Executive Summary

- Public health is the preventative arm of the NHS and which, when functioning well, reduces costs and pressures on other parts of the public sector such as social care and the acute NHS services. It is a vital part of our public services.

- Unite was concerned by the transfer of public health to local authorities in 2013 because it felt there was the potential to fragment public health from the wider NHS and lead to substantial cuts due to local government’s tighter budget constraints. It was also predicted to lead to cuts to staff terms and conditions as they were taken out of Agenda for Change.

- Unfortunately Unite’s fears have been confirmed with Unite members reporting:
  - swingeing cuts to public health services
  - reductions in staff terms and conditions, training and pay
  - poor morale and de-professionalisation
  - loss of status, independence and innovation within the service
  - false economies as reduced services and quality leads to greater costs in acute services down the line

- Unite members believe that Public Health budgets and services must be protected. Solutions include making public health either an independent NHS body in its own right with the secretariat and governance provided by local authorities, employing them as part of Public Health England, or for the specialist workforce to hold their contracts within the NHS (eg. CCGs), whilst being based within a local authority.

- Unite recommends that the Health Committee speaks out against public health cuts as these cuts are simply storing up bigger costs for the future.

1. Introduction

1.1. This evidence is submitted by Unite the Union - the country’s largest trade union. Unite’s members work in a range of industries including manufacturing, transport, financial services, print, media, construction, not-for-profit sectors and public services.

1.2. Unite is the third largest trade union in the National Health Service and represents 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA),
College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

1.3. Unite also has 80,000 members in local authorities and represents members in social work, social care, housing, schools, waste and refuse, craft and maintenance. As is clear from this list above Unite represents a significant number of members working in public health functions including public health specialist, consultants and directors of public health, school nurses, health visitors and sexual health advisors.

1.4. As well as the medical public health consultants included within the membership of the MPU, UNITE is acknowledged as the main trade union representing non-medical public health specialists and holds the seat representing such specialists on the BMA’s Public Health Medicine Consultative Committee.

1.5. By virtue of an agreement between the MPU and the BMA in 1950, Unite is party to the universal franchise negotiating machinery for the medical profession provided by the BMA. Five of the last ten chairs of the BMA’s Public Health Medicine Committee have been MPU/Unite members. Unite is the only union recognised in local government to be also party to that machinery.

1.6. CPHVA/Unite is the main trade union and professional association for health visitors and school nurses, the two largest groups of public health practitioners.

2. **The delivery of public health functions**

2.1. Public health has a vital role as part of the integrated universal NHS. Ever since 1948 the term “the NHS” has meant the comprehensive health service established under the NHS Acts and between 1948 and 1974 the local authority Health Departments were one of the three wings of the tripartite NHS.

2.2. Public health services’ importance cannot be over-stated as prevention is a key element in the long term affordability of the NHS, not least through the support for healthy ageing as a key element in the long term affordability of social care.

2.3. Local authorities and NHS bodies all have key roles in public health. As well as the specific public health functions conferred by the Act, local authorities can influence public health by considering the health impact of housing, transport, spatial planning, open spaces, cultural and leisure services and the promotion of resilient communities and healthy ageing. NHS bodies have key roles in avoiding iatrogenic ageing (people becoming dependent prematurely due to a treatable illness being
regarded as “just old age”), in work and health (need to be geared to supporting people back into work) and in using healthcare contacts as an opportunity to promote healthier lifestyles.

2.4. Unite believes that recognition must be given to the crucial role of public health specialists as health professionals whose job is to envisage a different future and their role as advocates for the health of the people. Sewers, safe pregnancies, clean air and smoke free pubs were all ridiculed when first proposed but have all made a huge impact on UK health and life expectancy.

2.5. While there are some good arguments for integrating public health with local authority provision, Unite was concerned about the wholesale transfer of public health to local government in 2013. Members feared that this would lead to fragmentation of services, undue political interference in clinical decisions and cuts to services as local authorities used the public health budget to plug other gaps in their budget. Sadly it appears many of these fears are being realised.

2.6. The Health and Social Care Act 2012 has changed the terminology with Public Health England and local government public health both now part of the comprehensive health service but now described as “part of the health service but not part of the NHS”. This has implications for finance, for access to data, for public branding and for working relationships. The public regard sexual health, health visiting, drug and alcohol services and NHS health checks as part of the NHS, however the Government now does not.

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

3.1. Unite members are reporting concerns that local authorities are failing to appreciate the importance of the public health function they have been given. This is being thoroughly exacerbated by the cuts (see section 5) but also there are major concerns with the status and independence of Directors of Public Health and their staff.

