Biographical Background
I am a former local authority chief executive and environmental health practitioner with wide experience of the strategic and operational implications of designing and delivering local community services.

I am currently local government advisor to NICE, advisor to the School for Public Health Research at the London School of Hygiene and Tropical Medicine, local government peer reviewer of health and wellbeing services and Vice Chair of the Royal Society for Public Health.

All comments made in this submission are personal, are not intended as criticism of the activities of any current organisation and should not be attributed to any individual organisation.

Summary of main issues raised in the submission

1. Has there been a successful transition of Public Health into Local Government?
2. How is PH now affected by the context of the new host organisations in terms of:
   a. Financial management,
   b. Organisational development?
3. The Public Health Workforce.
4. The Public Health Funding Envelope.
5. Concluding Comments.

1 - Has There Been a Successful Transition of Public Health (PH) into Local Government (LG)?

1.1 There is no doubt in my mind that the PH function has returned to its rightful place in local government. The majority of factors that impinge on the long-term health and wellbeing of the population are influenced by the decisions taken and the services provided or commissioned by local councils - education, employment, housing, welfare benefits, leisure & culture, environmental health, spatial planning.

1.2 Had the transition of PH into local government come at any time other than one of the most austere times for public spending, I would be optimistic and enthusiastic that great in-roads would be made in coming years into the chronic diseases that currently permeate our society. Nevertheless, I believe that the last three years have seen a strong internalisation of the PH function in local government and a growing maturity in the functioning and influence of Health and Wellbeing Boards (HWB).

1.3 The overt optimism and enthusiasm that may otherwise have been prevalent is substituted by caution, pragmatism and determination that a reducing resource will not dampen the spirit and commitment of public health professionals in giving their communities the best chances possible to enhance their personal health and wellbeing.
1.4 My overall view is that the transition of PH into LG has now, after almost three years, stabilised. Internal relationships have now had a chance to form and develop such that we are seeing good examples of strong corporate co-operation and shared (internal) fund holding which is being deployed on initiatives to address local community priorities identified in health and wellbeing strategies.

2. How is PH now affected by the context of the new host organisations in terms of:-

2a Financial Management
2.1 The PH budget that came to local authorities with the service in 2013 came with a ‘ring-fence’ which remains in place until 2018. This has been both a blessing and a curse.

2.2 It gave existing public health teams the reassurance that their current programmes would have ongoing protection until their community impact and effectiveness could be reviewed. It also gave reassurance to managers of public health funds that they would have the time to develop their own knowledge of political and financial processes within local government to ensure that public health issues secured meaningful recognition within the strategic management and corporate planning frameworks of local government.

2.3 However, the introduction of a new service, with a protected (ring-fenced) budget, into local government was met in some quarters of the local government family of professions with some degree of scepticism if not overt jealousy when managers incumbent within local government for many years were seeing their service resources reduced substantially. This was a negative effect of the ring-fence and initially compromised the development of corporate relationships.

2.4 As we move closer to the end of the ‘ring-fence’ and as the broader healthcare integration agenda takes greater hold, local authority management teams will be looking at how to achieve the greatest impact as is possible from available budgets for their local populations. Many local government functions are mandated and this is also the case for some public health functions. However, this has not prevented the removal of resources in recent years away from statutory services such as housing, trading standards, licensing, environmental health and planning. How the public health function will fare under these circumstances is open to conjecture, but it is inevitable that resource constraints will lead to a service which is less universal unless innovation, shared services and/or technology are able to bring service efficiencies.

2.5 The effectiveness of local authorities in delivering the future improvements in public health will inevitably be compromised by the ongoing austerity agenda and the associated ability of local government to balance public health priorities with other competing and significant demands.

2b Organisational Development
2.6 The current policy push for combined authorities may also bring some opportunities for service efficiencies in public health but this will only become relevant where health is an inherent feature of the combined authority agreement and where an open culture of
collaboration exists in the constituent bodies. If the latter does not exist then the bold rhetoric contained in any agreement will become moribund very quickly. What would be helpful to mitigate against this would be an underpinning, robust leadership and management support framework such as exists in modest form already in the peer challenge framework of the Local Government Association (LGA).

