Executive Summary

PHAST (Public Health Action Support Team) is an independent social enterprise public health consultancy. PHAST supports PH (Public Health) departments with PH projects, analysis, interim professional staff and training. PHAST has first-hand insights into the impacts on public health post-2013, with the implementation of the Health and Social Care Act 2012.

This written submission from PHAST builds on these insights to make observations as to the state of PH and makes recommendations in relation to the scope of the inquiry.

Structural changes:

1. Recommendations:
   i) Strengthen healthcare PH services at local and national levels including within NHS commissioning
   ii) Ensure Local Authorities (LAs) enable adequate support from PH to local CCGs to support local population commissioning
   iii) Strengthen access to NHS data for LAs and PH departments within LAs
   iv) Where mergers and sharing PH departments are implemented ensure robust systems are in place to provide full PH services to both/all LAs concerned and that there is adequate PH staffing to fulfill the full range of PH functions, across all three domains.

The delivery of public health functions:

2. Recommendations:
   i) Utilise powers within the Act to ensure all LAs are delivering a robust PH function.
   ii) A range of population health experts are needed at all levels to deliver PH functions. This includes both people from a range of backgrounds, including medical expertise, to bring richness to PH functions and a range of levels of expertise.
   iii) Address the gap in academic PH

Effectiveness of local authorities in delivering the envisaged improvements to public health

3. Recommendations:
   i) Strengthen the understanding of LAs of the how they can achieve the overall vision of a public health organisation, improving their population’s health and reducing inequalities
   ii) Develop, identify, promulgate and encourage good models of how PH can work with and influence LAs to improve health through all aspects of LA services.

The Public Health Workforce:

4. Recommendations:
   i) Maintain well balanced multidisciplinary teams in public health in both PHE and LAs
ii) Monitor and ensure that people from both medical and non medical backgrounds remain recruited and employed
iii) Monitor and ensure that PH professionals are suitably remunerated in LAs
iv) Support, maintain and monitor the independent PH voice of DPHs and the independence of their Annual PH Reports on the state of their local population, at the appropriate level of authority

Public Health Spending:

5. Recommendations:
i) Reverse the 20% cuts to PH funding
ii) Maintain and monitor the ring-fence PH funds
iii) Monitor PH spend within LAs to ensure it is being spent wisely on PH activities, if need be deploying regulatory processes identified within the Act.

1. Introduction:
i) PHAST (Public Health Action Support Team) is an independent Community Interest Company, social enterprise. It is a leading public health consultancy with over 100 qualified, experienced public health professionals with expertise in epidemiology, health economics, health/environmental impact & needs assessments and equity audits.
PHAST, set up in 2008, provides support to Public Health Departments, locally, regionally, nationally and internationally as well as to other NHS, health and charitable bodies. In particular at local level we have worked with PCTs (Primary Care Trusts) prior to 2013 and more recently with local authorities, post the 2013 Health and Social Care Act reforms.
ii) Undertaking a variety of public health (PH) projects a, training, and providing interim PH staff at all levels has given us first-hand insights into the impact of the structural changes and in particular, into the delivery of public health functions, how local authorities are delivering PH improvements, impacts on the PH workforce and recent PH spending changes.
iii) These observations have been made during work undertaken by PHAST working in a variety of LAs and with LA and national PH colleagues. In many instances it is not possible to cite specific examples or to cite direct comments from PH staff as they are often too afraid to be quoted as they consider criticism may be career limiting.

