## Association of Directors of Public Health – evidence to the Communities and Local Government Committee on the future role of English local authorities in health issues, October 2012

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. www.adph.org.uk

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities and other sectors.

ADPH has submitted detailed responses to consultations on the NHS White Paper, draft Health & Social Care Bill and Public Health White Paper; submitted and presented evidence to the Health Select Committee and APPG on Primary Care & Public Health; and made direct representations to the Secretary of State for Health. In May 2011 ADPH were co-signatories to a letter to the Prime Minister highlighting continuing concerns that the proposed reforms would endanger the effective delivery of public health, undermine existing collaborative work and fragment the specialist public health workforce – already at risk due to management cuts in the NHS.

Following publication by government in July 2011 of *Update & Way Forward on Healthy Lives, Healthy People* we issued our ADPH Position Statement Reviewing the Strategy for Public Health in England.

The ADPH President was a member of the NHS Future Forum and we continue to be members of key national groups developing the new Public Health system in England.

## ADPH response to specific issues identified by the Committee

### 1. The introduction of a public health role for councils

The Health and Social Care Act represents a fundamental restructuring, not just of health care services, but also of local authority (LA) responsibilities in relation to public health, health improvement and health protection and the coordination of health and social care. ADPH supports the important role that local authorities have to play in improving the health of the public and have worked hard to help develop both the structures (national and local) and effective working relationships that are vital to success. We continue to be concerned for:

- safely managed transition arrangements which avoid the loss of vital expertise;
- the resolution of very complex resource issues;
- the resolution of key local health protection issues;
- ensuring that no action should be taken that threatens or undermines the good work that already takes place across the country on integrated health and social care delivery.

### 2. The adequacy of preparations for the new arrangements

In paragraph 7 below we highlight concerns over resilience in key health protection issues.

ADPH continues to have significant concerns that the loss of local public health capacity and capability will seriously risk the success of the new system. The results of an ADPH survey of DsPH in England (May 2012) show that 25% of substantive DsPH do not plan to transfer to LA. Overall, 30% of DsPH (including Acting and Interim) do not plan to transfer to LA. This represents a significant loss of local PH leadership and consequent risk to PH outcomes. Taken together with the current posts covered by interim arrangements these figures show that there could be 50-60



Association of Directors of Public Health (UK)
Box CC1320, Castle Court
Shire Hall, Cambridge CB3 0AP
● Tel. 01223 706116
● e-mail: president@adph.nhs.uk ● www.adph.org.uk

vacant DPH posts to be filled. This makes support to retain current DsPH and succession planning essential and urgent.

In August 2012 we issued an ADPH response on PH Funding highlighting key financial concerns for the new arrangements – including that:

- Final figures need to be published as soon as is practicable to enable planning for the final transfer of PH to LAs in April 2013.
- An interim statement would be helpful assuring a minimum level of funding over the next few years based on the higher of the published baseline and the newer figures sent to DH.
- Assurance that the final ACRA formula will be progressive and will continue the support to those areas with the greatest need.

The government has indicated its commitment to public health. Movement towards target should be acheived by levelling up to avoid loss of resource in those areas that have made planned investments in public health programmes over recent years. To get all Councils to target quickly requires an increase in the quantum allocated to PH nationally (further information on this is in section 8 below).

On Baselines, there remain issues around increases after 10/11 (e.g. new burdens – health checks etc.) and decreases before 10/11 due to QIPP savings applied across PCTs.

Worryingly, some areas have discovered significant errors in the collections including:

- miscoding of Sexual Health spend to NHSCB rather than Public Health;
- inability to disaggregate block contracts;
- inadequate determination of overheads;
- inability to identify costs for use of properties now transferring to PropCo.

There is also concern that the DH 5.8% growth (as published in Feb 2012) has been netted off in the more recent collections by some Finance Departments.

There is a perception in many Councils that the baseline amounts already published may not be reflected in the final allocations (despite DH assurances) or if they are then the guarantee will only be for one year after which there will be a reduction. This is resulting in some Councils looking to reduce programmes and staff before PH transfers.