2.7 Even where the Director of Public Health is not a direct part of the senior Management Team of a LA, the existence of statutory HWB Boards in upper tier councils means that PH (or the LA role in protecting & enhancing the health and wellbeing of the local population) has become a major consideration in the political priorities within local authorities. Even in District Councils, which do not have a statutory role within HWB Boards and whose functions in two-tier local government areas include most of the services which have a direct bearing on community health and wellbeing (see para 1), are keen to engage with and support the efforts of their public health colleagues at the County level. The Kings Fund has reported recently on this specific subject - http://www.kingsfund.org.uk/publications/articles/district-council-contribution-public-health

2.8 In any consideration of PH functions it is difficult to not also consider the broader health and wellbeing of individuals or populations. This is pertinent to the social care funding and functions of local authorities and raises the question of how current managers and decision-makers in local government are building public health considerations into their Better Care Plans.

2.9 We have seen in the recent CSR that support for the Better Care Fund (BCF) will continue up to 2020, by which time it will be expected that health and social care services will have achieved a good degree of integration and, by doing so, will have reduced hospital in-patient stays by a significant number. Integration of the total spend on preventive services at the local level (i.e. including the public health function) into this process is essential if the full savings expected to the public purse are to materialise in practice.

3. The Public Health Workforce

3.1 I started my career in the Environmental Health service of a local authority in 1972 and have regarded myself as part of the public health workforce ever since. Many other colleagues within the traditional local government professions would offer the same conclusion if questioned on the broader impact of their work.

3.2 The breadth of this concept needs to be highlighted further in future years as the direct resources available to the public health function in local government reduce in real terms. In my mind this simply involves the extension of the principles of the ‘Make Every Contact Count’ initiative. Many DPH’s are already promoting this concept within their local authorities and are using their current funding streams (and also tapping into complementary corporate budgets) to harness the energy and the reach of other local government staff in the community to achieve health improvements.

3.4 It seems to me that Health Education England also have a role in this context. This is an organisation that is currently largely anonymous to LG, yet it has a substantial role (and budget) in planning for future healthcare workforce development. It appears to do a comprehensive job of planning and organising training and development for the clinical and allied health professional workforce, however, I am unaware of any current strategic, regional or operational links between HEE and local government. When one considers the long-term value of investment in preventing ill health, this is a matter which should be reviewed at the earliest opportunity.

4 The Public Health Funding Envelope

4.1 Public health funds channelled through local authorities represent a small proportion of the total public spending allocated to public health issues and it is appropriate to question whether the total envelope is deployed in the most effective way.

4.2 Public Health England (PHE) is the new national body established to oversee the improvement of the public’s health. As a new organisation it too has faced some turbulence during its initial set-up phase but it is now established as the ‘go to’ place for national public health advice and support (albeit is faced with similar ‘austerity’ measures as local government).

4.3 Now that this new national body is established, its voice and impact in the public health world, and its relationship with local government need to develop to the next level. It clearly has a key role as a health protection body and as a commissioner of public health services that have national significance. It also has a role in supporting the efforts of local authorities and in providing advice on issues of concern, e.g. the potential health impact of hydraulic fracturing.

4.4 Its relevance and importance to the public health role of local authorities is obvious to all in local government although it is not the only national body charged with supporting the public health function. Unfortunately, the other national bodies funded for public health functions (NICE and NIHR) remain, just as HEE, rather anonymous to local government. I would not wish to suggest that these organisations have not made significant efforts to engage with local government but, so far as my current networks extend, I have not seen any signs that this anonymity has been mitigated to any great extent.

4.5 The following paragraphs provide two examples of my observations of the apparent ‘disconnect’ between public health functions and services at the local level and the funding that is deployed at national level, ostensibly in support of the public health function.

