1. About the Local Government Association (LGA)

1.1. The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.

1.2. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

2. Summary

2.1. After 40-years, public health has returned to the heart of local government. The LGA supports public health responsibility being in local government, as local authorities and health and wellbeing boards are best placed to tackle the unprecedented challenges.

2.2. The transition of public health into local government has seen one of the most significant changes for councils in recent years. It has created opportunities for local authorities to make a stronger impact on improving the health of local communities and helped to re-frame public health to a social, rather than medical model of health and wellbeing.

2.3. Following the transfer of public health to local government, councils reported in some areas they inherited huge geographical inequities, lack of service for some communities and poor facilities needing modernisation. This is because, in many parts of the country, public health was seen as the ‘Cinderella Service’ of the NHS, operating as an add-on to their main business of treating sickness.

2.4. There was too much reliance on top-down targets that limited local initiative. Too many different organisations with a public health remit confused rather than clarified core public health messages. Public health services would have benefited from greater scrutiny by commissioners. The net result was a system which did not deliver the step change in public health outcomes that the country needs or secure the common understanding that health is about much more than just hospitals and GPs.

2.5. Councillors, officers, clinicians and local communities are passionate and dedicated, working closely to make the new public health system effective. Preventing illness and empowering people to stay well is not something health and care professionals can do alone, as broader action from across all sections of the community is required. To ensure people receive the right support
at the right time, we must continue to align services and ensure our limited resources are targeted in the most effective way.

2.6. Councils have been thinking creatively about their new role and asking important questions about how resources are used in order to improve the health of residents. This includes both the public health ring-fenced budget and using council resources more generally.

2.7. In local government we are evaluating established ways of working and drawing on years of experience of delivering better outcomes with less money. Where services are not delivering value they will be decommissioned and replaced by services that can deliver on our ambitions for the local community.

2.8. Critically, most public health teams feel that access to local politicians and key decision-makers has not been a barrier, as they have been welcomed into the council. There is recognition of a steep learning curve and how decisions need to be evidence-based.

2.9. Public Health professionals bring a range of expertise, skill and knowledge to local government, which itself is naturally well positioned to know and engage with people and organisations. With public health and local government professionals working together, there will be a renewed focus on early intervention and prevention, to help improve health and wellbeing outcomes.

2.10. A key challenge in the future will be ensuring the progress we are making is sustainable. If we are going to make the necessary step change required as a country, a fundamental shift towards preventative support is required from the NHS, local government and partners.

3. The delivery of public health functions

3.1. Public Health arrangements have ranged from ‘standalone’ public health teams with members attached to directorates across the council, to fully dispersed public health teams. We recognise the importance of ensuring public health is considered as a cross-cutting strategy, rather than a stand-alone specialism.

3.2. Some councils have a dispersed public health structure with a view to embedding public health specialists across a range of council functions. Others have kept the public health team together but ensured that it is part of the council’s corporate function, with an opportunity to feed a public health dimension into every important cross-cutting strategy.

3.3. There are many encouraging examples of innovative practice being implemented across the country. Blackburn with Darwen Council is undertaking major public health interventions through their investment in their social determinants of health fund.
3.4. In Dorset, the county has a public health team covering three upper-tier authorities in a three-year arrangement with a pooled budget. The arrangement is a good test bed for other joint working on integration of health and social care.

3.5. Bath and North East Somerset Council are using a more targeted, evidence-based approach and open procurement methods which has resulted in a wider range of providers from different sectors being involved in services and provided better value for money.

3.6. East Riding of Yorkshire Council have re-commissioned contracts with a shift in emphasis to location in communities such as leisure and community centres, rather than centralised, such as in hospitals, to give better access to people.

3.7. In Wigan the Council has developed a clear vision based on the Marmot Report *Fairer Society, Healthy Lives* which makes improving and protecting the public’s health and well-being a whole Borough endeavour supported by innovative political, public and professional leadership.

3.8. Most councils have maintained the organisational structure that they adopted in April 2013, but a few are now restructuring to bring capacity to policies that had become joint health and wellbeing strategy priorities. Similarly, councils report that a number of public health practitioners have needed to shift their work to locally agreed public health priorities.

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

4.1. Many local areas are now developing important synergies between public health and councils’ planning and regulatory functions, building on relationships that have been fostered over the past decade or so. The rise in obesity means councils are combining their planning and licensing functions to try to reduce the ‘obesogenic environment’. One of the ways they are doing this is by controlling the number of fast food outlets.

4.2. Similarly, public health teams are working with planning, licensing and trading standards teams, businesses involved in the drinks industry, the police and HM Revenue and Customs (HMRC) to reduce alcohol misuse and the harm it causes.

4.3. Public health staff have had to develop in a very short time the full range of skills and capacity needed for commissioning, since their involvement in the NHS had been less ‘hands on’. They have had to learn how to specify services, to understand all the stages of procurement, quality assurance and contract monitoring.

