Chartered Institute of Environmental Health

Evidence submitted to the Health Committee inquiry into Public Health

This evidence is submitted on behalf of the
Chartered Institute of Environmental Health
by
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About the CIEH

As a **Chartered professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across the UK and, increasingly attracting members in many other countries around the world.

Any enquiries about this response should be directed in the first instance to

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1. Introduction

1.1 The CIEH welcomes the intention of the Health Committee to scrutinise the plans for the Government's proposals for major changes to the organisation of the public health services.

1.2 We also welcomed the announcement of the Government's 'pause and listening' process which has included seeking further views from interested parties and the public and commissioning Professor Steve Field to head the NHS Futures Forum and to report on possible improvements to the Health Department's proposed NHS reforms in England.

1.3 It was our understanding that our contributions to the pause and listening process, and the work of the NHS Futures Forum would be limited to the proposals in respect of reforms to the public health arrangements for England. However, we have been concerned to note that none of the four work streams within the NHS Futures Forum includes any explicit reference to public health, and the Forum includes only one representative from the public health professions.

1.4 There is therefore a risk that, with the debate concentrating on other changes to the NHS, the effects of the proposed changes to the public health system are being overlooked. This could put the health of the public at risk, and lose the opportunity to improve on the current arrangements.

1.5 We hope that the report of the Health Committee may go some way to address these concerns which we believe are widely held amongst the professional bodies representing the public health workforce.

2. Summary

2.1 The CIEH supports the proposal to transfer the public health lead from the NHS to local government. Local authorities have democratic legitimacy for their role as community leaders and they are effective at engaging with communities and enabling individuals and communities to have more power over their own lives, a key theme of the Marmot review[1]. Local authority environmental health departments already provide the bulk of the public health workforce and they are best placed to deliver the effective public health interventions which serve to protect and improve the health and wellbeing of individuals and whole populations as well as prolong healthy lives.

2.2 A consistent and joined-up approach by all the public health partners across the three pillars of public health (health improvement, health protection and healthcare) will reduce health inequalities. The fairness of acting on the physical and social determinants of health is highlighted by Sir Michael Marmot's Review, and the opportunity to make significant savings to the NHS in the process was stressed in the work carried out by Sir Derek Wanless and others previously and reaffirmed in the Health Committee's most recent report.[2]

2.3 Since their inception, environmental health practitioners (formerly called public health inspectors) have worked with the Government and other partners to deliver such interventions, and that commitment will continue.

[1] Fair Society, Health Lives February 2010
[2] 5th Report – Commissioning: further issues HC 796 I and II 5 April 2011

2.4 In this submission to the Health Committee we have identified four key areas where we believe that there are outstanding issues which we hope that the Health Committee will be able to consider and address in its recommendations.

2.4.1 Accountability must be clear within the public health system
2.4.2 Local authorities must be seen as public health leaders in their localities
2.4.3 Directors of Public Health must be competent and powerful
2.4.4 The funding for the new public health services, nationally and locally needs to be adequate, stable, transparently distributed and predictable.

3. Accountability must be clear within the public health system

3.1 The individual and collective roles and responsibilities of the Department of Health, Public Health England (PHE), the NHS Commissioning Board, local authorities, Directors of Public Health, GP commissioning consortia and Health and Wellbeing Boards must be made clear and coordinated in the new system.

3.2 The CIEH is particularly concerned that the independent voices of bodies like the Health Protection Agency and the National Treatment Agency will be lost, with no proposal to introduce any substitute sources of independent advice and advocacy and no proposals to otherwise counteract this loss.

3.3 The CIEH has three specific propositions to make to help remedy the loss of independence and bolster the ability of PHE to speak out on public health issues, matters in which the public has a legitimate interest.

