My authority to give evidence comes from 25 years spent in the practice of Public Health, mostly in the NHS, but also in academic and, since 2013, local authority settings. I have worked in Merseyside, Greater Manchester and Yorkshire and Humber. I have been a Consultant in Public Health and a Director of Public Health (pre and post reforms).

The delivery of public health functions

1.0 There has been a dissolution of responsibility and a fracturing of public health functions. Formerly at regional and district level consultants, and particularly the Director of Public Health, had responsibility for the health of their population. They played a key leadership role within the NHS, taking the population perspective, driving forward the health inequalities agenda through partnership working with other local organisations in the public sector, the community and voluntary sector, and from time to time the private sector. They and their teams carried out needs assessments and evidence reviews to inform strategy, policy, planning and commissioning for their population and the local geography. This work covered health improvement, health protection and healthcare public health, and these core functions were underpinned by Public Health Intelligence. When specialist expertise relating to communicable disease control and environmental threats to health was required (including biological, chemical and radiation) advice was sought from the Health Protection Agency, but the responsibility (and some resource, or the ability to call for the resource in which the Public Health team was employed) for management of incidents remained with the Director of Public Health.

Health Protection

1.1 Primary Care Trusts, the NHS organisations in which the local Public Health function was based, were Category 1 responders under the Civil Contingencies Act – this level of local and regional population health response has been eliminated. Local authority functions have not changed in this regard to what they were previously even though the Director of Public Health is charged with assuring themselves (and others) that the health system can and will respond to a health emergency – I have no idea what this officer could actually do, having no managerial responsibility and no resources upon which to call if a coordinated response within the health system were not to happen. I wonder whether the major players (acute Trusts and Ambulance Trusts and perhaps NHS England) would even include the DPH in their response. Within the local authority I am not aware of any council where the DPH is an Executive Director, although I am sure there must be a few somewhere in England, and I believe that in some areas the DPH would find that the Executive Director who managed them, be it the Director of Adult Social Care, the Director of Communities and Neighbourhoods or similar, would attend meetings or would have been included in circulations where the DPH was not. I believe that in many councils the typical staff member does not know what Public Health is, and
would not even expect that the local authority had some health responsibilities, including knowing that some sort of emergency response might be required at some time. It was my concern while in the interim DPH post I held from Oct 2014 to July 2015 that one day a phone call to the organisation in relation to Emergency Planning and Resilience would be turned away by a member of the administrative staff, or more likely directed to a “Head of Service” in Environmental Protection. One of the major differences in culture between local authority and NHS is that the NHS recognises expertise, i.e. it is understood that there is a body of knowledge and skills which a Consultant possesses, and that even a Consultant who is not the Clinical Director would have those skills and it would be appropriate to approach a Consultant in Public Health to deal with a health protection issue.

1.2 There is no longer any direct relationship with general practice or community pharmacists – both potentially key players when a local incident happens. NHS England can be quite remote, covering a huge area with very few staff, perhaps one officer responsible for Emergency Planning and Resilience for what was formerly an Area Team and unlikely to have local knowledge or contacts in many areas. Clinical Commissioning Groups are Category 2 responders, and in my experience have no expertise in this area – often having a very small workforce, none of whom have had training in emergency planning, nor any experience of incident response, although generally EPR will be included in the portfolio of a senior officer responsible for quality or corporate assurance. Public Health departments formerly had prescription pads in case it was ever necessary to prescribe a prophylactic treatment. The example we all had in mind was in the case of a nuclear incident (whether an act of war, or a release of radioactive material from civil purposes) was the eventuality that iodine would need to be prescribed for the affected population. To my knowledge these were never used – but thought and preparation had been given into how this eventuality would be managed. The PCT-employed infection control nurses were experienced NHS delivery staff who could organise a mass immunisation programme if required. This would involve liaising with the Medicines Management staff with whom they had likely previously worked on Patient Group Directions, making cold chain arrangements perhaps utilising the fridges in general practices which they likely had visited to undertake cold chain audits and work with immunisers (practice nurses or community nurses) whom they had likely trained for the annual ‘flu immunisation updates. These local responses rely on local relationships and local knowledge. Post-transition arrangements for Infection Prevention and Control are in my opinion the most fragmented of all. In what we could most charitably consider to be an oversight in the legislation, the PCT Infection Control Nurses have found themselves in a number of different destinations. To my knowledge we have:

a) Direct employment by the local authority
b) Employed in a provider trust (Community or Acute)
c) Employed in a Community Infection Prevention and Control Team which pre-dated transition.

