1. I am submitting evidence partly to identify some of the strengths and weaknesses of moving from the NHS into the council and partly to express serious concerns as to the viability of preventive services under severe financial pressures that Councils are under.

2. Summary points.

2.1 The move of public health teams to councils, led to over two years of just about controlled turmoil, an immense loss of focus on improving public health and morale and the exit of many experienced staff from the system. This was despite a very great amount of work and goodwill from both PCTs and Councils.

2.2 Councils are natural homes for public health, as much or perhaps more so than the NHS and while most PCT public health teams already worked closely with local government at both tiers, engagement with a range of council departments has become much deeper now that we are on the inside and while it is early days this may lead to many benefits.

2.3 Public health teams have worked hard to maintain good links with local NHS commissioners, but equal and opposite to the situation described above with Councils, we are now inevitably less influential and to CCGs and probably less available than we were, even though local links between the Council and the CCG are really excellent in BaNES. Also in order to take advantage of the new opportunities in councils we are inevitably diverting staff focus away from the NHS as our teams have generally not increased in size. Indeed further inefficiencies have been built in as the public health and NHS commissioning organizations have become so fragmented and there are so many more interfaces to spend time and effort managing than pre 2013.

2.4 Most Councils have been very welcoming and positive about taking on public health teams and responsibilities, and at both officer and political level I have found my council to be an excellent and supportive home. However there is something of a perfect storm in operation in that we are new to Councils and so we are trying to establish and demonstrate to Councilors the importance of our services at exactly the time when they are under unprecedented financial pressure. This has meant that even in the most positive councils parts of our budgets have been used to offset other pressures, although often where that use can be badged against some public health outcome. But this has meant that services for some of the most important public health challenges such as obesity, smoking cessation services and school health promotion have been squeezed.

2.5 It is truly adding an insult and an injury to Councils that having passed over a range of important and thoroughly “NHS” based services, such as NHS health checks (clue in name!), sexual health, drug and alcohol treatment, school nursing, health promotion etc, the budgets were then subject almost immediately to an in-year cut, and it is now confirmed that further reductions will be applied to budgets partly in order to protect the officially-sanctioned NHS budget.

2.6 It is even more alarming that having embedded the most upstream preventive work of the NHS in Councils and in effect dropped any pretense that the NHS was a “health service and not a sickness service”, a new un-evidenced and untried preventive service - the diabetes prevention programme – is being rolled
out across the NHS effectively with money that will come from the
decommissioning of evidence-based council commissioned services as our
budgets effectively cross-subsidise the National Sickness Service.

3. More detailed points on questions in scope of enquiry.

4. Public health functions. The main commissioned public health services have not
changed very much in my Council. But it has taken a great deal of work and
willingness to embed those services in Council processes and contracts. In PCTs the
public health teams relied on the functioning of a large number of support services
including commissioning and procurement teams, finance departments, HR, nursing,
clinical governance, comms. teams, and so when our teams moved to councils we
lost all this back up and had to rebuild links within councils, and in many cases start
to recommission services very shortly after the move using a whole set of new
processes and rules. Within the same financial envelope there was very limited
scope for wringing significant improvements from resources that had already come
under pressure in the last years of the PCTs. Any improvements to commissioned
services have not been directly as a result of the move to Councils, especially in
BaNES where we already had close joint working between the Council and the PCT.
It is possible that in the future there will be further opportunities for better joint
commissioning of services perhaps especially in the children’s sphere, but as per 2.3
above what is made easier in relation to councils is made harder in relation to the
NHS, so it is a little difficult to see why there would have been much expectation of
any aggregate improvement in commissioned services as a result of the move.

5. The main advantages of working within councils are around joint working with other
council services. To give a few examples

5.1 We have developed a very wide ranging “Get Active” strategy with the Council’s
leisure and transport services. This underpinned the retendering of the main
leisure service contract which led to something much more holistic from what
might have been a more leisure-centre focused contract.

5.2 We have added significantly to regeneration and placemaking plans bringing in
some planning tools, evidence of links between health and the built environment,
and examples of good practice. I am certainly not saying that councils did not
understand the importance of these areas of work to health and wellbeing, but we
have been able to add usefully to the depth and impact of that understanding.