3.2. Pre-2013, although employed by Primary Care Trusts (PCTs), public health was regarded as an independent body and based on scientific evidence, ready to speak out against anything which might compromise public health. This is exemplified by the Annual Public Health Report (APHR) whose content is sacrosanct and under the total editorial control of the director of public health. It is clear from members’ comments that some local authorities are now exerting pressure to control the content of this report, thus compromising the director of public health’s independence.

3.3. The problem is, however, much wider than the APHR. Of even greater concern is public health’s inability to speak out without fear of prejudice or other repercussions on all matters related to public health. Unite members report a controlling regime exerted by many local authorities whose
agenda is to satisfy the needs of the members and its public. These aims often contradict public health aims as unfortunately, the best health advice is not always the most popular.

3.4. This lack of independence is probably one of the most important consequences of the transfer of public health from the NHS to the local authority.

3.5. The status of public health in the council hierarchy is tied into this. Unite members report that some local authorities are refusing to acknowledge the seniority of the director of public health in their structures, appointing them in name only and then making them accountable at an associate director level. This limits the extent to which the director of public health can be independent, as they are accountable to other directors rather than the Chief Exec.

3.6. Local authorities are further diminishing the independence of directors of public health by refusing to recruit them on a permanent basis, as many of them are kept on temporary contracts. For example in Liverpool members report that the director of public health has been interim for nearly two years, with repeated promises of being made permanent. Such a situation reduces the director of public health’s ability to provide effective challenge as they are constantly worried about their job. This means that other public health staff such as consultant and public health specialists are much lower in the management hierarchy. The problem is not the perceived lack of status, but more realistically, it is the lack of influence in many areas where councillors do not see public health as a priority.

3.7. This lack of independence means that public health staff are now also unable to take on speculative work which previously would have been done. This is the type of work which a specialist might want to do independently to evaluate a particular problem identified as part of other pieces of work. Restrictions on data access and the funding control of Clinical Commissioning Groups (CCGs) make this much more difficult.

3.8. Public health remains a medical specialty, albeit one which has established a non-medical route of entry so as to draw upon a wider knowledge base. All public health specialists from whatever route of entry have undergone a postgraduate medical training under the direction of a medical Royal College and they deserve the standing which goes with that.

3.9. Unite is concerned that these changes to highly specialised public health roles are having a damaging impact on the morale of the remaining public health specialists working in local authorities. Unite believes for the service to thrive their independence must be protected so that they are able to speak out and to delve into areas which they think could be important.
3.10. Unite members believe that Public Health budgets and services must be protected. Solutions include making public health either an independent NHS body in its own right with the secretariat and governance provided by local authorities, employing them as part of Public Health England, or for the specialist workforce to hold their contracts within the NHS (eg. CCGs), whilst being based within a local authority.

3.11. The experience of school nursing members is also worth highlighting. The new local authority responsibility for commissioning of public health functions for 5-19 year olds has meant that school nurse managers have spent much of the last couple of years engaged in getting their services reduced and ready for the commissioning process. This has meant a wholesale overhaul of what school nurses do, what the commissioners want, and what everything costs. The commissioning process is new to nurse managers and they have had to learn many new skills. This process has been frustrating and exhausting for all involved, because, by definition, there is no certainty at all about the outcome, and so a lot of work has been wasted.

3.12. Meanwhile school nurses report that they still spend the bulk of their time on safeguarding work, as posts are frozen, their caseloads expand, and referrals increase. Many school nurse teams have been pulled out of involvement with safeguarding children where there are ‘no identified health needs’ however, it is known that all children involved in safeguarding enquiries must have mental and emotional health needs but these are not being addressed by school nurses. Social services which are under pressure are not taking referrals which are ‘only neglect’ and are referring these back.

3.13. At the same time as responsibility for public health 5-19yr olds moved to local authorities, schools moved out of local authority control, so partnership working has been lost. School nurses report an increasingly fragmented service with no overall control or strategy. Some schools will no longer accept the services on offer, especially around sex and relationship education. There is also the problem that without Personal, Social and Health Education (PSHE) being mandatory, many schools simply ignore the topic or try to take it ‘in house’ rather than working with outside agencies. Where they do work with outside agencies, these are often commercial companies who may or may not offer evidence based advice and education. Some organisations (for example anti-abortion lobbyists) are very one-sided and may give inaccurate information.