1.3 Screening programmes are part of prevention. Over the years it was Public Health departments and Public Health staff who developed these
programmes. Typically it would be the Consultant who took the lead for Cancer who had responsibility for the 3 cancer screening programmes, the sexual health lead who would have responsibility for Chlamydia screening, the children's lead who would look after the antenatal and newborn screening programmes and the lead for cardiovascular disease who would be responsible for diabetic eye screening. These may not have been 4 separate staff, and the programmes often did not need much attention as they were established and things were ticking over, but every once in a while there would be an incident or near miss which would require an experienced specialist to manage. At transition we were asked if we spent 50% or more of our time on screening and immunisation – in the PCT where I worked none of us did, and in most PCTs this was the case. This function transferred to Public Health England, and was concentrated – all screening, and immunisation, for a very wide area, lumped together, meaning all those local connections and relationships built up over the years were gone at a single stroke. The one consultant has a team comprised of staff who had been either a specific screening programme coordinator, or an immunisation coordinator previously but now have to cover all the screening programmes, and immunisation, despite not having experience or expertise in most areas of the job.

The effectiveness of local authorities in delivering the envisaged improvements to public health

Public Health was transferred to local authorities during a period of unprecedented contraction, which confounds the effects of the transfer itself. The additional resource which came from the NHS with Public Health has been seen as a Godsend to cash-strapped Councils, which have used the Public Health Grant for things which one could say are legitimately Public Health, but were not what the money was spent on previously, and which was previously funded by the local authority; two examples from York - £50,000 into Air Quality (basically funding a member of staff in the Public Protection Team) - £100,000 plus into 8 voluntary sector bodies providing some degree of mental health support, to fill a hole in the Social Care budget.

In the case above North Yorkshire and York PCT split into 2 local authorities, so they divided the resource 75% / 25% in lines with the population distribution – this meant that the Public Health “Team” was too small to be viable, the DPH and 4 staff, of which one left within a few months and two of the others had intermittent attendance and one left after a year. Functions which were deemed to be broadly similar to Public Health were brought together; the 4 strong Drug & Alcohol Team, the 20 staff working in Sports and Active Leisure, two staff formerly working in the Children’s Directorate (one of whom had run the Healthy Schools Programme and the other had been the Teenage Pregnancy Coordinator) and a person from Democratic Services was brought in to run the Health & Wellbeing Board. So while that might appear to be a reasonable Public Health team, there was still only the DPH and 2 staff who had experience, knowledge and skills in Public Health. None of the others had any knowledge or experience of health protection or healthcare public health at all. So while they had transferable skills and some relevant knowledge for health improvement,
the local authority remained desperately short of Public Health capacity. There was no one to provide healthcare public health advice back to the CCG despite there being a requirement on local authorities to provide a “core offer” (of health intelligence and Public Health advisory service) to CCGs. So it was difficult for the local authority to be “effective” – it could merely continue to commission the services which had transferred. Making changes takes time from a strategic leader such as a Consultant or DPH; for example deciding to decommission pharmacist-delivered Emergency Hormonal Contraception, as teenage pregnancy is less of a priority and instead investing in suicide prevention, requires the strategic leader “having the time to think”, having accurate health intelligence, the time to spend gaining political support (from politicians, the local NHS), and being prepared to handle the media when news that a service once widely promoted was to be cut. This is quite separate to the commissioning and contracting transactions which can be undertaken by staff without specialist Public Health knowledge. There are only so many changes which one Consultant/one DPH can manage.

I think fundamentally local authorities could commission lifestyle and other health promotion activities just as well as an NHS organisation could. However in practice in the NHS there was no mandatory requirement (and still is not) to put services out to tender in the same way that local authorities have to (European regulations). In some cases this causes a disproportionate amount of effort. An example of this is a service costing £40,000 (oral health promotion for City of York) as part of a much wider clinical dental services contract. Formerly there was one integrated service, which also undertook the mandated dental epidemiological survey when commissioned by the PCT. The fragmentation in the case of North Yorkshire PCT means that the commissioning of that service is now split between NHS England (which commissions dental services) and the two local authorities. NHS England did not have going out to tender on this service on their schedule until 2017. But local authorities hit the regulatory deadline at end of March 2016. Neither the local authority nor the provider (Harrogate Trust) had sufficient capacity to make the tendering feasible, so the decision was taken to discontinue the provision of oral health promotion. This created tears on both sides, provider and commissioner, to have to break up a well-regarded service.

