Written evidence submitted by Dr Alison Furey (PHP0096)

Thank you for the opportunity to respond to this enquiry. This is an individual submission from Dr Alison Furey, based on her personal views. She is a consultant in public health based working across two local authorities.

Summary

The public health function has been negatively impacted by the move into local authorities in terms of delivery, workforce and expenditure in particular. Recommendations are made to address these.

The delivery of Public health functions

1. The delivery of the public health function is central to the realisation of the Five Year Forward View. Public health staff with specialist training have the skills to advise on preventive interventions that will reduce future demand for health and social care.

Action on Wider social determinants

2. The move into local authorities in 2013 has the potential to provide increased opportunities to act on the wider social determinants (employment, housing, welfare, education etc). One of the key ways to work on the wider social determinants is via the Health & Wellbeing Board (H&WBB), where partnership working should take place. The Director of Public Health is a member of the H&WBB. However, the H&WBB has no resource, and no implementation group supporting it in Lambeth or Southwark. Hence across the two boroughs they have aspirations and have developed overarching strategies, but have no “teeth” to do anything. In Southwark the H&WBB is chaired by the Leader of the Council, and not by the Director of Public Health or lead councillor for Public Health. In Lambeth the H&WBB is chaired by the Public Health Cabinet Lead.

Corporate leadership

3. The previous Health Select Committee enquiry (Health Select Committee Review - Twelfth Report of Session 2010–12, Volume 1 – III) recommended the Director of Public Health (DPH) be appointed at Chief Officer level, and report directly to the local authority Chief Executive. This was the case in Lambeth & Southwark until 1st October 2015, when this was downgraded in Southwark, so the DPH now reports to the Director Adult and Children’s Social Care. This has the potential to narrow the focus of public health to social care and reduce the influence on the other determinants of health.

4. In a shared public health function working across four organisations, clear governance of the public health function is important. In Lambeth & Southwark the governance of the public health function remains unclear.
Councils as public health organisations

5. In one council there has been no strong public health leadership on public health issues/developing the public health function within local authorities. No funding/resource/project management was made available to allow this to happen at the time of the transition into the local authority. This should be seen in the context of extensive reorganisation of departments in other parts of the local council, with high staff turnover, (mainly due to redundancies) thus increasing complexity of the transition.

Organisational culture in the local authority

6. The culture of the local authority is different from the NHS with a noticeable lack of trust, continuity, and respect for professionalism compared to the NHS. Decisions are made without reference to evidence based practice, or engagement with the right professionals. There is frequently a lack of communication between council officers, which undermines the public health function.

Transition to Integration of health & social care

7. There is a lack of alignment between council and CCG budgets which makes public health functions problematic. The relationship between council and NHS / CCG is frequently difficult, and problems are played out where there is service overlap.

8. The removal of public health from the NHS has meant it is more difficult to provide public health healthcare advice, and to lever health service quality improvements via health care public health advice/partnership working.

Supporting Functions

9. The difficulties with recruitment and retention (28% vacancy rates currently and all vacancies frozen in August 2015 due to cost pressures) is impacting on the delivery of the public health function, such as the directly provided Health Checks service, Intelligence Function, Health Protection function.

Data sharing

10. The previous Health Select Committee enquiry (Health Select Committee Review - Twelfth Report of Session 2010–12, Volume 1 – III) made recommendations on data sharing. One of the (unintended) consequences of the Health and Social Care Act and Caldicott 2 Review has been a reluctance of the NHS and HSCIC to share data with local authority Public Health to undertake their statutory advice to CCGs. This includes anonymised data. Access to data is of critical importance to undertake the health surveillance function and assessment of population health. In addition some councils appear variable in their capacity &
capability to deliver on Information Governance Level 2 or more requirements.

**Independent voice of Public Health**

11. The previous Health Select Committee enquiry (Health Select Committee Review - Twelfth Report of Session 2010–12, Volume 1 – III) recommended “Directors of Public Health should be free to speak out, if necessary to criticize their local authority, without inhibition or restriction.” The councils only wish to communicate “good news” stories and do not want communications on poor performance ie the advocacy role of public health. It is difficult to envisage a critical evaluation of a political intervention which it may be difficult to withdraw from e.g. the decision to provide “Healthy Free School meals” in Southwark. This calls into question the independent role of public health to speak out on issues that may harm population health.

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

12. There are many opportunities presented by the move of public health back into local government, i.e. tackling the wider social determinants of health. The move of public health into local authorities in 2013 comes at a time of major public sector funding contraction, and means many of these opportunities are sadly at risk of not being realised. Despite some of these challenges locally there are some notable good examples of improved working including the Lambeth Food Flagship Programme; this involved close partnership working to leverage £600,000 from the Mayor’s Food Flagship Programme to improve healthy nutrition and reduce food poverty, reaching 36,000 people in Lambeth schools and 60,000 income deprived communities.

Lambeth Early Action Programme, involving successful collaboration on a £36million Big Lottery Fund bid to improve the health in 0-4 year olds and reduce health inequalities in four Lambeth wards over the next 10 years

Provision of public health input to Lambeth and Southwark licensing and strategic planning processes to realise health benefits and mitigate harm to health

Use of Health and Wellbeing Impact Assessment as part of Regeneration proposals.

Public Health advice to support welfare benefits advice

Development of JSNA factsheets to support decision makers

**Commissioned local authority services**

13. Responsibility for public health commissioned services have become fragmented and divided between local authorities, CCGs, CSUs (on behalf
of CCGs) and NHS England. Public health no longer leads on the commissioning of health improvement interventions at local authority level, or on screening and immunisations at national (NHS England) level.