ADPH is asking for as much explicit assurance from DH as possible that funding will not be cut in the short and medium term.

ADPH is also concerned that assumptions around staffing levels are being made in advance of clarity on what functions will be part of the PH service in LA. We have sought further clarification of roles and responsibilities particularly in Health Protection services.

We have welcomed the constructive approach the DH team have taken in working with ourselves and the LGA to address these issues.

## 3. The objectives of the new arrangements and how their impact can be measured

A stronger national framework for integrated care – ideally supported by a single outcomes framework – would support both achievement of objectives and measurement of impact.

Where services are not meeting local needs, the H&Wb Board should be able to challenge and hold to account, and take a broad and holistic view of determinants of health.

Demand and referrals for CCGs can be supported by specialist PH input, as ensuring CCGs are firmly embedded into the JSNA process will be important to ensure strategies have a focus on need and outcomes rather than demand. To support the quality of CCG commissioning we would suggest specifying in more detail the public health science skills (e.g. evidence base critical appraisal, predictive modelling, health economic approaches etc) that should be expected to be delivered by public health resources in order to ensure effective NHS management. This would support CCG commissioning by assisting them in moving to evidence based commissioning with better care pathways.

We believe commissioners should be required to demonstrate the use of a strategy covering high quality, universal services, targeted services for communities of interest at greater risk especially



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deprived communities and tailored services for people with multiple and complex needs. This should be underpinned by evidence base, public health intelligence and needs assessments.

ADPH welcomed the opportunity to work with DH on the development of *Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups*.

## 4. The intended role of Health and Wellbeing Boards in coordinating the NHS, social care and public health at the local level

ADPH contributed to a joint publication on *Operating Principles for Health & Wellbeing Boards* and the ADPH President and Vice President have both been involved in the national learning set programme that developed the framework for this document.

H&Wb Boards should not become 'talking shops', but be able to robustly hold to account stakeholders. Roles, responsibilities and membership need clear definition to ensure the Board is robust.

The Boards must deliver strong, credible and shared leadership across local organisational boundaries.

Potential political tensions between their overseeing commissioning and promoting integration across public health, local government, local NHS and the third sector need to be addressed. Capturing lessons and best practice from shadow Boards is vital in order to support local determination of arrangements that best meet the requirements of local conditions.

National policy imperatives must be:

- balanced sensitively with local priorities;

- developed through co-production and dialogue;

- in accordance with the agreed findings from the joint strategic needs analysis.

Where services are not meeting needs the Board should be able to challenge and hold to account.

## 5. How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, well-being, social care, housing and education

DsPH are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning. DsPH will require a well-resourced, professional and co-located Public Health team providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.

We welcome that the role of the DPH has been clarified within the recently published guidance and will be enshrined in statute.

Directors of Public Health will be key to achieving this as the local strategic leader for Health & Wellbeing. As a Chief Officer of the Local Authority, the DPH must have direct access to the Council, Cabinet, elected members and Board, and direct accountability to the head of the organisation (CEO, Mayor or equivalent).

Health & Wellbeing Strategies and JSNAs should:

- be asset-building, wide-ranging and thorough and include qualitative 'citizen' views (not just service-user or patient views);
- include preventative and health protection issues;
- be the basis for all local commissioning.

Primary care has a key role in delivering equitable services to local communities. There will be some areas where primary care expertise is of national and international quality: inequalities, homelessness, travellers, substance misuse, learning disability, multiple and complex needs, remote and rural care etc.



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Public Health Academics and the PH professionals working in LA and the NHS need to work together to ensure that research and expertise is available across NHS, primary care and LAs.

## 6. Barriers to integration, including issues in multi-tier areas

The public heath system at local level needs to have full access to health data through information sharing agreements at national level to ensure effective health needs assessment through primary care and social care data systems.