Local authorities lack understanding of the unique skills and knowledge base of the public health analyst – most being drafted into Business Intelligence Unit where their skills are diluted. Good analysts are getting increasingly hard to find – several have left Public Health to go back into the NHS where they can have the Terms and Conditions they were used to, and usually can get a job on a considerably higher salary than the job is graded at in local authority grading systems. This, together with the difficulties in accessing NHS data has meant their ability to produce robust public health intelligence is severely limited.

Maintaining links between academic public health and local authorities present another challenge – local authorities are not used to funding staff to work some days in a University, unlike the NHS where there is frequent movement between
Medical School and service delivery in the NHS – including non-clinical specialties such as Public Health.

Lack of familiarity with “lead commissioner” arrangements seems to be a feature of local authorities. This was the case for North Yorkshire County Council and City of York Council who found it very difficult from a legal point of view not to hold separate contract – making it more complicated for providers and increasing transaction costs. NHS organisations are very used to having a lead commissioner for more specialised services and other commissioners being recharged for their share of the costs.

The public health workforce
There has been a de-skilling of the workforce. Consultants are trained, and able, to cover all 10 key areas of Public Health – this is part of the strength of the profession – the ability to be a generalist, to have the overview of the health of the population and the health services which contribute to, or damage health. Consultants have left in droves, in many cases (including my own) due to the lack of ability to practice Public Health.

There are no substantive Public Health posts in the NHS at any level. Some CCGs have a Consultant (employed by a local authority) based there part-time, and some even contribute some funding for such a post, but this is very variable, with some CCGs not having very much contact at all. There is no longer a career option in Public Health in the NHS. This also has implications for Registrars in Public Health; they cannot do rotations in the health service, not least because there is no one there to supervise them.

The skills deemed to be needed in local authorities tend to be generic service commissioning, and the importance of specialist skills is not acknowledged. Public Health Analysts are incorporated into Business Intelligence Units which focus on performance monitoring and not the production of high quality intelligence. They are thus separated from Consultants in Public Health who can interpret the results of their analysis in the wider health context.

I had hoped that we could get around this leakage of public health analyst capacity by having a shared analyst post with the Public Health England (PHE) Knowledge and Intelligence Team (KIT) who were based nearby. Unfortunately PHE had a recruitment freeze in place the whole 16 months I was based in York, so even though we had the resource to support 0.5 wte of an analyst, institutional constraints meant that this was not possible. The PHE KITs can no longer undertake commissioned analyses as the former Public Health Observatories used to do, which means that local authorities do not have the option of paying “someone else” to do public health analysis (short of a formally commissioned study).

Public Health Analysts are like gold – there are not enough to go around. Sadly no more are being created – the North West Public Health Analyst training programme ran it’s last cohort about 4 years ago.
When the PCTs were breaking up we Consultants were asked to say where we spent more than 50% of our time. In my PCT we split the screening along specialist areas, (as I detailed in 1.3), so none of us were transferred to Public Health England. I was very sad to have to give up working on Diabetic Eye Screening. Over the years I built up good working relationships with the local Programme staff, the Hospital Eye Service and diabetes specialists (Consultants and Specialist Nurses). This was a platform for joint working on diabetes. The close working relationship enabled us to establish a fast-track clinic to a Diabetologist for those patients found to have sight-threatening retinopathy (at no extra cost). The local diabetes services no longer have any relationship with Public Health at the local level.

**Public health spending**

There is a lot to say here, about level of funding and what it is being spent on, but I expect other informants have dealt with this issue at greater depth. Suffice to say that the division of budgets involved some rather bizarre decisions – the initial transfer into NHS England, and then the shift later to local authorities for the 0-5 Health Visitor services, but not for the Child Health Information System (which is remaining with NHSE until 2020).

It was also a very strange choice to not give a commissioning budget to Public Health England.

**Suggestions for case study**

I would have suggested City of York, but as there have been 3 Directors of Public Health, and no doubt will be a 4th by the time you would be doing the study it is not ideal – although there is one Band 7/ Health Improvement Officer who has been there from PCT to local authority and would certainly be able to give the history at a very practical level, and the DPH of neighbouring North Yorkshire would be able to provide some strategic context.

*14 December 2015*