2. Structural changes:
i) The Act: The main aims of the Act were changes to NHS quality, commissioning and provision of health care; the Act created Public Health England and took forward measures to reform health public bodies, including transferring public health functions from the NHS to local authorities. The Act (section 2B) transferred from the PCTs to the local authorities a “duty... to improve the health of people who live in their areas.” The Act also required local authorities (LAs) to appoint a Director of Public Health (DPH) ‘to provide local leadership and coordinate PH activity’, it establishes Health and Wellbeing Boards and related activities such as Joint strategic needs assessment and joint health and wellbeing strategies etc.
ii) The rationale of transferring PH duties and function from the NHS (PCTs) to the LAs is that the latter were already responsible for functions which impact on the health and wellbeing of their local populations, for example environment, education, housing, transport, leisure etc., and that PH should be able to better integrate with these functions to ‘improve the population’s health’ if it were within the same organisation ie the LA.
iii) **PH covers 3 main domains**: Health improvement, health protection and healthcare public health – the latter including assessing needs of the local population for health care and quality of healthcare etc. Population health expertise is needed to fulfill all three domains.

iv) **Observations on the structural changes**:

a) All structural change requires time and energy. PHAST provided support both to the NHS and to LAs (as ‘receivers’) during the approximate 2 years’ hiatus while PH departments transferred from NHS to LAs. This generally resulted in loss of momentum of PH activity to focus on their 3 domains including health improvement of their local population etc.

b) Some LAs took the opportunity to consider the structure of their PH department and some took the decision to ‘merge’ departments and in some cases to ‘share’ DPHs and departments of PH. PHAST undertook project work to address the “Delivery system of Public Health in London local authorities, including shared PH functions and DPHs” in 2012. This work identified key issues about shared services and identified key factors which needed to be put in place should such mergers and sharing be implemented. Although this work was well received at the time, there has been little follow through by LAs to put such factors in place. As a result in many instances the two departments of PH have been ‘merged’ frequently with loss of momentum and loss of key staff.

c) Such mergers and sharing are continuing to take place (e.g. recently Richmond and Wandsworth LAs in London). These appear to often be based on political decisions rather than robust analysis of the best way to deliver PH to the two populations involved.

d) While the rationale for the transfer of PH to LAs is sound, this mainly holds for the health improvement part of the 3 domains of PH. Health protection is now to some extent fragmented from LA DPHs by being provided by PHE. Many local DPHs are still considering how they need to function in respect of health protection and some have set up ‘health protection’ functions which could be seen to duplicate some aspects of PHE’s role. PHAST has undertaken work to support DPHs in this respect, for example “PH Governance arrangements for Health Protection in Tri-borough” 2014.

e) Provision of the healthcare aspects of PH relate to the ‘offer’ from local PH departments to local CCGs. In our experience, PH influence on CCG commissioning in respect of the local population’s needs etc. is strong in some instances, but in many the PH departments do not have adequate capacity to deliver their ‘CCG offer’ and some LAs do not recognize this commitment from PH departments to CCGs.

f) It should be noted that, prior to the structural changes, many DPHs and departments of PH already liaised closely with their LA to achieve good integration and local population health improvement. Some of the main areas where the new arrangements are working well (eg Stockport) are where such arrangements have been in place for many years.

g) For many PH departments, the move to LAs means that PH departments have to now ‘work back’ to liaise with the NHS in order to undertake functions in relation to healthcare PH (e.g. the CCG ‘offer’ from PH). But also that PH is often more removed from other parts of the NHS e.g. acute and community NHS Trusts, and is unable to support them, for example in relation to health improvement within NHS trusts both for patients and staff. Effective health services cannot be effectively commissioned without PH expertise.

h) One specific consequence of the transfer of PH to LAs has been an impact on their access to data. Previously PH could access NHS data to undertake their evidence reviews and needs assessments etc. Such data access is now markedly limited.

---

3. **Recommendations**:

i) **Strengthen healthcare PH services at local and national levels including within NHS commissioning**
Ensure LAs enable adequate support from PH to local CCGs to support local population commissioning

ii) Strengthen access to NHS data for LAs and PH departments within LAs

iii) Where mergers and sharing PH departments are implemented ensure robust systems are in place to provide full PH services to both/all LAs concerned and that there is adequate PH staffing to fulfill the full range of PH functions, across all three domains.