5.3 We have begun to work with the transport team and partly as a result of this the
new transport strategy is very heavily focused on active modes of transport as
well as on motorised transport.

5.4 We have also helped to develop bids for grants to improve the green space and
access around the area, adding health considerations and evidence to the work
of spatial planners and environmental officers.

5.5 We have worked with a range of partners inside and outside the council to
develop the safety of the nighttime economy in Bath and this has helped the
council achieve “Purple Flag” status.

5.6 We have generally been able to take advantage of the many meetings that
councils have with the public to better understand the needs and opinions of
residents.

6. We have acted as a link between the council and the NHS in many ways although
links were already strong through a range of joint officers and joint commissioning
processes. There is public health representation on the newly established health and
wellbeing board and as DPH I have opened the door for the Council’s birth and death
registrars to work from within the local hospital. That is a small but useful development.

7. The public health workforce.

7.1 There have been major effects on the workforce in the changes of 2013.
7.2 Probably the main positive one has been the pleasure of working with new colleagues who have a diverse range of skills in new and important spheres of work, as well as all the enthusiasm and commitment that is found across the public sector. Working in local democratic environment brings both a new kind of accountability, with some interesting challenges, and a closeness to the public both directly and through elected members that could be lacking in the NHS for non-clinical staff. Many public health workers were initially nervous of working under the control of Councillors after being in the allegedly “non-political” — at least at local level — NHS, but in general, and certainly in BaNES, the engagement between ourselves and Councillors as well as Council officers has been friendly, respectful, productive and supportive on both sides. My view is that the NHS has always been highly politicised but the politics was way above our level of engagement and so being able to talk to local government leaders across the table is actually a step forwards.

7.3 A few DsPH had expanded their portfolios considerable in councils eg. taking on emergency planning, public protection, environmental health teams and in a very few cases adult care too, and in time this may lead to interesting career opportunities to public health staff in local government and it is even possible that a chief exec or two will emerge at some point.

7.4 But against these plusses are many workforce problems. In no particular order:
7.5 The NHS and council salary structures were very different and while the NHS is used to paying people such as doctors for a high level of expertise in their professional fields, in councils remuneration is traditionally based more on management span and budget control, although there are exceptions. Also it is probably fair to say that salaries in the NHS were generally high compared to local government, especially lower paying councils as there is much variability. So there is likely to be, and in many cases already has been, downward pressure to reduce both pay and numbers of senior staff, particularly consultants. This means that there are fewer job opportunities at the highest level, and particularly for doctors who were pegged to the medical scales in the NHS and therefore attracted a premium. One could debate the merits and fairness of that position but it would be a great loss if the medical profession was gradually pushed out of the public health world.

7.6 Consultants, and particularly medical consultants were often the team members working most closely with NHS commissioners, or at least leading that work. As councils are ever more squeezed it is very probably that they will be less likely to want to pay very high salaries to staff who are working mainly to provide a service to the local NHS especially as the NHS is much more protected financially than Councils. In my view the whole model of the local NHS looking to Council-based teams for public health advice is probably unsustainable in the future, or will at least become very variable, and in due course the NHS will have to rediscover the need for public health skills within its different organizations.

7.7 The public health workforce is in danger of fragmenting between a host of small Council teams and Public Health England. And although PHE is under pressure itself, the Terms and Conditions for those that do remain there much more aligned with those of the NHS there is already a trend from people to leave council teams for a potentially better long term offer in PHE. It is of note that this is generally already a one-way traffic… although there are few examples of movement the other way as PHE also comes under budget pressures and is also
shedding staff. But there is certainly a danger that we will start to see the
development of a two tier situation whereby those who can move to PHE and the
council workforce feels second class and demoralized.

7.8 There is also a danger of stagnation especially in the many staff who came to
councils from the NHS under TUPE. Some people I know would liked to have
moved but have been told that their possible new Council won’t allow them to
keep their NHS pension. This is by no means universal, but it does make people
more concerned to move around the system to develop their careers. Conversely
DsPH may be nervous to send staff on promising secondments when many
Councils are subject to vacancy freezes and are even looking to reduce
headcount and so if people leave there may be a struggle to replace them. This
stagnation is particularly dangerous when so many of the council public health
teams are very small and so there is very little scope for internal promotion. In the
former system there was more scope for movement within different parts of the
NHS.

