Introduction

I was appointed as Director of Public Health for Sheffield in September 2006, and served in that role until April 2015. In this submission I make some general observations about the transition of public health from the NHS to local government, and in particular on the role and influence of Directors of Public Health, but these are inevitably based on my own personal experience, as well as my observations of the transition in other areas. Both the Local Government Association and Public Health England have presented the transition as having been a success, but in my view this has not universally been the case, and nor has the success been without cost.

My original appointment was a joint one between the then Sheffield Primary Care Trust and the City Council, though there was no financial contribution made to the cost of the post by the Council. In April 2013 my post, and almost all of the public health staff of the PCT, transferred to the Council as a result of the changes brought about by the Health and Social Care Act.

During the period 2006 to 2012 the PCT based public health team worked increasingly closely with the Council on public health matters, with the development of jointly funded public health programmes, establishment of jointly appointed Consultant in Public Health posts, and establishment of a ‘Director of Health Improvement’ post within the Council. During this period Sheffield won ‘Beacon Status’ for success in addressing health inequalities.

The rationale for the transfer of public health responsibilities at local level to local authorities has been clearly stated and is sound. Local government is better placed to influence more of the underlying determinants of the health of populations (and hence ill health and health inequalities) than the NHS. This is not to say, of course, that the NHS has no role in this.

There is however no one single part of local government business that influences health, to the exclusion of others. Indeed, it is difficult to identify any part of local government business that does not have some influence on health. For this reason, in Sheffield it was determined that public health should be organised on a ‘distributed’ model on transfer to the City Council, with public health teams led by public health specialists (Consultants) based in each of the three outward facing portfolios (‘super directorates’), and allocation of the bulk of the Public Health Grant budget to those portfolios. The DPH post was kept central in the organisation, with a small DPH office responsible for health protection and the provision of public health advice to the newly formed NHS Clinical Commissioning Group (the so called ‘core offer’). The intention was that by organising public health in this way, it would maximise the impact on all the Council’s business.

Public health post April 2013

The role and influence of the Director of Public Health

Prior to April 2013, Directors of Public Health were Executive Directors on PCT Boards, the highest level of decision making within the local NHS, and in that position had shared responsibility for the
full NHS budget for the area, as well as full executive director responsibility for those elements of it that were spent on public health staff and programmes.

The importance of the role of the Director of Public Health was recognised throughout the transition process, and documented in the October 2012 guidance from the Department of Health.¹

To support it, every local authority with new public health responsibilities will employ a specialist director of public health (DPH) – appointed jointly with the Secretary of State for Health – who will be accountable for the delivery of their authority’s duties. The post is an important and senior one. The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health.

The guidance, whilst not specifying any particular managerial arrangements, further stated that there should be direct accountability between the DPH and the local authority chief executive for public health matters, direct access to elected members, full access to the papers and other information that they need to inform and support their activity, and day to day responsibility for their authority’s public health budget. All of these are important requirements for Public Health to be a success in local government, but unfortunately they have not been universally met.

Despite this recognition, the role of the Director of Public Health has been significantly downgraded in many areas as a result of the transition to Local Government. This has come about partly because the post has moved from being at the highest level of decision making (i.e. a full board member) in the PCT, to being in many cases at third tier in the management hierarchy in local government, but also because, as local councils are democratic organisations, final responsibility in them rests with the elected members, not with officers. Directors of Public Health have thus moved from having ultimate responsibility for Public Health in their areas, to being simply responsible for giving advice to elected members on public health matters, which may or may not be followed.

The advantage, of course, of being based in local government is that DsPH should have the ability to have influence over a wider range of factors that determine the health of the local population. This is dependent both on being properly positioned and having the right level of influence within the Council, but also on being adequately supported by other public health consultants. Where consultant posts have been cut, or left unfilled, as has happened in many Councils, the scope for public health to have influence across the full breadth of the Council’s activities has of course been constrained. Moreover while Primary Care Trusts were organisations whose only purpose was health, including promoting good health, and preventing and treating ill health, local government has a far wider range of responsibilities, the pursuit of some of which directly militate against the promotion of good health.

Overall, therefore, the role of the Director of Public Health has moved from being one of having a very high level of responsibility, accountability and control over a narrower range of factors that influence public health overall, to one of significantly less influence over a wider range of factors, and no longer being ultimately accountable. Whether this leads to better or worse public health in

any local area will depend on how much influence the DPH is able to exert within her or his own Council.

Public Health budgets

Prior to 2013 considerable efforts were made to identify how much money was spent by PCTs on those public health functions that were to be transferred out of the NHS, to Public Health England and local government. This resource was then taken from the NHS and transferred to Public Health England and local councils, as the Public Health Grant, ring fenced for public health purposes. There were also increases in the value of the Grant in 2013/14 (compared to what had previously been spent in the NHS) and 2014/15. This was to ensure that there was no disinvestment in public health on transfer to local government.

In fact the supposed ring fencing of the Grant has proved illusory. This is because although Councils have been required to give assurance that the Grant itself is used for public health purposes, that was never strictly defined, and nor was overall public health spend monitored. There has always been a wide range of activity that was paid for by local government that contributed to public health, expenditure on which could very legitimately be described as being for public health purposes. This meant that it was possible for Councils to use the Public Health Grant to pay for activity that had previously been paid for by Council budgets, and to disinvest from public health activities that had previously been paid for by the NHS (prior to 2013) in order to do so.

Since it was not the totality of public health spend that was ring fenced, only that element that transferred from the NHS in the form of the Public Health Grant, it was quite possible for Councils to disinvest from public health activity. At a time of considerable pressure on local authority budgets it was perhaps inevitable that this should have happened. This has been widespread across Councils, though the overall extent has not been centrally monitored by Public Health England or any other agency, so far as I am aware. In Sheffield, by financial year 2015/16 approximately 30% of the Grant was being spent on activity previously funded by the Council, with previously NHS funded activity having been sacrificed to pay for it.

Since the additional health costs that follow from disinvestment in public health programmes fall on the NHS rather than local government, there is perhaps less disincentive to disinvest than was the case when those public health budgets were in the NHS. Finally, whilst given the very significant overall squeeze on local authority budgets it may be justifiable to disinvest from previously NHS funded public health activity in order to pay for previously Council funded activity that would otherwise be lost, this would only be the case if the activity that is lost is of lesser public health value than that which is saved. This has not always been the case.

Furthermore, whilst NHS budgets have been protected by National Government during the general retrenchment of funding of public services, neither the Public Health Grant nor local government spend overall has been. It is quite possible therefore that overall spend on public health is less than would have been the case had public health remained an NHS responsibility.

Conclusion

The arguments for making Public Health the responsibility of local government rather than the NHS are strong. Not only does local government have more scope to influence the underlying
determinants of health than does the NHS, but it is right that such an important function should be brought under local democratic control.

However the transition has come at a cost. This has been in the form of loss of influence, capacity and resource.

The role, responsibilities and influence of Directors of Public Health have in many areas been downgraded, and the full benefits of basing public health in local government will not be realised unless and until Directors of Public Health (supported by a cadre of public health consultants) are able to be fully influential within their Councils. Local government needs to recognise and value specialist public health expertise in a way that has not, unfortunately, been universal.

Specialist public health capacity has also been lost. Numerous established and experienced Directors of Public Health in primary care trusts elected not to make the transition to local government, or left soon after doing so. A further loss has been the reduction in public health consultant posts, either through posts being cut or left unfilled.

Finally, resource has been lost through the widespread use of the Public Health Grant to fund activity previously funded by local government by other means, and now through the reduction in the Public Health Grant both this year, and in years to come.

14 December 2015