3.14. The commissioned school nurse services look excellent ‘on paper’ but the available workforce cannot possibly deliver all that is asked, and this is causing enormous pressures in the workforce, many of whom cannot wait to retire. All in all, the lack of a strategy for children’s health and a lack of understanding of the depth and breadth of public health nurses is a missed opportunity to improve the health of school–aged children.
3.15. Unite is concerned that similar experiences may be replicated in health visiting services as they begin to be commissioned by local authorities.

4. The public health workforce

4.1. The changes to public health in conjunction with the wider cuts agenda have had a negative impact on public health staff. As discussed above morale is low because the independence and innovation of some roles have been curtailed, either by local authority structures or constraints caused by the CCG funding regime. Other groups such as sexual health advisors have also faced privatisation under the 2012 Act.

4.2. Public health staff at all levels have suffered significant cuts to their terms and conditions. This has affected many of the groups transferred and mirrored problems faced in the NHS e.g. funding cuts have led to down-banding and deskilling in other roles such as school nurses, sexual health advisers and health visitors.

4.3. Members report that public health specialists on NHS terms and conditions are viewed by the council as very expensive in comparison to existing council employees. Unfortunately, the local authority system for job evaluation is based on budgetary and management responsibilities. This is in contrast to the incoming public health specialists whose jobs were evaluated (using “agenda for change”) according to their knowledge, skills and level of expertise. This level of expertise is such that some specialists give advice regionally and in some even at a national level. The consequence is that councils are not prepared to pay these higher salaries. As a result, many jobs (including directors of public health) have been downgraded. Examples include in Croydon where all public health staff have been dismissed and re-employed on significantly worse terms and conditions and Tower Hamlets where similar proposed changes under discussion.

4.4. The knock-on effect is that many specialists are leaving or have left the service. Ultimately, this will have severe consequences as the number of highly qualified specialists dwindles to zero. This will leave the local authority public health teams full of highly competent but generic workers who simply do not have the knowledge and skills to provide the support and advice which is required.

4.5. This is particularly true for ex-NHS specialists with clinical backgrounds (e.g. doctors, nurses, pharmacists etc). The specialists are leaving in large numbers because their work is neither appreciated nor understood by the local authorities. It is unrealistic and short-sited to assume that clinical services (such as sexual health, drugs and alcohol) can be commissioned effectively by generic public health workers without a clinical background or free access to clinical advice from within their team.
4.6. It is a worrying and bizarre situation where the same generic public health workers will be expected to give statutory “public health advice” to hospital consultants (many working at the top of their field) and CCGs without the same clinical background or access to clinical advice from within their team.

4.7. Members also report the use of ‘market testing’ to erode pay for directors of public health, such as in Cheshire West and Chester advertised for a director of public health at a salary significantly below the medical consultant and Agenda for Change rates of pay. This ‘market testing’ means that they could possibly recruit newly qualified consultant into the post at that level of pay, but that person will not have had the experience to provide appropriate challenge to the local authority.

4.8. Unite members would like to see far more support from Public Health England to maintain the terms and conditions of the wider Public Health workforce and take action to prevent local authorities from ‘market testing’.

4.9. At consultant level members report an erosion of their function within local authorities. There are numerous instances where local authorities recruit something called a ‘head of service’ to administer their consultant function. Consultants cost around £65-90k and a head of service costs around £50k so it is a significant cost saving. These heads of service may have a background in public health but they are not Faculty of Public Health registered. Unite is concerned that these roles do not have the technical specialist knowledge to carry out the role affectively.

4.10. Members also report fewer and fewer consultant level posts advertised, and those that are advertised tend to be locum posts on local authorities terms and conditions, which are much worse than NHS. One member told us that “out of ten newly qualified consultant colleagues, only 3 have been appointed on full time, permanent contracts with NHS terms and conditions”. The others are on a mixture of NHS and local authority conditions with no recognition of length of service and on spot pay with no room for upward movement.

4.11. Unite is concerned that this is all leading to a divergence of the medical and non-medical workforces, with non-medics moving towards local authorities and medics towards Public Health England. Non-medical members are concerned that Public Health England is making this worse by releasing documents such as 'Public Health in the 21st century'\(^1\) which sets a worrying precedent for the de-professionalisation of the workforce and a failure to acknowledge the contribution of the non-medical workforce.

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4.12. The professional side of the Public Health Medicine Consultative Committee, the official professional consultative body for public health has produced detailed guidance on employment of public health specialists in local government which shows how these gradings are mistaken and explains the errors that are being made. The professional side includes the BMA, Faculty of Public Health and Unite. It is unfortunate that the management side including Department of Health, Public Health England and the Local Government Association has failed to engage with this document.