4.4. With public health becoming a council function, areas report more targeted, evidence-based service specifications and open procurement resulted in a wider range of providers from different sectors delivering better value for money.
4.5. Many areas have been reporting that they have re-commissioned contracts with a shift in emphasis to:

- a social, rather than medical, model of health and wellbeing, for instance a sexual health service that would be alert for child sexual exploitation, or domestic violence.

- more local services rather than centralised, such as in hospitals, to give people better access to services.

- a holistic approach to health and wellbeing services, tackling public health issues such as obesity and smoking prevention, as well as wider issues including preventing social isolation or supporting people with learning disabilities.

4.6. Commissioning patterns are beginning to change and will continue to do so as contracts are renegotiated with providers, and spending is matched to local priorities identified by Health and Wellbeing Boards through their Joint Strategic Needs Assessment.

4.7. Spending on different aspects of public health varies significantly between local authorities, which is not surprising given local autonomy and differing needs and circumstance. It is worth providing the context that variation also existed and in some cases was greater, under the previous NHS arrangements.

4.8. Public health teams already have a well-established relationship with the relevant Clinical Commissioning Groups’ and have therefore had little difficulty in reaching agreement on how public health support would be given to the NHS.

4.9. Consistent with the Department of Health’s role as principal adviser on health matters, public health is sometimes seen as having a broker role for discussions between the council and the NHS. The ‘core offer’ to the NHS was seen as providing an opportunity to influence CCGs’ commissioning towards greater prevention and addressing health inequalities.

4.10. The relationships between CCGs and councils is critical to ensuring an integrated approach to population health care and prevention. Councils recognise that they need to build on the significant progress which has been made in building these relationships through Health and Wellbeing boards in order to further develop place based approaches to prevention.

4.11. Several councils have expressed their concerns to the LGA, that CCGs might not have the resources to focus on prevention and early intervention, despite them being a priority in the Five Year Forward View. In particular, they were concerned that the focus on reducing unplanned hospital admissions could mean wider initiatives to tackle health inequalities and improve life expectancy, could be neglected.

4.12. The integration of health and social care is gathering momentum, public health professional have a significant role to play given their expertise in effective prevention and early intervention work.
4.13. Councils are closely involved in the Better Care Fund and implementation of the Care Act. The main initiatives in which public health was directly involved were:

- A comprehensive information and advice service. This includes a public health perspective, which is linked to Making Every Contact Count, health trainers and community referral agents.
- Social prescribing: ensuring primary care involved in referral to health and wellbeing services for healthy lifestyles and mental health.
- Prevention; supporting a range of initiatives to prevent ill health and promote wellbeing, particularly in older people and those with long term conditions investment in communities taking an asset-based approach.

4.14. Councils publish information on budgets and revenues, performance, salaries, assets and annual reports. This allows residents to hold them to account and helps drive innovation and efficiencies.

4.15. We are concerned that additional powers could be used by central government to manage local performance and that local priorities will be either undermined or overridden by national imperatives. This would require the mandation of all public health services, and could fundamentally undermine the idea of a locally led public health system.

4.16. Within a locally-led public health system, councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area.

4.17. Through sector-led improvement schemes, local government can intervene in areas of poor performance, before central government has to take further action.

4.18. Alongside this, the LGA and councils worked together to develop a new approach to improvement. This was set out in the LGA’s document ‘Taking the Lead’ in February 2011, supplemented in June 2012 by sector-led improvement in local government which describes a coordinated approach to sector-led improvement across local government, the support being provided and where to go for further information and advice.

4.19. The role of the Public Health England is to nurture and support the local led-public health system; maintain an overview of the whole system’s progress in implementing the Public Health Outcomes Framework and are also in a unique position to take a strategic overview of the impact of service delivery and should be able to challenge and question commissioners.

5. The public health workforce

5.1. As public health becomes embedded into local government there are three main continuing issues in relation to the workforce:

- The approach to senior appointments needs to take account of a wider range of potential candidates who do not
have traditional public health qualifications.

- The development of necessary skill sets through both a secure supply of future specialists and continuing professional development for existing staff.
- Ensuring that there is an efficient and effective and sustainable labour market in public health.

5.2. There is now a variety of public health employers including local authorities, PHE and others, all with their own needs and interests. However there is a single public health profession with a need for coherent career paths. All these interests need to be taken into account as plans are made for workforce development.

5.3. Directors of Public Health are developing their new roles, by taking on additional responsibility for services like Environmental Health, Leisure Services and Housing. We are now seeing a number of Joint Director of Public Health and Director of Adult Social Services posts, which further strengthens the interplay between social care and public health. However, we are concerned that the appointment criteria suggested by some organisations often focus on professional qualification which restricts the opportunity for aspiring directors from other sectors to enter these positions. We would be happy to work on further advice on this issue using partnership arrangements with PHE (Public Health England).

