This response is on behalf of the public health teams in Shropshire Council and Herefordshire Council. This may not reflect the opinion of the respective local authority officers or the respective cabinet members and is not intended to represent such views.

1. The delivery of public health functions

1.1 It was considered that challenges still persist relating to who commissions which element of services between NHS England, Public Health England, CCGs and Local Authorities. School Nursing Services are commissioned by Local Authorities however immunisation programmes in schools are commissioned by NHS England supported by PHE. There is a perceived complexity based upon the various commissioners which contribute to a care pathway; this has added complexity where there are also a number of providers.

1.1 This perceived fragmentation alongside financial challenges results in adverse impact on providers. For example at a less complex level; some special schools require clinical intervention; this may be funded via existing school budgets at the expense of teaching staff whilst commissioners resolve who pays from already stretched NHS budgets.

1.2 Competition in the market has brought about some improvements for example substance misuse commissioning, however some organisations have a limited ability to compete due to less developed business acumen. Financial reductions in administrative staff may have led to reduced quality of tenders; which as a consequence has disadvantaged some NHS Trusts and Third Sector Organisations.

1.3 Procurement processes to deliver PH functions may be bureaucratic; with disproportionate transactional costs. In some cases a review of services and transforming delivery has resulted in improvement without the need to procure.

1.4 Reorganisations may adversely impact on strategy and ability to deliver complex pathways. For example staff changes; loss of legacy and changing leadership results in commissioners having less confidence and focusing on quick wins as the most complex pathways and programmes require resource to build effective relationships; engagement and complete highly complex governance processes. The latter potentially being a disincentive to innovation and bidding for external funding. PH is a specialist field and requires delegated authority and flexibility to be creative and respond efficiently to opportunities. Opportunities may be missed due to lengthy and bureaucratic processes.

1.5 As public health staff based in local authorities are no longer NHS employees, they are not able to access NHS data easily which restricts their abilities to carry out some of their statutory duties to assess the needs of the population and to monitor the effectiveness of some services, e.g. GP based immunisation programmes. This could be addressed by giving public health staff honorary NHS contracts. This can be done at no cost to the NHS.
2 The effectiveness of local authorities in delivering the envisaged improvements to public health

Following the transfer of public health responsibility to local authorities the following were considered:

2.1 Any outcomes and improvements were still in their infancy and it was too early to confirm effectiveness.

2.2 PH have the skills to develop resilience and build on the assets of communities; however this requires providers to be confident to work in integrated ways with others by being able to share information effectively and without being protectionist. Investing in communities is complex and requires resource and time. PH sees their role as facilitative and enabling however there is limited resource to dedicate the time required to realise real improvement.

2.3 Working in local authorities enables access and engagement with a number of services and networks which may have been more difficult to access in the NHS. However as resources are reduced (i.e. significant resource reductions in youth services) and some devolved to local levels; the ability to influence wider impact and outcomes may be limited. This may be like commissioning ‘with hands tied around your back’.

2.4 There are positive opportunities to work collaboratively with more established providers such as schools; and the positive transitions of public health nursing services to local authorities has advantages for community planning and better start related programmes.

2.5 PHE leadership to ensure that public health is embedded across local and national government policies and departments as well as the Department of Health.

2.6 PHE to provide leadership and contribute to research; local strategy development and disseminating best practice; to enable effective use of resource and reduce duplication. PHE to contribute to developing frameworks and business cases; which include the associated evidence base and cost benefit analysis. PHE to provide high level expertise to support local PH teams and improve efficiency.

2.7 Opportunities to influence health at work and develop effective relationships with local industry and SMEs.

2.8 It was considered that Health & Wellbeing Boards required more influence and accountability.

3 The public health workforce

3.1 Recognition of the competencies and skills of health intelligence (HI) teams; these are different to research and performance management teams are not interchangeable. The team suggested that PHE provide more leadership in relation to promoting the unique contribution of HI.

3.2 LGA peer reviews include health competencies which are viewed as positive.
3.3 It was considered that PH had variable ability to influence the local authority agenda. The ability to influence was highly dependent on effective leadership from the DPH and CEO; and the lead elected member holding the health portfolio.

3.4 Due to PHE and LA changes; there may be insufficient specialist posts available to encourage PH as a profession.

3.5 The PH is becoming increasingly fragmented within LA organisations and this leads to a risk of erosion and dilution of the specialist skills. PH is a specialist profession and would appreciate this recognition to maintain role integrity.

3.6 A number of colleagues report nationally that they feel undervalued as posts are demoted. The DPH is a statutory and independent role with high level responsibilities; competencies and capability. PH is key to transformation; protection of health and better integration; having the ability to influence health and industry. This role needs to be able to directly influence the strategic direction of local authorities and communities through direct accountability to the CEO.

4 Public health spending

4.1 Concerns expressed that some of the PH grant is under pressure to fund local authority core statutory services which may not contribute as fully to the public health outcomes framework.

4.2 The Treasury’s in-year cut of the PH Grant by £200m nationally during 2015/16 has adversely affected the ability of PH departments to deliver key programmes. The further proposed cuts to the PH Grant following the Comprehensive Spending Review will further undermine the ability of PH departments to invest in prevention programmes that will reduce the pressure on the NHS and social care in the longer term.

4.3 The current funding formula used to allocate the Public Health Grant does not take into account the needs of rural communities or the true costs of providing accessible services to the public living in rural areas. Currently rural councils receive significantly less per capita allocation compared to urban areas. For example Shropshire receives £32 per person compared to Camden which receives £112 per head or Westminster that receives £133 to commission the same services for their respective populations.

4.4 Public Health England has acknowledged that the current funding formula does not identify effectively the levels of health inequalities of rural communities or the costs of providing accessible services in sparsely populated areas.

4.5 Following the Comprehensive Spending Review, PHE has yet to identify whether the new funding formula will address the needs of those local authorities who are under their target allocation by reducing the allocations to over target local authorities. As this pattern of over/under funding has been in place since the transfer of public health to local government in April 2013, it is time for a fairer funding allocation to be made to each local authority.

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