4.13. It should be noted that local authorities which understand and value public health have no difficulty in recognising the need for pay and conditions which maintain public health as a medical specialty, and maintain freedom of movement between the different parts of the system. They also have no difficulty understanding the need for professional independence. These authorities will suffer from the poor image of public health in local government which other authorities are creating.

4.14. Unite believes that processes need to be put in place to guarantee mobility between different parts of the system, particularly around salaries, pensions, continuity of service. It must be a condition of public health grant that local authorities have regard to the issue of mobility between different parts of the service when setting pay and conditions for health professionals.

5. Public health spending

5.1. In June this year the Chancellor’s budget announced that £200 million would be cut from the public health grant to local government. This was followed in the autumn statement with further 25% cuts to the Department of Health, including Public Health England. This confirms Unite’s worst fears about the transfer of public health function out of the NHS to local government. Public health is the crucial preventative arm of the NHS but by transferring it to local government, central government is abrogating responsibility for it while outsourcing the cuts to local councils. This is likely to get worse if the ring fence is removed. They are also hiding what are essentially cuts to the NHS in another less politically toxic department.

5.2. Unite submitted evidence to the Department of Health on the impacts of these cuts in August this year and the Government response was frustrating as it ignored the weight of public feeling to push for its own preferred choice. The Department of Health document details each local authority’s ‘saving’ (cut). While relatively small compared to the overall Department of Health budget £200 million has had the effect of cutting 6.2% from each local authority budget.

2 http://www.unitetheunion.org/uploaded/documents/Unite%20response%20to%20local%20authority%20public%20health%20allocations%202015-16%20in-year%20savings%20a%20consultation11-23868.doc
5.3. The cuts to local authorities are being felt differently everywhere and while they are being driven by the overall, cuts some local councils are also misusing the grant. There are some worrying examples. In Barnsley the local authority has put the 0-19 service out to tender at nearly 20% lower than its current cost to run. That can only be done through reductions of frontline professionals. Similar Unite members in Portsmouth City council have been presented with huge cuts to services £2,605,100 from the public health budget which is nearly a quarter of all their £11 million cuts. Unite is aware of Swindon’s plans to close all children’s centres which are another service vital to council’s public health work.

5.4. Government policy on public health is contradictory. It is impossible to make savings of this magnitude without an irreversible effect on the nation’s health. This will not only impact on the public in 2015/16 but also the generations that follow. Public health is often promoted as important, and as a solution to the efficiency savings that can be made, but then it appears to be one of the first functions to be cut. While it is politically easier to cut preventative services, such cuts are false economies as they lead to much higher acute problems further down the line as prevention is reduced.

5.5. Cuts to funding mean cuts to staff numbers and Unite has already seen significant cuts to staffing numbers across both local authorities and health services, this will only exacerbate matters. As has been described above many of our members not only face pay cuts but also down-banding of their posts. Managers will often argue that as the same staff are in post, delivering services, the loss to the service has been negligible, but in truth the damage caused to both the quality of the service and staff morale has been extensive, and will become more evident as experienced staff retire. These proposals mean that those staff who the Department imagine will plan and deliver these local services will no longer be in post.

5.6. Health Visiting is a useful example. As a partner in the recent Health Visitor Implementation Plan, we were pleased with the gains made in correcting an historical low number of health visitors in the service. These gains were made through the commitment of health visitors, many other staff and manager groups and organisations. With the failure of the Secretary of State, Jeremy Hunt MP, to state any ‘ring fencing’ of health visitor numbers we are seriously concerned that when local authorities are faced with these cuts, at the same point of the transfer of health visitor commission (‘Children’s 0-5 public health allocation’) that they will be faced with impossible decisions about how to safeguard children’s services. This is compounded by the fact that commissioning of public health services for 5-19 year olds has already suffered by lack of identified funding to support it,

5 http://www.bbc.co.uk/news/uk-england-wiltshire-34983055
resulting in the fact that our country has some of the highest levels of obesity, mental and emotional health disorders and teenage pregnancy in Europe.

5.7. It is difficult to see how staff in reduced departments will have the resource and expertise to liaise with their partner stakeholders and adequately commit to working with them at the Health and Wellbeing Boards. This erosion of local authority public health work will impact on the Clinical Commissioning Groups who will find problems escalate, subsequently costing the exchequer more money. If local authorities do not achieve the preventative public health work it is inevitable that public health issues; smoking, obesity, cancer, inactivity, etc. will be exacerbated. Professional staff who are registered with one of the regulatory bodies will find it very difficult to maintain their registration while offering sub optimal services.

5.8. Unite recommends that the Health Committee speaks out against public health cuts as these cuts are simply storing up bigger costs for the future.

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