7.9 The NHS was pretty good at ensuring study leave and development space for
professionals working in it and senior staff such as consultants had time and
money for development built into their contracts. I am finding it harder now to
justify to myself, let alone the organization I work in, spending time and money on
conferences and courses when I and other council colleagues are having to face
cuts to front-line services.

7.10 All these factors potentially limiting career development, prospects and
mobility in the system, may make public health a less attractive career when we
are facing so many real population public health challenges and when in some
ways the opportunity opened up by going into councils could bring such benefits
if enough skilled and motivated staff were available.

8. Public Health Spending

8.1 It is hard to be sanguine about what has been done to public health budgets
since the move to Councils. By any reasonable definition the services that are
commissioned from the public health grant are NHS services from NHS providers
and yet the government has seized on the opportunity afforded by moving the
budget and teams to Councils to chop these budgets down while maintaining the
fiction that NHS budgets are being fully maintained. It is almost as if a zero sum
game is being set up between the curative services of the NHS and the
preventive ones left with Councils, and that the dice in this game are loaded in
favour of the NHS. Worse still the first raid on the budget was not only made
within two years of the move to councils, but was made as an in-year cut with
final confirmation of the amount coming in November of the year to which the cut
was applied.

8.2 And now, in the CSR, despite the fact that the in year cut was explained on the
basis that councils held excess reserves it has been made recurrent with
additional cuts which will likely give a very steep fall in public health budgets
particularly in 16/17 which gives us very little time to plan reduced spending and
is likely to lead to some very damaging and opportunistic cuts.

8.3 Reducing the already relatively tiny budgets that are focused on primary
prevention, year on year, will obviously lead to less control of the development of
the main disorders that are putting such pressure on the NHS such as heart
disease, cancer, obesity, diabetes, liver disease, dementia and mental illness. It
is also against all stated national policy which is that the salvation of the NHS and
social services lies in society’s ability to prevent the wave of lifestyle-related
illness sweeping through our population.
8.4 Most Councils have maintained fairly high levels of investment in public health services relative to the amount in the grant (indeed often they have protected it more than PCTs did) but the great majority have found ways of using at least a proportion of this money to support wider budgetary pressures. So far this has more often been through using historic underspend or uplift, but many public health teams have already had to decommission existing and valuable services in order to meet spending targets and with councils under such extreme pressure the ring fence has been a relative but by no means an absolute shield.

8.5 In many cases, including my own, DsPH have taken the view that other council services, particularly those in adult and children’s social care, but also leisure, environmental health and others, are just as vital to public health as those funded from the ring fenced budget. And so based both on this recognition, and also on the need to be “good corporate citizens” of our new home organizations, we have agreed to allow the use of portions of our budgets, although after the CSR it may be necessary to become stricter if we are not to lose too many existing services of those that we commission. But there can be no doubt that even if money diverted from the ring fenced budget is used for other equally important services it is still at the expense of other preventive services.

9. Recommendations

9.1 Reverse cuts to the public health budgets so that primary prevention is not further downgraded, leading to even more extra demand on the NHS, as well as harm to individuals. Give the public health trams the tools to make the most of the opportunities for promoting public health within local government.

9.2 Remove the “mandation” from the NHS health check and the chlamydia screening programmes, neither of which have a proper evidence base for population benefits or cost effectiveness, and allow councils to decide whether they wish to continue them fully or in reduced, and more targeted, form or whether there are better uses for the money that these cost.

9.3 Encourage such legislation as will clearly lead to improvements in public health. Of these the one with a rock-solid evidence base is minimum unit pricing of alcohol.

9.4 Consider putting PHE back into the NHS both so that it is freed from the political constraints and bureaucratic rigidity of the DH, and also so that it can begin to provide detailed public health advice to NHS commissioners as the service from local authority public health teams will likely prove unsustainable and unacceptably variable in the long run.

9.5 Do not lose sight of the importance of the NHS in prevention, and especially secondary prevention, and also its role (particularly in primary care) to support efforts to reduce health inequalities.

I would restate that these thoughts are my own and are not attributed to any other person or organization.

14 December 2015