4.6 NICE is a Non Departmental Public Body whose work is largely commissioned by the Department of Health (DH). It’s main role in supporting the public health function is the production of guidance on public health topics for policy development, service design and practitioner delivery.

4.7 It is also commissioned by DH to produce Quality Standards for public health, indeed, during 2014 NICE was provided by DH with a list of public health issues for which
quality standards should be developed. The public health function was transferred to local
government in April 2013 and it is not apparent whether any prior consultation or
engagement took place with local government representatives before this referral from DH
was made to NICE.

4.8 Now that a clear expectation for the delivery of public health improvement lies on
the shoulders of local government it would seem equitable that the funding associated with
the commissioning or development of public health quality standards and public health
guidance, which will be key to ‘value for money’ considerations in future, should lie within
the sphere of responsibility of local government. The LGA could provide an accountable
body status for such a commissioning role. It would also seem to provide a clearer and more
logical line of accountability in the public health system if PHE were to host the primary or,
indeed, sole role of provider of such standards and guidance.

4.9 The other national body undertaking public health work which has relevance to the
functions of local authorities is the National Institute for Health Research through its School
for Public Health Research.

4.10 During the period 2012 – 2022 the School will deploy approximately £40 million on
research to evaluate the impact of public health initiatives. Although a governance
framework has been established for the School, the frequency of meetings and the breadth
of engagement with local authority representatives are rudimentary even in late 2015. This
creates a landscape for the ineffective use of public funds and for effectively assessing
whether the public health work of local authorities is actually making any meaningful
contribution to health improvement.

4.11 Now that responsibility for the public health function sits within a direct
accountability framework, i.e. democratically elected councillors, it should logically follow
that financial responsibility for (the commissioning of) quality standards, advice, guidance
and research should also rest at the same level.

5 Concluding Comments

5.1 Many public health issues are influenced by lifestyle choices and will rely on local,
community based health promotion initiatives or behaviour change programmes to bring
about health improvement. Localism, which has a strong base in current national policy, is
one mechanism through which this will be achieved. However, while lines of accountability
for a substantial proportion of the public health function remain outside of local authority
control (although the common rhetoric will place responsibility at the foot of local
government) and whilst the national public health spend is as dispersed as it currently is,
there must remain concerns that the effectiveness of local authorities in delivering the
envisioned improvements to public health will be compromised.

5.2 The Five-year Plan for the NHS developed under Simon Steven’s leadership places
great emphasis on the role of prevention in improving the nation’s health and making the
NHS more cost efficient. This has received cross-government support and should provide
the foundation for a larger proportion of current NHS investment to be deployed on the
public health function.
5.3 Prevention is a key component of the work of Health & Wellbeing Boards and they will need to ensure that the public health function is integrated seamlessly into BCF programmes at the local level. However, the outcomes associated with these programmes will only be truly effective from the patient’s perspective (“no decision about me without me”) if integration extends also into the funding streams which form the totality of the public health system spend.

5.4 In this context a review is also necessary of The Responsibility Deal. In a world of reducing public expenditure, the role of self-help and personal responsibility will become greater and the concept behind The Responsibility Deal warrants further attention in this scenario. Opinion is divided on the merits of the current scheme but a more robust version of it with greater traction and accountability at a local level may be something worthy of future consideration.

5.5 Finally (and I think this is pertinent to public health spending now that some of this sits within local government), I would offer a counter view to the recent suggestions that local authorities should make more routine use of their reserves in order to support the maintenance of current service levels. Audit guidance suggest that local authorities should maintain a minimum balance of reserves equivalent to 5% of their annual revenue budget to cover any in-year financial contingencies. When annual budgets are reducing, although this has the obvious effect of reducing the recommended level of reserve’s requirement, it also has the effect of introducing greater caution into local decision-making and leads logically to the trend for keeping a higher level of reserves. Reserves are also held for other very valid reasons such as to plan for future capital infrastructure projects that may span several years or to respond to emergency situations, which local authorities have an obligation to plan for.

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