There needs to be clear agreement on the roles and responsibilities for DsPH and local health protection units, including assurance that health protection work carried out in second tier local authorities - by environmental protection teams for example - is connected with coordination and planning mechanisms organised at the top tier of local government.

In two tier authorities existing health and well-being partnerships should continue to work together. District Authorities should have specific roles and duties for the improvement and protection of health and the reduction of health inequalities.

PH professionals will be needed who have experience across all relevant organisations including NHS, PHE and LAs. This requirement means that training, continuing professional development and career pathways should be available without barriers such as changes of terms and conditions.

## 7. How the transfer to local authorities of the front-line health protection role and the creation of Public Health England will affect resilience arrangements at the local level

ADPH has been working with the HPA/PHE to develop solutions to key local health protection issues. However, concerns remain over significant health protection issues and systems, including: Infection Prevention & Control, and Out of Hours arrangements for health protection.

Capacity for emergency preparedness and response must be maintained within the new structures – and robust interim arrangements to ensure a stable transition.

There remains a risk that emergencies, outbreaks and epidemic situations, will not be properly managed or responded to, may quickly escalate, and the public will come to serious harm because clarity is still urgently needed over who, within the various local agencies involved, has lead responsibility for ensuring that the response to an emergency or outbreak is effective and appropriate.

Clarity is vital over which part of the system will lead responses to incidents at local and sub-national/supra local or regional levels. Clear delineation of responsibilities for health protection at local, sub-national and national levels, including the LA, the DPH, the NHS and the 15 centres of PHE is needed.

PHE needs clear leadership/coordination when PH emergencies cross local boundaries; and the relationship between local hubs of PHE and the DsPH need clarification.

LAs should ensure an effective response is made to any outbreak of disease or other public health emergency in its area. It is important to establish that this responsibility lies locally with the LA and on their behalf the DPH, who will need to have the necessary resources to do this effectively.

As acknowledged in the Health Protection and Local Government factsheet issued on 30.8.12 there are routine and local health protection issues in which the DPH needs to have a lead role, retaining local health protection and infection control resources where agreed, to manage in accordance with local needs.

Accountabilities and responsibilities need clarification and need testing locally to assure a safe and resilient system.

An effective working relationship between the DPH, Director of PHE local centre, NHSCB LAT and CCGs is critical to making the system work effectively. These components of the system are still coming into place – so there is a risk in the short term and rapid progress is needed to test new systems once key individuals are in place - and well ahead of April 2013.



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The data and info required to inform PH decisions must remain easily and rapidly accessible to PH staff working in local authorities, in PHE, in CCGs and other new locations. Arrangements for maintaining systems of surveillance and monitoring need to be secured and real-time data flows for detection of health protection threats and response need safeguarding.

It must be ensured that there are no organisational or financial barriers to the flow of information and there must be strong leadership and mechanisms at local (DPH) and national (PHE Executive) level – with PHE taking a lead to ensuring collection, analysis and dissemination of population level data.

PHE and the NHS will need to liaise closely with public health agencies in the devolved administrations to ensure that: cross border support remains robust in relation to UK health protection issues; and also to ensure that this scarce expertise is organised and delivered such that there is a critical mass to service the needs of the UK, Europe and beyond.

## 8. The accountability of Directors of Public Health; and the financial arrangements underpinning local authorities' responsibilities, including the ring-fencing of budgets and how the new regime can link with the operation of Community Budgets

We welcome that the role of the DPH has been clarified within the recently published guidance (and soon through statute), giving clarity on accountability and maintaining professional standards – important issues for protection of the public.

The Director of Public Health is the local strategic leader for Health & Wellbeing, is a statutory member of the H&WB Board, and must be an individual trained, accredited, and registered in specialist public health. As a Chief Officer of the Local Authority, the DPH must have direct access to the Council, Cabinet, elected members and Board, and direct accountability to the head of the organisation (CEO, Mayor or equivalent).

The DPH must have day to day responsibility for management of the ring-fenced PH grant.

