution across the domains and levels should *follow* that design, and not be limited by existing or historic budgets. We have serious concerns about the current Department of Health (DH) exercise to identify current Primary Care Trust (PCT) funding for public health, already jointly expressed to the Public Health Minister, and the basis on which funding for local government's new functions will be allocated. We are concerned that there may not be sufficient funding allocated to the new public health system both for PHE itself and for local authorities for their responsibilities for health protection, health improvement and improving health services.

3. Many public health arrangements, for example disease surveillance, need to be organised at a supra-local or sub-national level. We support an integrated model for the new public health system in which large local authorities can host a sub national function on behalf of PHE – the Mayor of London and the Greater Manchester Combined Authority are two examples where this could happen. Where such authorities do not exist local authorities could host sub-national functions through joint arrangements and Directors of Public Health and their consultant/specialist colleagues could have portfolios of responsibilities for the national system in addition to their local responsibilities. While local authorities and PHE will need to consider economies of scale in creating appropriate systems at sub-national level they will also need to be adequately funded.

4. Councils should have flexibility to organise their public health arrangements to best meet their statutory responsibilities and local circumstances. It is the role of Directors of Public Health to advise a population and they need to have a professional independence to do so. Local authorities need to take account of the health implications of all their policies and decisions and their Director of Public Health will need to be of sufficient seniority to fulfil their corporate role.

5. In doing so, they should have regard to the need for collaboration with other councils to achieve sufficient scale for some functions and may wish to consider appointing a Director of Public Health (DPH) jointly with neighbouring authorities especially where they share a large part of their senior management structures or share a Health and Wellbeing Board. However they should also be aware of the need for their Director of Public Health to be embedded in their structure so as to influence the full range of decisions.

Transfer of public health functions to local government

6. Councils welcome the transfer of local public health functions back to local government and recognises the important role of district councils in county council areas.

7. Public health has been part of the NHS since its foundation, including when it was managed by local government from 1948-74. The Government's new distinction between "the NHS" and "the health service", with public health apparently being seen as part of the latter but not the former, is not helpful in ensuring a smooth transition. Local authorities carrying out public health functions for the health service should be able act as, and exercise the powers of, NHS bodies and access appropriate NHS systems. For example, the ability for local authorities to appoint their DPH at NHS consultant grade in order to strengthen their position in their dealings with the NHS is an important instance of why councils should have the powers of NHS bodies.

8. We recognise the need for full engagement of district councils in these arrangements in two tier areas. It is up to county councils, in partnership with their district councils, to determine how resources are allocated and whether public health duties are to be delegated (if legislation permits).

9. We welcome the population focus directors of public health will contribute to councils, cabinets and senior management teams' discussions on health improvement and public health priorities. DsPH will also make a vital contribution across all dimensions of health improvement (beyond service provision), health protection and influencing health services including economic development, environmental stewardship, building the community's assets. The status of their advice to the council and its cabinet should parallel that of directors of children's services, adult's services and directors of finance.

10. Directors of Public Health should continue to be appointed with the advice of the Faculty of Public Health through a formal; appointments process. They need not be medically trained but must be properly qualified and should be subject at least to the same requirements of continuous professional development as other local authority chief officers. While yet to agree a formal position, the Local Government Association (LGA) recognises the benefits that a statutory register of public health specialists, from whatever background, eligible for consultant appointment could bring.

11. Staff joining local government from the NHS now and in future should continue to have access to the NHS for their continuous professional development, accreditation, revalidation and regulation (as determined), as well as the flexibility to move in and out of the wider public health system as their careers progress. Organisational and funding plans should address this.

12. Many staff in local government have also worked on public health issues and some of them will wish to join the specialist workforce. The Faculty of Public Health will discuss with local government transitional arrangements to ensure they are not disadvantaged by having made their career in local government rather than in the NHS.