5.4. Skills development is being pursued through a focus on more effective workforce planning led by Department of Health (DH), Public Health England (PHE) and Health Education England (HEE) in a way that is supported by LGA. However, the workforce would benefit from additional investment in skills development.

5.5. The development of future specialists is coordinated through HEE and the Local Education and Training Boards (LETBs). However given that these bodies have so many pure NHS specialisms to deal with, it is very difficult for public health which is a rather small and diffuse specialism to get adequate focus and attention.

5.6. It could be beneficial for PHE, with its strong partnership links to the LGA, to have a more directive role in commissioning public health training. What is needed is a more effective way to assess the changing skills needs of a diverse group of employers, so as to produce a new generation of local government-focused public health specialists as well as the continuing scientific and academic cohorts.

5.7. Through work with the Centre for Workforce Intelligence (CfWI), a greater understanding of future needs is being developed, but this must lead to markedly different outcomes from the past to be worthwhile. We support the concept of a workforce strategy for public health which requires development by a broad partnership to be successful.

5.8. Turning to the skills of the existing workforce, we are encouraged by Public Health England’s programmes to develop people in a wide range of public health-related disciplines. It merits continued funding as do the various programmes focused on existing and
aspirant leaders.

5.9. Fundamentally though, the funding of public health skills development is inadequate because it has to be drawn from a small and diminishing pot based on the current HEE remit. The HEE remit is focused on future specialist pipelines with, in effect, residual funding for current workforce development. This needs to change as the country moves to a greater emphasis on wellness and prevention, with public health a prime candidate for greater funding under a revised HEE remit and greater PHE involvement, as mentioned earlier.

5.10. The market for public health recruitment brings in a number of areas for improvement. Fundamentally, a climate is needed in which individuals see their career path as involving moving between different organisations which work in close partnership. A modern public health career should encompass local government, the NHS and the civil service.

5.11. The LGA has argued, with the support of the PHE, that regulatory barriers that make it difficult for people to move from one sector to another, should be removed. The main barrier concerns continuity of service which at the moment cannot be offered for all aspects of employment (most critically redundancy) when people move between the NHS and local government. This must be addressed so that employers know that they are choosing between the best candidates and that individuals do not feel constrained in their job choices.

5.12. The sources of common information available to employers and prospective employees need attention. For example, the old Public Health Careers website has been subsumed into the wider Health Careers website. This provides a very broad sweep of information and choices but the new site is heavily focused on the NHS; more work needs to be done to explain and illustrate the role of local government in integrated services and the career choices it offers.

5.13. Likewise the NHS Jobs portal needs further focus. The offer for local authorities to use the system for free to ensure that information on their public health jobs reaches the right people is a good one. However the system does not always seem flexible enough in allowing councils to shape the interface with potential applicants in appropriate ways.

6. Public health spending

6.1. Against an increasingly difficult financial and economic backdrop, councils place great emphasis on the need to change the way that public health is being delivered, to deliver better services and improve value for money.

6.2. It is important that local areas be given autonomy to allocate their resources according to local priorities. Allowing local Health and Wellbeing Boards to select areas for investment would help to steer finite investment and resources to address inequalities and deliver better outcomes nationally.

6.3. There is a case to be made that public health spend has historically been too low to achieve a significant and sustained
positive impact on health outcomes and on health inequalities. It will be important to ensure that the total resources available for public health are sufficient to meet needs. Councils in some areas have serious and well-founded concerns that the future public health investment in their communities could fall well behind likely need.

6.4. We are calling for a clear commitment from the Department of Health for an increase in resources to a level that will maximise the value for money available from well targeted investment in public health.

6.5. At a time when the Government has issued its firm commitment to the NHS Five Year Forward View, with prevention put very much at its heart, the recent announcement in the Spending Review to make significant cuts to the public health budget over the next five years could undermine the objectives we all share to improve the public's health and to keep pressure off the NHS and Adult Social Care.

6.6. The Spending Review announced that public health funding will be cut by 9.6 per cent between 2015-16 and 2020-21 in cash terms a £331 million reduction. This is on top of the £200 million reduction in 2015/16.

6.7. Local government can only fulfil its new public health duties if councils are adequately resourced to do so. This will allow councils to be at the forefront of tackling the social and economic factors that contribute to poor health and enable them to provide the services that help people to live long and healthy lives.

6.8. In future, we want to ensure greater certainty of funding for longer periods to enable local authorities to make strategic decisions in commissioning public health services. We need to look at the impact of the changes on the ground, and it is vitally important that this dialogue continues to address challenges which arise over the coming months and years, and to ensure sufficient ongoing funding to ensure all local authorities can continue to meet their new public health responsibilities beyond 2015/16.

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