1. Introduction

1.1 This paper is a personal submission in response to the request for written evidence in relation to the Public Health post 2013 Inquiry. I am a Consultant in Public Health and this submission is a representation of my personal views and experience of Public Health following transition into a Local Authority (LA) setting as a result of the Health and Social Care Act 2012.

1.2 Whilst I welcomed the acknowledgement of the important role of Public Health and the potential vehicle that the local authority can have in the delivery of the public health function, there have been significant unintended consequences of the transition into LA.

1.3 This paper aims to succinctly raise some of these issues with recommendations for resolution which I hope will be given due consideration. I am willing to discuss the content of this paper in more detail if required.

Recommendations

- All Directors of Public Health are established as strategic directors within the LA, directly accountable to the Chief Executive/Managing Director

- Professional accountability for the Public Health Function, and employment arrangements, should be returned to the NHS in a similar agreement to that which exists between NHS England and Public Health England. This will enable:
  - Independent and autonomous delivery of the public health function
  - Re-establish access to data to support commissioning of services, assessing health needs and reducing inequalities
  - Support recruitment and retention of a highly skilled workforce
  - Ensure a dedicated budget for the delivery of public health function

2. The delivery of public health functions

2.1 Since the transition of Public Health into Local Authority (LA) I have observed the overt and covert undermining of the public health function primarily through the operationalization of the role of the Director of Public Health (DPH).

2.2 It was stated by Andrew Lansley, in July 2010, that the government was returning responsibility for improving public health to the LA for several reasons:

- Population focus
- Ability to shape services to meet local needs
- Ability to influence the wider social determinants of health
• Ability to tackle health inequalities
The overall aim was to foster and promote innovation supported by public health expertise.

2.3 However, the only way to achieve this aim and the objectives that underpin it, is if the DPH has the authority to drive the public health agenda through LA processes. This is currently not the case in a majority of LAs where the role of the DPH is ‘hidden’ with Adult Social Care or the People Directorate. Whilst there may be a ‘dotted’ line of accountability to the Chief Executive/Managing Director, the DPH, in essence has lost the strategic director role to influence change on a large scale.

2.4 The independent and autonomous delivery of the Public Health function has been lost within a ‘supposedly democratic’ process. How can Public Health truly be the independent, population focused ‘torch of truth’, when some DPHs role has been reduced to a head of service, with no real say in the decision making and integrating public health principles into the wider LA? How can really important, yet controversial issues be raised if the Member with responsibility for public health deems it to be unpopular and not a vote winner? Not to mention halting service development and implementation because it is not expedient during the election period.

2.5 It is possible to address these concerns by ensuring that Public Health is acknowledged as a core, corporate function of the LA, not a delivery arm within a directorate. Therefore I recommend that all DPHs are established as strategic directors within the LA, directly accountable to the Chief Executive/Managing Director and involved in all LA decision-making as an equal partner to the Directors of Adult Social Care, Children’s Services (People) and Finance etc.

2.6 Additional to this recommendation, to maintain and independent and autonomous public health voice, I recommend that the overall accountability for the public health function should be returned to the National Health Service (NHS). If we really want to see the impact Public Health can have, the accountabilities have to change.

2.7 I am not suggesting a large scale transfer of teams and equipment, as visibility is importance to the influencing role. I am suggesting that, ideally, just like the relationship between NHS England and Public Health England, we are seconded to the local authority for synergistic working, but our professional accountabilities and employment should be back under NHS governance.

2.8 The reinstatement of NHS accountability will have a significant impact on the access to data that is currently hindering the ability to effectively commission and assess health needs alongside addressing inequalities via public health within the LA. Restricting public health access to this data, that was previously available when part of the NHS, is a prime example of the grossly underestimated unforeseen consequences of the Health and Social Care Act 2012.
2.9 Therefore, re-establishing NHS employment and accountability will have the dual benefit of enabling the independent delivery of the public health function within a LA setting with access to the data that is essential to fully supporting efficient and effective delivery.

