My perspective is that of an Environmental Health Officer by trade, for 12 years in District Councils, then moving to the new Public Health Directorate in a County Council, six months after the change, at a frontline/operational level.

**Functions** – the functions in the main (that I work on Smoking, healthy weight, fuel poverty, mental wellbeing, breastfeeding) that came across from PCTs do not seem to be too bad a fit for local authority. There is ample opportunity to link across, however it sits very much with public health, rather than being embedded or established in other departments.

It is my opinion there has been little priority around building contacts with Trading Standards, Environmental Health, Planning, transport, economy, housing, food safety, leisure services, schools/education, Young Peoples services, with the focus being on commissioning services and bedding in to how the County wishes to run contracts and grants. There was insufficient knowledge and staffing to deliver this easily.

**Organisation** – Public Health at an operational level sits distant from other departments, including the team working on the JSNA. The team is small, with very limited administrative support.

There has been issues with sharing mutually beneficial between the CSU, the CCG and the County. Issues with Information Governance, around sharing postcodes, which is likely to have the biggest impact.

The relationship between the CCG/GPs and the Council is poor due to challenges of communicating directly with them across the range of Locally Enhanced Services, as well as other initiatives which would benefit the success of various projects and services, such as Fuel Poverty and single point of contact project.

**Funding** – the challenge of local authorities being asked to invest in preventative work/project that benefits the NHS and GPs, who do not contribute themselves up front or in retrospect if and when there is a reduction in demand on their service.

Much is made nationally of investing in “Health” – but the reality is cuts to public health and other services, such has health and social care budgets.

The ring fence has been helpful, but the lack of certainty is frustrating to work with (written prior to Autumn Statement).

The 38% cuts to local government means there is a greater demand on public health. The local play association who provides play days, has seen funding drop from £43k to £0 in three years, this means there is an increased demand on Public Health to perhaps fund this work.

Due to the size of the team and the uncertainty of the funding levels it is difficult to spend the grant. In turn, due to any underspend this is taken away in subsequent budgets. This does not encourage good use of public money or for it to be used specifically on public health work.
The perpetual spectre of cuts means it is not possible to provide security to the third sector, particularly smaller organisations, who provide the services to deliver public health work. This impacts on their staffing levels and in turn their ability to respond flexibly to changes in demand, as good staff are lost elsewhere.

**Delivery** – I do not think this Council has taken full opportunity of the fact that Public Health has moved to local government. A procurement/commissioning mindset was taken from the PCT to the local authority and significant resource has been invested in commissioning services. This has led little time to invest in partnership working and influencing across other council departments. There is an assumption that these departments know what public health is, what the drivers are, what their responsibilities are under relevant NICE Guidance etc. Even those professions where there is a shared history of public health, there is limited engagement in broader Public Health initiatives, such as Trading Standards, Environmental Health, the focus being on mandatory services, based on enforcement.

There are others such as planners, transport planners, economy professionals who have very limited professional interest and there is resource needed to explain the links, find the champions and then providing the support to encourage their development.

The availability of financial resource to persuade some investment in non-mandatory work may be a useful lever to direct attention, however this is less effective due to the degree to which other departments have been cut back over the years.

There is a tendency to default to traditional “health” partners, rather than local authority partners/professionals.

There are additional challenges in Two tier areas due to the disconnect of management as well as the political challenges, which can come into play on local Health boards.

The Health and Wellbeing Board and its associated Health Improvement Board, is predominantly a board to discuss issues, however there is little priority setting, mostly maintaining the status quo, and certainly no call to action and championing additional investment from partners.

Much of the Health and Wellbeing boards time is spent discussing health matters, such as delayed transfer of care.

Strategies are agreed, but they must deliver with a small envelope of existing staffing and shrinking financial resource and inability to plan, due to ever present funding cuts. I believe we are currently in the situation where the budget for 2015/2016, is being decided in November 2016. Six months into the year, leaving six months to deal with any shortfalls, and cut services, or in the unlikely event of not such a harsh cut, spending a potential underspend, so as to limit cuts to the budget next year.

The first two years has been spent bedding into a new organisation, recommissioning, dealing with cuts and the uncertainties of cuts.
The good news is that there are some partners who are keen to engage, such as the Fire and Rescue service, certain departments of District Councils, who are already working in partnership between themselves and others e.g leisure and arts.

I am just starting to make more operational links across providers, to a) improve the offer to local residents and b) to make the most of the contract in the first instance.

Smoking services – currently there is only a focus on quits and the failing rate against the contract, rather than the better than national rate compared to an ongoing inequality in routine and manual workers.

Healthy Weight – the decision of the County Council to fully fund a near full Tier 3 weight loss service has meant a significant amount of resource, staff time and finance has been invested in a treatment service. The local CCG has only recently been active in being involved in the obesity pathway.

Mental Wellbeing – difficulties around the boundary between adult and child and mental health. Suicide also sits with public health, but there is an expectation that it leads it, however, suicide is a crisis type topic, which requires others such as health trusts to provide suitable services to properly manage it, such as crisis beds.

Other topics include breastfeeding, which is primarily lead by HVs and midwifery services and to a lesser extent due to potential cuts, by childrens services, through Childrens Centres.

**Public Health workforce** – the department is made up of professionals from various backgrounds, before coming to work in the local authority, as well as staff who have come from the PCT, none have come from the County Council itself – dentist, Environmental Health, Sexual Health Nurses, Disability nurses, psychologist. There is generally minimal clinical expertise available and one post has recently been recruited to, to address this gap, however their expertise will cover, drug and alcohol, smoking, weight loss, sexual health services, Health Checks, Community drug and alcohol provider, Integrated Sexual health services, School health nurses, Health visitors. There is no recognition (financial or otherwise) of Registration with the UKPHR as a Practitioner for Practitioners. Some staff have MScs in Public Health, however at an operational level this is not required. Trainees Registrars are used to deliver some specific project work, such as Health Impact Assessments and Suicide Audits.

3 December 2015