They are:

3.3.1 PHE must be established with a degree of independence, including in overseeing the arrangements for collecting, analysing and disseminating the data valuable for public health purposes. PHE should be assisted in its work by an advisory panel (or forum) comprising representatives of the public and of relevant public health interests, including environmental health. This approach enables Public Health England to stay in touch with public health practice and the public's priorities as well as test out its thinking on a knowledgeable yet independent body of people.

3.3.2 There should be a post of Chief Environmental Health Officer, answerable to the Chief Medical Officer and able to advise Public Health England, Parliament and the public on environmental health aspects of public health. There has been such a position at times in England's history and there is such a post today in other parts of the UK.

3.3.3 PHE can only effectively operate as a truly national public health service if it has a genuinely comprehensive and strategic remit for all relevant functions including national commissioning, not just those elements now covered by the Health Protection Agency.

4. Local authorities must be seen as public health leaders in their localities

4.1 For localism to be meaningful, it must be for local authorities themselves to determine the

public health needs and arrangements in their locality, in consultation and collaboration with the other public health partners, including the local NHS.

4.1.4 Public Health England should support local authorities in their extensive public health facing work protecting and improving the health of their local populations through all the services they control.

4.1.2 Health and Well-being Boards must have the power to sign-off local commissioning plans, ensuring that they are aligned with the Joint Strategic Needs Assessment and the Health and Wellbeing Board's local public health strategy so as to address the identified needs of the population and that strategies as far as they are able are "joined up" to aid efficiency.

4.1.3 Under the new arrangements there will be a continuing need for co-operation between different agencies and providers, including PHE, Councils at both County and District level, the NHS, all commissioning bodies and all other public health partners. A statutory duty of cooperation is an essential tool to ensure adequate partnership engagement and should be placed upon all these, comparable to the statutory framework that exists for dealing with civil contingencies.

5. Directors of Public Health must be competent and powerful

5.1 In the multi-disciplinary public health workforce, the leadership and support given by the Directors of Public Health will be crucial to success. The new arrangements clearly acknowledge the multi-disciplinary approaches to public health and it would be anachronistic if the qualifications for Directors of Public Health were not to reflect this.

5.1.1 Directors of Public Health should have adequate legal duties and powers to enable them to do their job effectively.

5.1.2 They should have a right to direct access to both the local authority's Chief Executive and all its Councillors, as well as to the relevant commissioning bodies operating in their area.

6. The funding for the new public health services, nationally and locally needs to be adequate, stable, transparently distributed and predictable.

6.1 Vital capacity, especially in terms of skilled personnel, is already being lost from the Health Protection Agency, local authorities and the NHS due to current public spending cuts and uncertainty as to future structural needs and funding levels. In order to avoid further loss of skilled support to the implementation of the new arrangements we urge speed of decision making at least in the final shape of the proposals.

6.1.1 The public health partners will benefit in making their plans for future public health services from the earliest possible disclosure of the likely ring-fenced funding for the early years of the new services.

6.2 We have particular concerns regarding the ring-fenced funding to local authorities. It is clearly vital that the new services are launched successfully and there is a great deal of work to be done in a short space of time to ensure this success. It is right therefore that

at the outset of these new services the grant funding should be ring-fenced. The grant-funding should be appropriately weighted to reflect levels of deprivation and health inequality and the formula used for assessing and distributing the grants to local authorities should reflect this.

6.2.1 The total amount of funding available for the new services must be sufficient for all the public health functions expected to be delivered.

6.3 We also have concerns regarding the health premium, intended by the Department to incentivise a successful public health performance by local authorities, but which runs counter to the Government's ambitions for a successful launch and for enhanced localism. There is a danger that a plethora of confusing outcomes and indicators, linked to short-term performance of long-term public health objectives will make the overall distribution of funding for the new services obtuse, perverse and unfair.

6.3.1 The proposed health premium must be applied simply and fairly and recognise that some public health gains are won over the longer term.

7. Conclusion

7.1 The CIEH would be happy to clarify and discuss these matters further to ensure that public health is protected and improved by the new arrangements that will be put in place for England.