**Introduction**

I am Dr Andrew Howe and have been a Director of Public Health for 12 years both for NHS Primary Care Trusts and Local Government. I am employed by Barnet and Harrow councils and manage a joint Public Health Service, established on 1\(^{st}\) April 2013 on transition from the National Health Service. In my current role I am a member of Councils’ senior executive teams, a member of both Barnet and Harrow Health and Wellbeing Boards and the governing boards of the Clinical Commissioning Groups. The public health service is hosted by Harrow Council and provides a joint service to Barnet Council. In this submission I focus my reflections on the local experience since the transition of public health to local government.

**Executive Summary of submission**

Local government is the right place for public health. Health is about more than medicine and wellbeing about far more than clinical input. In local government we can influence the wider determinants of health: housing, leisure, education, social services, environmental services, transport planning etc. The challenge now is to make sure we do this.

There have been challenges in the transition from the NHS to local government, and it remains a focus. Some of the difficulties we have to manage are set out in this submission; data access; working with national bodies; working across different organisational cultures.

However, the benefits of joint working between councils and adopting a partnership approach far outweigh the difficulties we face each day in making this work well and examples of this are also outlined: cross fertilisation of ideas; greater staff resources; implementing joint initiatives.

Two particular examples of the benefits of joint working across London are the London Sexual Health Transformation Programme and the work of the Association of Directors of Public Health.

**The delivery of public health functions in the new system**

In preparing for transition from the NHS we undertook some ‘shadow operating’ with Harrow Council for the 12 months prior to transition; this was useful to understand the governance arrangements of the councils. Both Councils were positive and welcoming about the transition of Public Health and arranged induction programmes which provided insight into local government culture.
In the early period of our work in local government we focused on ensuring the safe transition of our commissioned services. But it was also important to forge new relationships with council departments in order to develop the opportunities to build ‘health in all policies’. By pump priming investment into other cross council initiatives we have been successful in attracting external funding to extend new initiatives. For example, employment support for people with mental health issues and winter well programmes for older people.

Despite the fragmentation of the public health system at transition we are broadly doing well in London at building and maintaining relationships with the wider health system.

**Joint working across two councils**

The joint public health service across two councils has been successful and the benefits have outweighed the challenges. The challenges relate mainly to servicing two governance systems as well as ensuring that services are tailored for each borough based on local needs. It has been beneficial to have a larger group of professional staff operating within two local contexts to develop expertise, skills and knowledge which can then be shared. The advantages have ranged from adapting services developed in one borough for the other borough (for example Alcohol Brief Intervention), to the economies of scale achieved in delivering the Pharmaceutical Needs Assessment for both councils. We have also used the shared development work and purchasing power to re commission more effective services: the Drug and Alcohol and School Nursing service being one example.

**The problem of data**

Data is crucial in public health epidemiology. In 2012 the access to data was curtailed. As a result for the past few years we have had no direct access to any health service data with which to support the CCGs in their commissioning and we have not been able to look at whole systems approaches to improving health and wellbeing. PHE data has been vital in this time.

One of the projected benefits of public health in local authorities was the ability to combine health data with social care, housing and environmental data to inform whole systems changes. The lack of data has hampered this. Currently local authority public health teams can get a pseudonymised health data set which allows some analysis to be undertaken but still limits us.

An example of what could be achieved if we could effectively combine data is the work we do with troubled families. If we were able to compare the health service usage data with the social care data, school data and antisocial behaviour or crime data we would be able to look at all of the issues affecting the family, put in the support they need and measure the outcomes for them and for the local economy.
**Working with PHE, HEE and CCGs**

The London office of Public Health England have worked effectively across the London health and care system including with DsPH; outcome indicators have been introduced that track key health priorities. In addition, in London, we have a memorandum of understanding signed by all Councils and PHE with respect to health protection responsibilities and the system works smoothly.

The nationally produced PHE health profiles are very helpful locally in monitoring demographic changes and planning services.

We also work well with Health Education England in London. I am the public health Board member for Health Education North West London where we are developing a public health strategy. HEE in London has funded, over the last 2 years, a workforce development programme for public health specialists.

In our work with CCGs we continue to be concerned that local CCGs do not have the resources to allow delivery of prevention work as outlined in the NHS 5 year Forward View.