14. Councils tend to re-procure services to get more “value for money” or buy less of a commodity. The (Re) commissioning of health improvement services was a new area of commissioning for both councils. It has been fraught with difficulty due to a lack of understanding of how health services operate, and evidence based practice in particular. The councils are seeking to reduce all health improvement service budgets, without an understanding of the wider impact on other sectors, and on population health. One example is sexual health services. These are walk-in services and therefore difficult to control spend. When held within the Commissioning Support Service (NHS) portfolio it was possible to flex the budget across other services. Negotiations were also possible across CCGs or by one CCG on behalf of another. This is no longer possible.

15. Some of the services transferred are very clinical in nature eg cardiovascular risk (health) checks, sexual health services. There is now separation of responsibility for commissioning (councils) from those who benefit (NHS). Councils have no understanding of clinical services and no experience of commissioning these services.

16. These services could be returned to the NHS, as with local authority cuts, there is little prospect of their being appropriate safe services with proper clinical governance mechanisms being put in place in the near future.

Enabling Legislation

17. Some of the envisaged improvements to public health require enabling legislation for example changes to licensing or food regulation. The previous Health Select Committee enquiry (Health Select Committee Review - Twelfth Report of Session 2010–12, Volume 1 – III) recommended that these proposals be the subject of further public consultation. This enabling legislation has lagged behind practice and is only now being proposed /consulted on, such as the sugar tax on canned fizzy drinks.

The public health workforce

Terms and Conditions and lack of parity

18. At the time of transition, public health specialist staff transferred to local authorities on existing NHS Terms and Conditions. All local authorities have employed new public health staff on council terms and conditions at lower grades, hence a 2 tier system is in place in the department. It is not possible for staff to move between/within local authorities on existing terms and conditions, hence career prospects /mobility are much
reduced. Some local authorities are seeking to change the Ts and Cs of staff in post, with salary cuts.

19. Recruitment procedures are really challenging in the local authority context, with an emphasis on generalist rather than specialist skills, tending to make the local authority an unattractive place to work.

Career Progression

20. There are potential opportunities for the wider local authority workforce to gain skills working in public health. However, there is no career progression for public health staff within local authorities. There has been little investment in workforce development for 2 1/2 years. Local authorities will need to find ways to retain specialist staff.

Supporting Functions

21. The supporting functions that public health relies upon (e.g., IT, HR,) are unreliable and existing web-based systems do not work, thus undermining productivity, compared to the previous work environment in the NHS.

22. There has been inadequate HR support of public health due to under-resourcing of the council HR department. There has been a learning curve while HR attempt to understand NHS Terms and Conditions. Many people are on short term contracts. Frequently, staffs do not get paid the correct salaries. After one year of negotiations, the correct pension payments were made.

Staff Morale

23. The specialist public health workforce that transferred from PCTs are in the process of developing the political skills needed in local authorities. The workforce feels undervalued, and is viewed as expensive by local authority officers/Directors. Recruitment and retention has been poor and some staff have left public health altogether (The Faculty of Public Health does annual surveys of this). At the time of the transition from PCT (NHS) to local authority in April 2013, money was allocated for organisational development within public health. This money was however used to manage council savings elsewhere.

Public Health spending

24. The recession, welfare benefits caps, and housing benefit caps all point to the need for more, not less public health investment. Cuts to local government of c 30% means public health investment (national and local) has reduced since April 2013.
Cuts to the public health budget

25. The “ring-fence” to the public health budget in local authorities envisaged by DH is hypothetical only. There have been cuts to the local authority public health budget a) at transition from PCTs in April 2013, b) in 2013/14 in the public health commissioned services budget (e.g. Health checks budget reduced by 12%), c) DH reductions to the public health allocation to local authorities of 6.2% in 2015/16 -in year, d) reductions in the DH public health allocation to local authorities allocation from 2016/17 onwards. The local authorities wish to make cuts of 25% to 2017/18.

26. These should be seen in the context of local authority wide cuts of c 25% in 2014/15 onwards, and cuts to Public Health England budget. In addition, the impact of changes to the ACCRA formula are likely to have a further negative impact on councils budgets.

Combined Sexual health, substance misuse and specialist public health budget

27. Under the Health & Social Care Act 2012 the budget for specialist public health advice is bundled up with sexual health services and substance misuse service. Any overspend on one part of the budget impacts negatively on the other. When funded by the NHS, the sexual health budget was based on the previous years’ outturn.

28. In Lambeth & Southwark there is high need for sexual health services, and substance misuse services, and overspend is common across inner London. So in the local authority, the overspend on sexual health must be compensated for by cuts to the substance misuse service budget and specialist public health service budget. This in practice means fewer staff available to provide specialist public health advice. This “bundling” would be best uncoupled, with some services best returned to the NHS.

29.Underspends on the specialist and/or commissioned public health budget in some areas is not a reflection of reduced need, but rather of inefficient council processes of authorisation etc, and the freezing of recruitment to public health posts. Hence there are not the staff to do the public health work we would wish to do.

Concluding remarks/recommendations
The dis-benefits of the Health & Social Care Act in Lambeth & Southwark outweigh the benefits, and the balance is unlikely to change in the future. Solutions to some of these problems might be to

1. Create a central public health employing agency such as Public Health England/Deanery, for all local authority public health staff, and to second staff back into local areas/devolution pilots on rotation.
2. Maintain staff on Terms and Conditions which allow them to transfer between NHS organisations.
3. Return clinical services to the NHS (sexual health, substance misuse, health checks, smoking cessation and obesity services).
4. Continue to ring fence public health funding, and enforce this
5. Create a Prevention Fund for each sector level.
6. Integrate Health & Social Care Commissioning, with mandated public health advice.

16 December 2015