4. The delivery of PH functions

i) Given the structural changes above and the work of PHAST in supporting PH departments in LAs through projects and interim appointments over the last two years, we are in a position to observe PH and its delivery within a considerable number of LAs having completed in the region of 45 projects, and training projects for LAs.

ii) Observations on delivery of PH functions:

In general, PH functions continue to be delivered in most LAs. There are some notable exceptions where there is extremely limited PH but this is frequently where there may have been limited PH even prior to the changes (e.g. Bexley LA). However, these LAs do not appear to have improved the situation.

In many LAs, there has been a diminution of PH delivery both as a result of reduced staff and expertise and more recently with financial cuts to the PH budgets (see below).

The transfer across to LA encouraged some more senior PH consultants and DPHs, especially those with medical backgrounds, to retire, hence the loss of expertise. Similarly both with mergers and sharing between LAs there has been a decrease in available expertise. Both the Faculty of Public Health and PHE hold or are collecting data on these numbers.

Delivery of PH functions requires expertise from a multidisciplinary team. The PH specialty has developed an approach utilizing both people with medical backgrounds and those from other backgrounds. The team also needs to include a range of levels of expertise. It appears that some LAs do not appreciate this requirement and tend to be unwilling to appoint or continue to support this range within a MDT, with a particular impact on people from medical disciplines. Within LAs there is a lack of understanding of the different perspectives from PH professionals with different backgrounds bring to the richness of PH delivery. It would be unfortunate if such a range of expertise were lost before it’s advantage is recognized. It will be difficult to reproduce the range once lost to the specialty.

Similarly PH needs input from academic PH experts. PH relies heavily on ‘evidence’ as part of its repertoire and PH strength is to bring objective evidence to bear on a range of topics including commissioning. There appear to be gaps in academic PH and linkages between LA PH departments and their local academic counterparts have often been ‘squeezed out’ during the transition.

5. Recommendations:

i) Utilise powers within the Act to ensure all LAs are delivering a robust PH function.

ii) A range of population health experts are needed at all levels to deliver PH functions. This includes both people from a range of backgrounds, including medical expertise, to bring richness to PH functions and a range of levels of expertise.

iii) Address the gap in academic PH

6. Effectiveness of local authorities in delivering the envisaged improvements to public health.

i) The aim of the changes to PH was to consolidate PH within LAs and to make LAs health improving organisations. The intention was that this would build on the roles of LAs not just
in relation to health and social care integration but in such areas as environment, planning and housing, education, children and older people, transport and leisure.

ii) All of these areas have potential synergy with PH to improve the health of the population. For example, the way a community is developed and planned has major impact on the wellbeing of the community’s residents; transport plans which include more active transport such as cycling and walking are both good for the community, in reducing air pollution, and good for individuals in encouraging exercise to improve health and reduce cardiac and respiratory disease, diabetes and obesity. In addition there is a benefit to the environment and reduced emissions to reduce climate change.

iii) Further examples include the important benefits of early interventions, prevention of ill health and health improvement. This was described well in the reports by Sir Derek Wanless, commissioned by the Treasury, (2007, 2004) showing the economic benefit to the NHS and society of taking this approach.

iv) Similarly ‘giving every child the best start’ (Marmot 2010) is the best evidence-based approach to addressing inequalities and improving the health not only of children but for adults and for future generations.

v) Observations on Effectiveness of local authorities in delivering the envisaged improvements to public health.

a) Some LAs have understood the concept behind the transfer of PH to LAs (as described above) and are building such approaches into their Health and Wellbeing strategies and related activities. Some have taken ‘Fair Society, healthy Lives’ as a basis of their work, thus fundamentally addressing inequalities. However it is our experience that this is only the case in a minority of LAs.

b) Many LAs have not taken the opportunity, through their broad range of services to improve health and wellbeing. They have pigeon holed PH either to focus only on health and social care or to maintain PH as an isolated entity.

c) PH departments have developed a variety of initiatives to engage with other LA departments, to develop their understanding of PH issues and to try to develop joint work. These have had varying degrees of success, often depending on how ‘receptive’ the other LA departments have been.

d) There are however, notable exceptions where the vision of how PH can influence and improve the local population’s health, through the wider gamut of LA services, is being achieved.