As the principal advisor to a Health & Well Being Board, a DPH should not relate to more than one Board. However, we recognise that where local arrangements lead to a shared Board, then it may be appropriate for one DPH to work to this Board. We are aware that shared DPH arrangements are being established in some areas and in such instances would stress the need for LAs to ensure that such a shared arrangement is safe and effective.

DsPH must be able to produce a robust and truly independent annual report on the current health and future health needs of their population (and how well they are being met). We welcome recent clarification of these statutory duties – with the DPH required to produce and Council required to publish the annual report.

DsPH (and all consultant level posts) must be jointly appointed by the LA and PHE through a statutory appointments process (or equivalent consistent with FPH standards), with the SofS for Health having a veto over the termination of employment of the DPH.

Directors of Public Health and other specialists working in health services public health possess skills that are highly specialised, including ethical and evidence based skills to enable robust decision making on prioritisation, rationing and clinical/cost-effectiveness. Expert professional public health support to CCGs is required for effective prioritisation and disinvestment decisions.

ADPH has recently produced a paper *'The Case for Additional Investment in Public Health'* setting out the evidence that there is a health need that warrants additional investment, and that this can be invested in cost-effective, evidence based interventions to deliver improved population health and reduced demand on health care services whilst facilitating more efficient healthcare service delivery.

- An additional £1.2 billion pounds investment in public health programmes in 13/14, increasing to £1.5 billion pounds in 15/16, would ensure delivery of the government's aspiration to improve health through its existing commitments to roll out the NHS Health Checks programme, reduce smoking prevalence, implement NICE recommendations in relation to alcohol brief interventions, meet cost pressures particularly in relation to GUM provision, build capacity in relation to school nursing and to tackle obesity.



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- As well as delivering improved health outcomes for individuals a major beneficiary will be the NHS, with more cost efficient care delivery and a reduced burden of ill health.
- It would also allow local communities to embrace the public health agenda unfettered by inequity resulting from historical under-investment by the NHS in preventative services, whilst not reducing the allocation for those who have invested more in effective public health programmes.
- This amount whilst being significant for public health would have a marginal effect on the overall comprehensive health service budget (a 1% shift in the comprehensive health service budget to Public Health equates to £1 billion). It would also represent a reasonable proportion of the QIPP savings that we understand are to be re-invested in front-line services including public health programmes.
- Much of the investment would be used to develop and increase provision within programmes that are already established such as NHS Health Checks, tobacco control and GUM provision and therefore money can be committed immediately.
- There are however a number of areas of investment (school nursing, primary care, public health, leadership and community empowerment) where there will be a constraint on commitment of resources because of shortage of staff. In these areas capacity can be developed over a three year period in a similar way to that being undertaken currently with health visiting.
- In the case of alcohol misuse there is an increased level of investment in year 1 but as an increasing number of people are screened and receive a brief intervention there is a reduction in spend in future years.

In a (May 2012) survey of ADPH members in England, 77 Directors of Public Health (52% of total surveyed) responded giving their views on specific issues relating to transition issues including concerns around current and future resources. We asked those DsPH who felt the funding was insufficient what programmes might be affected. The answers were predictably varied with: Sexual Health; Health Checks; Chlamydia Screening; obesity prevention (weight management; physical activity; diet); alcohol services; smoking cessation; mentioned several times each. Also mentioned several times were leadership capacity and indeed all non-mandated service. These are real concerns and high risk to local Public Health.

**Conclusions**

In summary, ADPH believes that:

- the DPH leadership role is critical to the success of the new PH system;
- a smooth transition is essential to enable LAs to pick up their new role and responsibilities quickly and to capitalise on the opportunities afforded by their new PH role and responsibilities;
- elements that are key to achieving a smooth transition are: clarifying outstanding PH financial issues and addressing the case for additional investment in PH; supporting staff through change to avoid further loss of capacity; ensuring all key components of the new system are in place so that new and effective working relationships can be forged quickly and systems tested and assured;
- going forward, there needs to be assurance that the PH profession is appropriately trained and developed; and that succession planning is addressed.

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**October 2012**



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