3. The public health workforce

3.1 The transition of public health into the LA resulted in a near fatal ‘haemorrhage’ of skilled and experienced individuals from the profession. Subsequent recruitment has also been hampered by lack of understanding, at LA level, of the complex role of the public health practitioner, particularly the specialist role consultant. This has resulted in a ‘down-grading’ of the role and created disparities in remuneration regionally and nationally.

3.2 The role of the public health intelligence analysts has also been misunderstood, with a number of LA choosing to subsume this specialist into a wider business information function with a loss of essential technical skill to support the public health function.

3.3 The future of the public health workforce is uncertain as there has been a steady reorganisation of public health within the LA resulting in less favourable terms and conditions and developmental opportunities. Therefore, it is difficult to retain staff following internal restructure and equally difficult to recruit experienced personnel.

3.4 This indicates another benefit of establishing NHS accountability and employment arrangements for public health within the LA as it will ensure equitable recruitment and support retention of a skilled workforce.

4. Public health spending

4.1 Public health transitioned into the LA at a time of austerity which has had a significant impact on the ability to deliver the public health function. The whole reason that public health was moved into the LA was to improve outcomes and reduce inequalities.

4.2 However, in a number of areas public health has been seen as a ‘cash cow’ with a significant stripping of the so called ‘ring-fenced grant’. How can this be justified when there are worsening poor health outcomes and increasing inequalities?

4.3 It is insufficient to state that the DPH will sign to approve proper administration of the grant. The ethical and moral dilemma faced by DPHs is unquantifiable and, despite concerns regarding professional integrity, very few would openly challenge their employer. NHS employment of public health would ensure fair and transparent accounting for the public health spend.
5. Public Health Funding

5.1 In 2004, Sir Dereck Wanless advocated a step change in the way public health is viewed, resourced and delivered, highlighting the fact that there was a total imbalance between spending on treatment and spending on prevention. Simon Stevens reiterated these findings in the *Five Year Forward View*, calling for ‘a radical upgrade in prevention and public health’.

5.2 The delivery of high quality services is dependent on adequate resources and public health has honed the process of using these resources to maximum effect. Yet the Autumn Spending Review 2015 indicates that alongside the in-year cuts, we are facing additional unprecedented cuts to the public health funding year on year, whilst our colleagues in the NHS will experience a significant increase.

5.3 There does not appear to be any acknowledgment that a cut to the public health purse will have a significant impact on the NHS as there will be a reduction in the funding available to commission services from the NHS.

5.4 Equally, if public health is restricted by funding to just commissioning mandated services such as NHS health checks and childhood weight measurement programmes, there will be no additional funds for discretionary service to promote smoking cessation, reduction in alcohol consumption and improve healthy eating.

5.3 There is too great a focus on the acute care setting and it is well evidenced that prevention is the best way of dealing with escalating costs, promoting public health through the prevention agenda and raising public awareness to influence healthy choices. This is not just preventing admission to hospital.

5.4 The health outcome benefits associated with investment in public health and the prevention agenda, means that the UK would find itself much better placed to deal with increasing pressure on health and social care.

5.5 This can be achieved in one of two ways:
- Maintaining the ring-fenced public health grant
- Moving accountability of public health back into the NHS

5.6 It has already been demonstrated that the ring-fenced grant does not ensure that public health funds will not be used inappropriately unless more robust measures of accountability are enforced. This is difficult to achieve internally.

5.7 NHS accountability for the public health workforce and subsequent spend would provide an accountable, transparent process for delivery of the public health function. This would truly would ensure the ‘radical upgrade in prevention and public health’ with a dedicated influence on the social care agenda with significant improvement in population outcomes.

5.8 I am requesting, therefore, that serious consideration is given to future-proofing the discipline of public health and ultimately the health of this and subsequent generations. This can be achieved through the recommendations outlined within this paper.