7. Recommendations:

i) Strengthen the understanding of LAs of the how they can achieve the overall vision of a public health organisation, improving their population’s health and reducing inequalities

ii) Develop, identify, promulgate and encourage good models of how PH can work with and influence LAs to improve health through all aspects of LA services.

8. Public health workforce

i) Many of the issues concerning the public health workforce during the transition and subsequently have already been identified above, under ‘the delivery of PH’ which is highly dependent on the workforce.

ii) Data on workforce patterns have been collated by the Faculty of Public Health (FPH) and both the FPH and PHE remain concerned re PH workforce issues.

iii) The independence of the Director of Public Health (DPH) and the independence of their Annual Report of the health of their population are key aspects of the Act. The independent
The voice of the DPH has been recognized as a key feature in addressing and improving the public’s health since the original Public Health Act of 1848.

iii) Observations on PH workforce:
   a) Recruitment to PH should not be a barrier as many medical students and those from a variety of other disciplines remain interested in the specialty. At a recent RSM careers fair for medical students 30-40 students expressed interest in PH.
   b) PH Training programs remain considerably oversubscribed.
   c) However if there continues to be a lack of substantive jobs or if there are real or perceived disadvantages to medics entering PH as a specialty this interest will quickly diminish. One current perception is that soon PHE will employ mainly PH expertise from a medical background and LAs will employ those from other backgrounds. This will lead to a lack of balanced appropriate MDTs in either sets of organisations to deliver PH, at local regional and national levels.
   d) Appropriate remuneration of PH expertise has not always been understood nor followed through in LAs. Some LAs are attempting to transfer PH staff to ‘downgraded’ LA contracts.
   e) Some DPHs are not being regarded as independent and their Annual PH reports have been ‘censored’ by LA staff and councilors.

9. Recommendations:
   i) Maintain well balanced multidisciplinary teams in public health in both PHE and LAs
   ii) Monitor and ensure that people from both medical and non medical backgrounds remain recruited and employed
   iii) Monitor and ensure that PH professionals are suitably remunerated in LAs
   iv) Support, maintain and monitor the independent PH voice of DPHs and the independence of their Annual PH Reports on the state of their local population, at the appropriate level of authority

10. PH spending
   i) Some of the above issues are underpinned by the reductions in PH spend and in the cuts to LAs across the board that have meant they are looking to PH funding to support other services.

Observations on PH spending:
   a) The transfer of NHS funding to LAs to support the transfer of PH functions was identified as ring-fenced. This has not been the case
   b) The Wanless reports (2004, 2007) and health economists have identified the importance of prevention and early intervention in reducing the burden of costs on the NHS and society. For example sexual health services (part of the PH functions transferred to LAs) has been shown to have a return on investment (ROI) of £12 for every £1 spent. This order of magnitude is rarely seen for a ROI in NHS services.
   c) Cuts to PH funding are a false economy. For example many PH departments in LAs have programs addressing obesity. Obesity leads to diseases such as diabetes and heart disease, which cost the NHS and society substantially more than preventative obesity programs. Costs of Obesity in UK are estimated at over £2 billion per annum.
   d) The substantial reductions in general LA funding have meant that many LAs are deploying PH funds for non PH activities. Some DPHs are being put under substantial pressure to ‘sign off’ PH funds to support inappropriate services.

11. Recommendations:
   i) Reverse the 20% cuts to PH funding
   ii) Maintain and monitor the ring-fence funds
iii) Monitor PH spend within LAs to ensure it is being spent wisely on PH activities, if need be deploying regulatory processes identified within the Act.

References.

14 December 2015