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

Effectiveness is increasing. We are seeing increasing successes in embedding public health thinking in the planning for and delivery of a range of council services. For example, locally, place based initiatives such as the ‘Altogether Better’ locality approach helping older people to keep well and independent; the use of the public health equality impact assessments for the location of outdoor gyms; obesity work in primary schools and the housing elements of regeneration initiatives.

Further examples of Public Health cross council working examples are:

- Barnet Council Benefits Task Force, Job Centre Plus, and Barnet, Enfield and Haringey Mental Health Trust work together to develop two employment support services for people with severe and enduring mental health problems.

- Harrow and Barnet working together to implement the London healthy workplace charter

- Older Peoples Assembly, Adults and Communities and Third Sector organisations work jointly to develop older people’s physical activity provision

- Barnet council Street Scene, Adults and Community, Middlesex University, Barnet College, Saracens rugby club and Barnet Football club work together to deliver outdoor gyms and activators programme.

- Teachers, School Sports Partnership, PE consultants and service providers deliver nutrition and physical activity as part of the Barnet Schools Well-being programme.
• Children’s Centres Managers, Early Intervention and Family’s team work to incorporate health priority areas in Children’s Centre work.

• Environmental health: the control of Shisha establishments, tobacco control, licensing of fast food outlets Parks and Open Spaces Strategy.

Locally we would echo the call for councils to be given the power to include health as a licensing objective.

The Association of Directors of Public Health in London

The London group of the Association of Directors of Public Health (ADPH) was formed at the time of transition to local government and has played a key role in developing collaboration between councils and supporting the work of local DsPH. The work has included: a programme of Sector Led Improvement (for example using peer review methodology to look at local tobacco control initiatives); sharing good practice to improve children and young people’s health and preparing for the transfer for Health Visitor commissioning from the NHS to Councils; development of a London Digital Mental Wellbeing project; ensuring robust health protection arrangements; implementing a workforce development programme; and developing and implementing the London HIV prevention programme.

The London Sexual Health Transformation Programme

I am the Director of the London Sexual Health Transformation Programme which is a partnership of 30 London Boroughs to deliver a new collaborative commissioning model for sexual health services. It aims to improve sexual health outcomes for patients and save money for councils. The programme is necessary as the demand for sexual health services in London is increasing at a greater rate than anywhere else in the country. Demand is going up year on year and councils now spend over £100m per annum.

After a series of engagement exercises with commissioners, clinicians and patients we have now had the business case approved by 18 council cabinets, with a further 9 agreeing to proceed without the need for a cabinet decision. Our hope is to use the partnership of councils to establish improved service models. By making the best use of technology and contract specifications to better address current and future service demands we hope to reduce the incidence of STIs, HIV and teenage pregnancies.

Discussions and development work on the clinical specification continues and the new services will be in operation by April 2017.

The public health workforce

The transition of the specialist workforce to local government was not without challenges. However since then we have successfully recruited to a number of posts and our local team is able to continue training a range of NHS GP and Public Health specialist trainees. A
significant benefit of working in local government is the ability to work much more closely with a broad range of practitioners who have a real impact on the health and wellbeing of local communities. There are opportunities to develop and expand this work: for example, training front line workers in ‘making every contact count’ initiatives.

**Public health spending**

No one in the public sector is finding it easy to cope with the reducing finances.

Harrow Council receives the second lowest public health per head allocation in London, while Barnet Council receives the third equal lowest in London. The timing of the transition in financial terms has been difficult. The protection offered by the ring fencing of the grant has been helpful in allowing a safe transition of services but reducing budgets has impacted significantly on preventive services and negotiation has been required to maintain and promote a preventive perspective. We do this by focusing on demand management and return on investment.

As well as funding traditional public health services we have deployed resources in various other areas of the councils to influence the wider determinants of health. Rather than seeing this as a loss of resources we have used the leverage to influence service delivery to include public health principles and practices. We have invested funds in a number of areas which have added value to the ‘host’ services: for example schools programmes encompassing healthy eating, physical activity and emotional and social wellbeing. Additionally we have pump primed a number of initiatives, notably in employment support services for people with mental health issues, where we have demonstrated good returns on investment. The establishment of good local partnerships has attracted external funding to expand this work.

**Conclusion**

While remaining a challenge, and exacerbated by the reductions in local authority grants, public health services have benefited from being in local authorities and the possibilities for further benefits to residents and patients are considerable. The achievements of the London Sexual Health Transformation Programme and the effective working of the Association of Directors of Public Health are just two examples of what can be delivered by Councils working in partnership.

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